STATE OF CALIFORNIA

DEPARTMENT OF MANAGED HEALTH CARE

FINANCIAL SOLVENCY STANDARDS BOARD (FSSB) MEETING

THE DEPARTMENT OF MANAGED HEALTH CARE

PARK TOWER, 980 9th STREET

CONFERENCE ROOM, 2nd FLOOR

SACRAMENTO, CALIFORNIA

WEDNESDAY, FEBRUARY 5, 2020

10:00 A.M.

Reported by: Ramona Cota

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APPEARANCES

BOARD MEMBERS

John Grgurina, Jr., Chair

Larry deGhetaldi, MD

Paul Durr

Jen Flory

Theodore Mazer, MD

Jeff Rideout, MD

Shelley Rouillard

Amy Yao

DMHC STAFF

Pritika Dutt, Deputy Director, Office of Financial Review

Sara Ortiz, Associate Governmental Program Analyst

Sarah Ream, Acting General Counsel

Mary Watanabe, Acting Chief Deputy Director

Michelle Yamanaka, Supervising Examiner, Office of Financial Review

ALSO PRESENTING/COMMENTING

Jacey Cooper, State Medicaid Director and Chief Deputy Director of Health Care Programs
Department of Health Care Services

Anthony Wright
Health Access California

Jeff Album
Delta Dental

Diana Douglas
Health Access California

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PROCEEDINGS

10:00 a.m.

CHAIR GRGURINA: Let's start with some housekeeping notes. Please make sure to silence your cell phones.

For those who are going to be presenting at the podium, if you could leave your business card or write down your name and title down and leave it with our transcriber.

For our Board Members, remember to click the little microphone. It will be green when you are on, red when you are off.

And then finally, the restrooms are located on this floor. They are around the back and they are locked. There are keys in a dish in the back of the room. The women's restroom, turn the key to the right, the men's to the left. The men, you have to walk across a catwalk. Please don't throw any food down to the animals below (laughter). And just for the record-keeping and the transcript, this is what was given to me, I did not test the keys on the women's restroom (laughter).

Why don't we go ahead and move forward. Let's have the Board Members introduce themselves and then Shelley is going to introduce our newest Board Member. We'll start with Amy.

MEMBER YAO: Hi. Amy Yao, Chief Actuary from Blue Shield.

MEMBER DEGHETALDI: Larry deGhetaldi, family physician, Palo Alto Medical Foundation.

MEMBER RIDEOUT: Jeff Rideout, CEO of the Integrated Healthcare Association.

CHAIR GRGURINA: John Grgurina, CEO of the San Francisco

Health Plan.

MEMBER ROUILLARD: Shelley Rouillard, DMHC Director.

MEMBER FLORY: Jen Flory, Policy Advocate at Western Center on Law and Poverty.

MEMBER DURR: Paul Durr, CEO, Sharp Community Medical Group.

MEMBER MAZER: Ted Mazer, independent physician, San Diego.

MEMBER ROUILLARD: So welcome, Dr. Mazer, really thrilled to have you join the Board today. I have a short bio, I am going to tell our audience who you are.

You are an otolaryngologist-head and neck surgeon in private practice in San Diego since 1988. He cares for a large Medi-Cal population along with Medicare and commercial PPO and HMO patients. Ted served as President of the CMA from 2017 to '18 and has been on the CMA Board of Trustees for 17 years.

He has also served as President of the San Diego County Medical Society, President of the Pacific Foundation for Medical Care, Chief of Staff at Alvarado Hospital, a member of the Anthem National Physicians Advisory Commission, and on the boards and management of several IPAs, including as a current director of a messenger model IPA throughout San Diego County. I would also note that he was also a participant in the soft launch of the Symphony Provider Director and there is a video of him describing his experience with that (laughter), so check it out.

Ted practices full-time while also being an active advocate for access to care locally and nationally, including as an intervenor in a US Supreme

Court case involving Medi-Cal. I'm interested to know more about that. He is also a frequent media spokesperson on medical access, insurance and financing issues. He has been a licensed California physician since completing his residency at Baylor College of Medicine in 1988.

So please join me in welcoming Dr. Mazer to the FSSB (applause). All right, great.

CHAIR GRGURINA: Okay. Well next up we have the transcript from the meeting from November 7. And you will note that what the Department has done for us is they have given us a summary identifying each of the areas and the pages in the 90 page transcript. So if you have a particular interest you want to see it makes it easier to find, in addition to the very lengthy transcript.

Do I have any comments from the Board Members, changes, edits to the transcript? Which is kind of difficult because we actually said those things (laughter). If not, do I have a motion to move the transcript forward?

MEMBER DURR: I'll make a motion to approve.

MEMBER DEGHETALDI: Motion to move.

MEMBER DURR: Second.

MEMBER YAO: Second.

CHAIR GRGURINA: Great. All those in favor?

(Ayes.)

CHAIR GRGURINA: Opposed?

(No response.)

CHAIR GRGURINA: All right, the motion carries, thank you.

All right, we will move on to the Director's remarks.

MEMBER ROUILLARD: Okay, great, thanks, John. I've got a few

updates for you. Some of this you may already know.

On January 10th the Governor released his 2020-2021 proposed budget. The total budget is $222.2 billion, of which $153.1 billion is general fund. It includes reserves of $21 billion to withstand a downturn in the economy and to address emergencies and disasters.

Some of the health-related programs and initiatives include expanding Medi-Cal to cover low-income adults 65 and older regardless of immigration status, proposing an Office of Health Care Affordability, with a proposal to be submitted in the spring. The goal of the office is to increase price and quality transparency, develop specific strategies and cost targets by health care sector, industry sector, and impose financial consequences for entities that fail to meet the targets.

There are proposals to continue working to reduce prescription drug costs through three new proposals. One is expanding Department of Health Care Services' authority to consider the best prices offered by manufacturers internationally when negotiating for state supplemental rebates, leveraging Medi-Cal's purchasing power to negotiate supplemental rebates for target populations outside Medi-Cal and expanding partnerships with local pharmaceutical purchasers to participate in the state's pharmaceutical purchasing program. In the spring the Administration will propose two additional initiatives related to prescription drug costs, establishing a single market for drug pricing within the state and establishing the state's own generic drug label.

In the area of behavioral health, which is another high priority area for the Governor, the budget seeks to improve outcomes for the state's behavioral health system by establishing a behavioral health task force to

improve quality of care and coordinate system transformation efforts to better prevent and respond to the impacts of mental health and substance use disorders. And also strengthening enforcement of mental health parity laws and to focus on timely access to treatment, network adequacy, benefit design and plan policies.

With respect to Medi-Cal I'll defer to Jaycee Cooper who will be here in a little bit to explain some of the proposals of DHCS's budget. I will just mention that the budget did assume federal approval of the Managed Care Organization tax that was authorized last year; and some of you may know that last week the Trump administration rejected the MCO tax proposal. However, this won't impact the 2021 budget because the state did not plan to receive in the budget, it was not going to start accruing until the following year.

The Department continues to review mergers, proposed mergers. We did approve the Anthem/Beacon merger on December 12th. Beacon Health Options is licensed to provided employee assistance program services statewide. The Department's review of the purchase determined it was not a major transaction as defined by Health and Safety Code Section 1399.65, which was enacted in AB 595 by Assembly Member Wood in 2018, and therefore no public meeting was required.

We also are reviewing right now the purchase of Epic Management LP by Optum through one of its subsidiaries. Epic Management LP is an MSO which owns Epic Health Plan, a licensed, restricted full service plan with commercial, Cal MediConnect and Medicare lines of business. Epic Health Plan has about 72,700 enrollees and serves four Southern California counties. In addition, Beaver Medical Group is an RBO with approximately 130,000 members

and they own a limited partnership interest in Epic Management.

The proposal is for Optum to acquire 100 percent of Epic Management from the Beaver Medical Group and the plan's other owners. The material modification was filed on December 23rd and is currently under review by the Office of Plan Licensing.

Moving on to the Pharmacy Benefit Management Reporting Task Force. I have mentioned this at prior meetings, that last year's AB 315 by Assembly Member Wood required the Department to convene a task force on PBM Reporting, which we did in July. The task force has completed its work and the DMHC is presently working on the report to the Legislature.

The task force was charged with recommending what information, if any, related to pharmaceutical costs, health care service plans or their contracted pharmacy benefit managers should report to the Department. I really want to express my appreciation to the task force members for sharing their expertise with us and to the stakeholders that participated in all of the task force meetings. I also want to give a special thanks to Yolanda Richardson for working with us on this project; and you may know that she was recently appointed to be the Secretary of the Government Operations Agency by Governor Newsom.

Continuing on with prescription drug costs: We released our *Prescription Drug Cost Transparency Report for Measurement Year 2018* on January 10th. The Department considered the total volume of prescription drugs covered by health plans and the total cost paid by health plans for those drugs. Additionally, we analyzed how the 25 most frequently prescribed drugs, the 25 most costly drugs, and the 25 drugs with the highest year-over-year increase i total annual spending impacted health plan premiums.

Some of the key findings include health plans paid nearly $9.1 billion for prescription drugs in 2018. That's an increase of about $400 million for 2017.

Prescription drugs accounted for 12.7 percent of total health plan premiums in 2018.

Health plans' prescription drug costs increased by 4.7 percent in 2018, whereas medical expenses increased by 2.7 percent. Overall, total health plan premiums increased 6.2 percent from 2017 to 2018.

Manufacturer drug rebates were approximately $1.058 billion, up from $922 million in 2017. This represents about 11.7 percent of the $9.1 billion that was spent on prescription drugs in 2018.

While specialty drugs accounted for only 1.6 percent of all prescription drugs dispensed, they accounted for 52.6 percent of total annual spending on prescriptions.

Generic drugs accounted for 87 percent of all prescribed drugs but only 22.4 percent o the total spending on prescription drugs.

So we will be holding a public meeting in San Francisco on March 5th where we will present information on large group rate increases and our findings from the large group filings related to prescription drug costs. You are welcome to attend.

The *Timely Access Report for Measurement Year 2018* was also released in January. The report is based on the results of surveys of contracted providers conducted by the health plans to determine whether the providers at the time of the survey had an appointment available within the timely access standards. The timely access regulation requires health plans to ensure that

each of its provider networks has the capacity to offer enrollees appointments within the established timely access standards.

So key findings for full service health plans:

The percentage of all surveyed providers who had appointments available within the wait time standards, and that includes urgent and non-urgent appointments, ranged from a high of 89 percent to a lot of 67 percent.

For non-urgent appointments the range is 94 percent to 71 percent.

And for urgent appointments the percentage of all surveyed providers who had appointments available within the time standards ranged from 83 percent to 57 percent.

For behavioral health plans:

For all appointments that ranged from 80 percent to 73 percent.

Non-urgent behavioral health plan appointments ranged from 90 percent to 82 percent.

And for urgent appointments the percentage of all surveyed providers ranged from 70 percent to a low of 64 percent that they had appointments available within the wait time standards.

As many of you know we are in the process of finalizing a regulation to establish a rate of compliance that we will be enforcing and we expect to send that to the Office of Administrative Law later this month.

Okay. Shortly after the Governor signed AB 290 to limit the reimbursement financially interested third-parties may receive from health plans, the American Kidney Fund filed suit challenging the law saying it would violate the AKF's federal operations guidelines and consumer privacy. During the legislative process the American Kidney Fund had threatened to cease

operations in California on December 31st if the bill was enacted. The American Kidney Fund pays private health care premiums for approximately 3,700 individuals who have kidney disease and require dialysis treatment.

On December 30th a federal judge granted a preliminary injunction to block the statute from going into effect on January 1st. The injunction prevents AB 290 from taking effect until the lawsuit is decided. So the state is vigorously defending AB 290. And with the preliminary injunction the American Kidney Fund has stated it will continue to provide premium assistance to dialysis and transplant patients including opening the program to new applicants.

Last but not least, the work groups for Health Net's encounter data initiative have been meeting monthly since October to develop a solution or solutions to the industry-wide problems related to accuracy, completeness and timeliness of encounter data. So the work groups will wrap up this month and a final summit is planned for March 30th in Sacramento.

And that concludes my report.

CHAIR GRGURINA: Okay. Any comments, questions from the Board Members?

MEMBER DEGHETALDI: Yes, Shelley. In the scope of pharmaceutical inflation are infusion drugs in scope? Because I think Paul, we have commented on probably the greatest explosion in expenses on the pharmaceutical side are infusion drugs. I hope we keep that in mind. Wonderful drugs, wonderful results for patients but amazingly costly.

MEMBER ROUILLARD: And they are not included in the report, the SB 17 report. This is just -- it reflects the health plan costs for retail and mail order, not drugs administered in a physician's office.

MEMBER YAO: Hi, Shelley, I have a question around the HealthNet encounter task force.

MEMBER ROUILLARD: Yes, Amy.

MEMBER YAO: After March will there be a phase 2? what is the next step?

MEMBER ROUILLARD: Well that is one of the things that the March 30th summit will determine. It is bringing together all of the participants and other folks who have been working on this to decide what direction to go in from here. So HealthNet will be continuing to lead that effort since they still have a fair amount of funds left from the undertaking.

MEMBER RIDEOUT: Just a comment not a question on the encounter data. I am on the governance work group; it has been a very good process. We are getting through a lot of, I think, important industry-wide issues pretty rapidly.

MEMBER ROUILLARD: I agree, yes. And I have been serving on the governance work force, the work group too.

MEMBER MAZER: Going back to the PBMs. I understand at this point the law only requires the reporting. Is there any indication of what we are going to be able to do with the data in order to drive a -- at least curtailment of the growth of the drug costs?

MEMBER ROUILLARD: So right now, as you said, PBMs have to register with the Department. They are not required to report anything right now. The charge of the task force is really to identify what data elements we should require the plans or the PBMs to report to us. So once that report is out it will have the task force recommendations. Then it will be up to the Legislature to

decide what they want to do from here. And I know Assembly Member Wood is very interested in pursuing that.

MEMBER MAZER: Thank you.

MEMBER ROUILLARD: Yes.

MEMBER DURR: To Larry's point, can the scope of that be expanded to include the drugs that are in the --

MEMBER ROUILLARD: It would require the Legislature to expand that, yes. It could be but there is a process.

CHAIR GRGURINA: Okay. There's no other questions, thank you, Shelley.

MEMBER ROUILLARD: Sure.

CHAIR GRGURINA: Next up and great timing. I see Jaycee just walked in a moment ago so Department of Health Care Services Update. Jaycee Cooper, the new Chief Deputy Director and State Medicaid Director. Congratulations, Jaycee.

MEMBER ROUILLARD: Congratulations.

MS. COOPER: Thank you, thank you. Good morning.

I am going to give a budget update for all of you today in regards to Medi-Cal. One thing I would just note for everyone is DHCS always posts a budget highlights document on our web page. We also link to Agency's overall kind of budget highlights, just if you have additional information or want more information other than the high points that I will touch today.

In fiscal year 2021 the Governor's budget reflects a $107.4 billion budget of which $1 billion of that is state operations. That is currently what we were projecting. I think there are some major components of the budget that I'll

walk through and then open up for questions.

As you have probably heard there was a very large, unprecedented commitment of general fund from the administration in our proposed budget regarding Medi-Cal Healthier California for All. So I had the opportunity to come and speak with you a few months ago regarding that opportunity. In the budget it reflects half-year dollars, so a $695 million general fund commitment of those dollars, of that which for an annual basis would be $1.4 billion to invest in the Medi-Cal Healthier California for All initiatives that we are moving forward.

The main components which were outlined in that budget were the enhanced care management, so $450 million for enhanced care management for the target populations that have been identified.

Additionally, $115 million for the in lieu of services, the 13 various in lieu of services that are comprised of various housing bundles and home and community-based service type initiatives in that budget. Just to earmark and clarify for that one, that is to continue existing services over. And then as we build up infrastructure within in lieu of services that would be built into the rate structure moving forward within the managed care plans.

There additionally was $600 million for incentive payments. That is a 2.5 year budget item. And really that is to use incentive dollars through our managed care plans, which would go down to downstream providers to build out the in lieu of services statewide. So we know that there are gaps in the state in regards to housing infrastructure, coordination services and the home- and community-based services that have been earmarked for the in lieu of services. The idea behind those incentives is to close gaps statewide where we don't have recuperative care beds or access to those types of services over that 2.5 years,

ultimately moving to the services side of that.

There is also $225 million of Dental Transformation Initiative. So we currently in our 1115 have the Dental Transformation Initiative, we plan on transitioning that into statewide programs. There are four programs that are listed specifically. So there are two new benefits, which is the silver diamine fluoride being added for zero-to-six skilled nursing facility as well as our developmental disability population; you also have the payment of the caries risk assessment, which was also seen in the Dental Transformation Initiative. And two proposed Pay-for-Performance Initiative, one is for preventive services on dental, both adults and children, and then the other is a dental home, paying for continuity of care within a dental home. So those are the four kind of dental initiatives which comprise the $225 million in the budget on that side.

You will also see that given CalAIM is focused - Medi-Cal Healthier California for All, I'm still training myself - focuses on broad base, not just within our managed care side but also our behavioral health side. There was $25 million in '20-21 and $22 million in '21-22 that would be going to our county partners to update their systems to be prepared for behavioral health payment reform as well as some of the medical necessity changes that we are hoping to make on the behavioral health side. And it really has to do with making sure that our systems are capable of those changes, that they are ready, that there are processes put in place at the delivery system in order to be ready for those changes, some of which go live January 1, 2021 and some that come after that time period. So there was a commitment there in regards to that, it is called the Behavioral Health Quality Improvement Program.

The other piece that you will see in the budget in that we have

expanded full scope Medi-Cal to undocumented children previously up to age 25, and you will see in the budget the proposed to expand eligibility for full-scope beneficiaries age 25 and older. Of that -- on full implementation it would be $320 million ongoing and that is inclusive of both DHCS and IHSS costs, and this is proposed no sooner than January 1, 2021, currently in the budget.

You will also see updated savings for the Medi-Cal Rx Initiative. So the Governor released an executive order that would require we carve pharmacy services out of our managed care plan contracts and move that to the fee-for-service when billed on a pharmacy claim. We have updated our fiscal analysis for that and it is reflected in the budget. Out-year projections are still close to $400 million in savings, which you will see reflected in this year's budget as $178 million savings.

The other thing I would point out is the Department is proposing to implement trailer bill in a number of areas. Our trailer bill has been posted and is available for review. Where we would remove the six Rx limit that currently exists in fee-for-service as well as removing the $1 co-pay for pharmacy services is currently being proposed.

Through that process we also heard from a large number of our FQHC clinics in regards to that policy change and the impact it could have on them and so the Department worked closely with our FQHC partners to gather information and data. We have proposed a supplemental payment pool for non-hospital 340B clinics equal to $105 million in which we would work with them to distribute those funds once Medi-Cal Rx goes live, which is estimated for January 1, 2021. I would just point out that is currently focused just on the non-hospital FQHC clinics.

There are two other pharmacy proposals within the budget, one is around trailer bill for Medi-Cal best price. Really just updating language to allow us to leverage as much as possible our negotiations on rebates within the state. And the next one is rebates for non-Medi-Cal drug purchases. There is federal guidance that allows you to expand certain rebate programs to non-Medi-Cal populations within certain parameters and guidelines. So the state does want to look at that and evaluate if we could be maximizing our rebates on the pharmacy side for non-Medi-Cal populations. The easy ones to think about are state-only programs but there are others that we are going to be engaging with and having those conversations.

You will also see within the budget that we are proposing to transition dental managed care, which currently only resides in both Sacramento and in San Diego, to be fee-for-service statewide. Sorry, it's Los Angeles. Los Angeles has both fee-for-service and managed care and Sacramento is completely managed care, and so we will be, our proposal is, by January 1, 2021, statewide dental fee-for-service on that part.

You will also see that we are moving forward with our nursing facility financing reform. There will be future trailer bill on this to share. Really the idea behind it is moving to a value-based payment methodology or a reimbursement methodology and framework where we are really focused on quality and ensuring that quality is embedded into the payment structure methodology moving forward. And that would expire December 31st, 2024. The current fees are set to expire in August of 2020, just for time periods.

You will also see that we are proposing that Medi-Cal implement the MAT benefit changes required by federal law that would require any MAT

services be available to Medi-Cal beneficiaries as long as it is available to the market. And so we will be submitting a state plan amendment to that effect to ensure that we have full access to all MAT services across the state of California.

You will also see that we have in our budget a non-Medi-Cal hearing aid coverage program for children. This program is for children under the age of 18 who are at or below 600 percent of the federal poverty limit and it really is looking to if they are under-insured or their insurance does not cover hearing aid services, that we would provide that. That is estimated to go live July 1 of 2021 and the budget currently reflects a $10 million general fund contribution.

So I will pause there and see if there are any questions.

MEMBER RIDEOUT: Jacey, first of all, congratulations.

MS. COOPER: Thank you.

MEMBER RIDEOUT: A question on the housing, in lieu of services housing. The simple question, are the local MCOs always the decision point for that? And second question, is there any connection between the counties that participate in the 1115 whole person care waiver in terms of how that program will roll out eventually?

MS. COOPER: So the way that we get the authority for the in lieu of services is through federal authority under 438 where it does have to go through our managed care plans for that. You do have to be a risk-bearing entity in order for us to add in lieu of services to your contract, which is why it is not allowed to go through both our mental health side or SUD side.

And so it will be a contract with our managed care plan. We would

list the in lieu of services, it would be their responsibility to contract with entities to provide those services, including the housing services. We are working with them now to come through a transition plan where we would hope, and in fact may be and are considering mandating that the managed care plan work with the existing whole person care entities to successfully transition over any infrastructure that was built within those areas as long as they are providing quality care and they can meet all of the requirements, of course, and that they want to and are willing to provide those services.

We are also encouraging the managed care plans to start conversations with counties because a lot of them are the housing experts within the state, statewide. So there will be a lot of conversations to be had in regards to how we get those in lieu of services up and running. We would imagine that there will be a large group that would go live January 1, 2021, and then through various negotiations to build their network some could come after that as well, it's not like if you are not in on that day you can't go live. And so we imagine that it would be.

So yes, we hope that they work that they work with the counties, we hope that they work with the whole person care entities who have been doing some of this today and then other experts within that field to make sure that they aren't just doing it themselves but working with people who have done this for quite some time.

CHAIR GRGURINA: Ted.

MEMBER MAZER: Jacey, thanks for the report, it's a lot of information in a very succinct amount of time. Curious on the dental managed care. So you had two areas of dental managed care and now you are saying

going fee-for-service statewide. Can you give us a reason why that happened, what was the failure?

MS. COOPER: Yes. We have been evaluating the effectiveness of our dental managed care for quite some time and we have seen historically and over time, even though corrective action plan efforts by the Department an under-utilization of services, including in our preventive, other than what we are seeing in fee-for-service. Given that we are seeing more success on the fee-for-service side with the dental we are proposing to transition to that at this time.

MEMBER MAZER: Are there lessons to be learned in the medical side of managed care?

MS. COOPER: Tell me more in regards to what you're saying.

MEMBER MAZER: The failures on the dental side as far as utilization, as far as coverage. Is there anything to be learned to transfer that into the medical side of Medi-Cal?

MS. COOPER: Well it won't be going into the -- it will be on the -- it will still be managed through our dental FI on the fee-for-service side. I think one of the things that we are just seeing is there is just lower penetration, there's more barriers. For some reason you're getting services but not preventive services at the same time visits are taking place, and so we are not seeing that on the fee-for-service side. I don't know if we necessarily have lessons learned but really just wanting to invest in the delivery system that seemed to be more effective at this time.

MEMBER MAZER: Thanks.

CHAIR GRGURINA: Jen.

MEMBER FLORY: I understand you just got news of the MCO tax

recently.

MS. COOPER: Yes.

MEMBER FLORY: And that there are unfriendly pending proposed regulations. But have there been thoughts of pushing back on that denial or anything that could be done there?

MS. COOPER: Sure. Yes, the Department last week did receive a denial of our MCO tax methodology by CMS. We have had a conversation with CMS and we are currently looking internally in regards to what are our options and we will engage people once we have more information on that. There's a number of options that we need to consider and so we are looking at that now.

MEMBER RIDEOUT: On the care management for CalAIM.

MS. COOPER: Yes.

MEMBER RIDEOUT: I know that's not the right name but it's easier.

MS. COOPER: It's okay, I know what you're talking about (laughter).

MEMBER RIDEOUT: Is there any intention at DHCS to create a standardized benchmarking process and predictive model to see how the MCOs are actually implementing those objectives?

MS. COOPER: We are having a lot of conversations in regards to evaluation of the effectiveness of it so we haven't put a proposal out yet. We do want to make sure, though, that we are monitoring it closely after it rolls out, we wanted to make sure it is meeting the intention. So we already cover complex case management today in our managed care plan contracts. We really want to make sure this is above and beyond what that is. It is really about going out of

the four walls into people's homes, into the community, and we want to make sure that we are watching it closely to make sure it is being effective, we are targeting the right people and that we are seeing improvements. So we will be having a monitoring and evaluation plan, we just don't have it yet, to make sure that we are evaluating the success of that program.

MEMBER DEGHETALDI: With the new name of CalAIM are we staying with the January 1st, 2023 duals proposal?

MS. COOPER: Yes.

MEMBER DEGHETALDI: Is that still the scope?

MS. COOPER: That has not changed at this time. Just to be clear, are you referring to -- so there's two things that happen January 1, 2023. There's the mandatory managed care for dual populations.

MEMBER DEGHETALDI: Correct.

MS. COOPER: That would go live January 1, 2023 with the exception of restricted scope or share of costs would stay in fee-for-service. And then there is also the DSNP mandate for all managed care plans to have a DSNP up and running as we close out CCI and those are still currently the dates that we have at this time.

I would say that on February 24th, I believe is the date, we will be having a stakeholder work group around long-term care transitions, LTSS and the DSNP policy to get feedback from people.

MEMBER DEGHETALDI: When you spoke last I was really glowing about CalAIM, I thought it was -- it's just a wonderful vision. This is kind of an anecdote. We have an infectious disease doc in our group who in her training saw two severe endocarditis cases in two years at NYU, which is near

Harlem in Manhattan. She is seeing one a week now. And these are all Medi-Cal patients. These are patients who, you know, with homelessness, substance abuse, dental disease, are -- they are million dollar expenditures per year when this happens.

So this is the reason why we need a holistic view of these patients because each one of those patients would be 3,000 children that we could cover, you know. So we have to get ahead of the hot spots. So everything we can do to address that is, it's essential. I know you are seeing them in San Francisco. These are tragic medical cases that could have been avoided. And they will cost one to two million dollars and the recidivism is very, very high. It's just tragic stories.

CHAIR GRGURINA: A question, Jaycee. I know you talked about the 340B and you had mentioned the $105 million set-aside. Was that general fund or total funds?

MS. COOPER: We will draw down federal funds. I don't have the split with me so it's some portion, it's probably 50/50 at this point since we don't know how we will do the supplemental payment pool.

CHAIR GRGURINA: I'm sorry to do this to you but can you just walk us through the process of how this is going to be decided. Obviously it has to be approved.

MS. COOPER: The supplemental payment pool?

CHAIR GRGURINA: Yes.

MS. COOPER: Sure.

CHAIR GRGURINA: For the 340B entities for the non-hospital.

MS. COOPER: So it will -- the biggest thing is we'll have -- so it's

only for non-hospital FQHCs. So we will need to make sure that is clear in regards to who is in that pool. And then the one thing we also have tried to make clear to people, we requested data requests in order to get to the $105 million that we are at. But that doesn't preclude that it would only go to those who submitted data, it would be for anyone in that pool. At this point we are trying to keep the supplemental payment pool clean. It will be on the fee-for-service side, just to be clear there, and it most likely would be driven by number of prescription, is what we're thinking. So we are having conversations and we will have future information in regards to how we will develop the supplemental payment pool.

We are also trying to figure out how we can get money out sooner than later but there are rules that we have to follow within CMS and so we will be looking at that guidance as well.

CHAIR GRGURINA: Thank you.

Any other questions from the Board Members?

MEMBER DEGHETALDI: Just linking back to our comment on infusion drugs. The opportunities for FQHCs should they have infusion centers to access 340B funding to care for Medi-Cal beneficiaries. Because that is a huge need for so many of us who care for Medi-Cal patients who need these amazingly expensive drugs. If you don't have 340B status it is incredibly challenging to provide that care.

MS. COOPER: And just to be clear, we are not changing anything in regards to FQHC policy and if the individual is going to be a 340B entity with our proposal, it is just a matter of the payment methodology tied to 340B.

CHAIR GRGURINA: Okay, are there any questions from members

of the audience?

If not, questions or comments from members on the phone?

THE OPERATOR: No questions on the phone lines.

CHAIR GRGURINA: She said no?

MEMBER ROUILLARD: It was kind of low.

CHAIR GRGURINA: I am being told she said "no" on the phone, I did not hear that. (Laughter.)

All right. Well, Jaycee, thank you very much.

MS. COOPER: Of course.

CHAIR GRGURINA: Congratulations and we look forward to seeing you again.

Okay, next up is the regulations update, so Sarah.

MS. REAM: Good morning. I am Sarah Ream, the Acting General Counsel with the Department of Managed Health Care. So I am going to be talking about the regulations that the Department has in the hopper currently and what we are planning to do this year.

Just to recap, our achievements from last year with regard to regulations. We promulgated four regs. The General Licensure or what we call the risk reg, that one took effect in July. We promulgated the Standard Prescription Drug Formulary Template regulation; a regulation clarifying requirements regarding Cancellations, Rescissions and Nonrenewals; and we updated the RBO Financial Solvency Standards. Those three regulations took effect in October. So we did four regs.

This year we are going to be much more ambitious. We were ambitious last year, we are going to be a lot more ambitious. We plan to

promulgate or get at least ten regulations into the formal rulemaking process, so I am going to go through the laundry list of those.

The first, which our Director already mentioned, is the timely access to care regulation. So the Legislature requires the DMHC to develop a standardized methodology regarding how health plans report their compliance with timely access to care requirements. The DMHC has worked closely with stakeholders on developing this methodology and the regulation will codify the methodology and clarify how plans report this information to us. The regulation also sets a rate of compliance the plans must meet to be considered compliant with the timely access standards. We have shared a draft of this regulation with stakeholders this past fall and received their input, which was very helpful. We expect to start the formal rulemaking process, meaning we expect to submit -- put the regulation out there for the formal comment and comment review period starting within a month, so we are moving, we are moving ahead quickly on that one.

The second regulation we plan to work on is to make some tweaks to the general licensure risk reg that we promulgated earlier last summer. Since we promulgated that regulation we have had access to information we did not previously have access to, specifically the variations in contracting between hospitals, provider groups, health plans and others. We have a view into this through the health plans, but if there are contracts between providers and hospitals in which a plan is not a party we don't have a good window into seeing those arrangements. So this risk regulation has allowed us to sort of open that door and see what's going on.

Based on that information, though, we realized we may need to

tweak this regulation to make sure we are not sweeping in arrangements that involve minimal risk or that really do not pose a harm to consumers or to the stability of the health care system. We also want to make sure that value-based payments, which have been shown to increase quality, lower costs, are not deterred. That is certainly not a goal with this regulation, it's quite the opposite. We want to encourage those types of arrangements, encourage quality care and cost savings.

And then finally, we want to make sure that entities that do need an exemption because they are taking on global risk in such a way that we need to look at that, but we want to make sure that filing for an exemption is easy, is not burdensome. So we are looking at the contracts we have received, having many conversations with stakeholders. And we anticipate sharing a draft regulation hopefully with stakeholders by mid to late spring and starting the formal rulemaking process in August. So that has been a very interesting process, to learn all these things we didn't know before.

Switching gears, large group rate review. So we have two regulations in process on this topic. The first is to implement AB 731, which was passed last year. AB 731 establishes rate review processes for plans in the large group market. Plans must begin submitting their rate filings as of July 1st. The bill also requires the DMHC to hold an every-other-year public meeting to discuss large group aggregate rates. AB 731 also allows certain larger group contract holders to ask the DMHC to review proposed rate changes. While AB 731 doesn't require the DMHC to promulgate a regulation a regulation is likely necessary to effectuate the purposes of that bill. So we are in the preliminary stages of developing the regulation and hope to start the rulemaking process this

summer.

The second large group rate reg relates to SB 546, which was passed back in 2015. As I know all of you know, SB 546 requires plans to annually file their weighted average rate increases for all group benefit designs. It also requires the DMHC to hold an annual review -- an annual meeting, excuse me, to discuss those rate changes. The DMHC previously gave guidance to plans via a Director's letter and we are now working on a reg to codify that guidance and to add additional information regarding health plan reporting of prescription drug costs as was required by SB 17. We are planning to share a draft of that regulation with stakeholders in the spring and to start the formal rulemaking process in July.

Speaking of SB 17, we have another regulation regarding SB 17, we actually have two in process regarding prescription drugs. The first, again regarding SB 17, would update and require information regarding -- information from plans regarding the prescription drugs they dispense. As you know and as we have recently released, the DMHC must issue a report to the Legislature and the public on the overall impact of drug costs on premiums. This SB 17 regulation will clarify certain terms that were included in SB 17 to ensure that the DMHC is receiving from plans information that is consistent and accurate. We anticipate having a draft of this regulation to share with stakeholders in the summer and plan to start the formal rulemaking process in September. Our goal is to have the regulation in place by the summer of 2021. We anticipate receiving quite a few questions and having a fairly lengthy, formal regulatory process for this regulation.

The second prescription drug regulation concerns anti-

discrimination in drug tiering on plan formularies. So this is harkening back to AB 339 from 2015. That bill prohibits plans from maintaining a formulary that serves to deter or discourage enrollment of individuals with high-cost health conditions. The DMHC is working on the regulation to clarify AB 339's requirements and to update our current prescription drug regulation to make sure that it is consistent with AB 339. We plan to start the formal rulemaking process on this regulation in the summer and we will certainly share a draft of that reg before we start that process. And our goal is to have this regulation in place by spring of 2021.

The next regulation. I feel like I'm just, the next, one, the next one (laughter). There's a lot. The provider directory standards. So SB 137 from 2015, 2015 was a very busy year, requires the DMHC to develop standards to ensure that health plans provide directories that are accurate and readily available to their enrollees. The bill gave the DMHC an exemption under the Administrative Procedures Act until 2021 to develop and promulgate standards before having to adopt a formal regulation. That is very helpful because we can refine, see what the plans are going to provide to us, work with the plans, work with stakeholders to make sure that the regulation really captures what we need it to capture. We have also been working closely with IHA on the Symphony project and are incorporating lessons learned from that work into the regulation, so that has been very, very helpful. At this point we are finalizing the draft regulation, the draft language, and plan to share it with stakeholders in March, next month, and our goal is to start the formal rulemaking process by May.

And I promise I only have three more (laughter).

Out of pocket max tracking. So as I have talked about before and

as you know, it can be very difficult for enrollees to track where they are with respect to accumulating towards their out of pocket, their deductible. We have heard about people with shoe boxes full of receipts and having to pay way over the deductible and then be reimbursed by the plan. So this regulation would require plans to provide timely and accurate information to enrollees upon request. When an enrollee calls or contacts the plan the plan has a certain amount of time to respond to the enrollee with accurate information. If the plan failed to provide accurate timely information that would be considered the grievance, the enrollee could come to the DMHC's help center for assistance.

One thing that we cannot do is we can't change the realities of the health care system with respect to how plans receive information on what an enrollee has paid. So this won't necessarily provide enrollees with a real-time, up-to-the-minute accounting of what they have spent. The reason being is that there is a lag time between when an enrollee goes to see a provider and when the health plan receives the claim information from the provider. But it will help in that plans will have to provide the information they do have quickly, have to make sure it's timely.

We expect to share a draft of this regulation informally with stakeholders in June and to start the formal rulemaking process in August. We have already had a fair number of informal conversations with various stakeholders and received their feedback so we don't anticipate that informal process to be particularly protracted.

Updating the Help Center. We call this the Help Center cleanup regulation. We have a number of regulations regarding grievances, appeals and IMRs that have not been updated in a while. They do not necessarily reflect how

the plans and the DMHC are interacting with each other. These are really going to be non-substantive changes, updating the forms that the plans, updating some of the terminology, but it will be certainly of interest to the plans. We hope that this will allow us to handle grievances and appeals more efficiently and also allow the plans to handle them more efficiently. We plan to share this regulation with stakeholders in the summer and start the formal rulemaking process in August.

Last but not least, take a breath, the dental matrix. So SB 1008 from 2018 requires the DMHC and the California Department of Insurance to develop a dental benefits and coverage disclosure matrix. The matrix is intended to be a way for consumers to be able to compare dental plans across different products to know what they are buying.

The DMHC has worked with the California Association of Dental Plans, the California Dental Association and Department of Insurance to develop a matrix. We are finalizing that matrix and its accompanying regulation. I think it will be, it is going to be a big benefit for enrollees to be able to see clearly this is what -- you know, this product, I can expect to pay this amount for a cleaning, for a crown, common services, and look across the products to compare them. So we hope to begin the formal rulemaking process on that one in March.

So I will take a breath, happy to answer any questions, provide more information.

CHAIR GRGURINA: Okay. Any questions or comments from the Board? Ted.

MEMBER MAZER: I want to go to the out of pocket max tracking.

MS. REAM: Sure.

MEMBER MAZER: The regulation, apparently, is just for the access to the individual premium payer or insured. It is a problem on the provider side as well. For instance, when we are trying to schedule somebody for surgery in the office. And we contact the plan and we hang on the phone for 30 minutes, tying up staff time, to get an idea of what that patient's deductible is, how much they have met to date, so that we can give them an idea of what their responsibility is going to be.

It's a process that is highly inaccurate. We have had cases where we are told people have done 80 percent; and then when we go to bill they have actually not had anything met on their deductible and now we have to tell the patient that they are responsible for that up-front money. So as those regulations are promulgated I think we need to look at how both the insured and the provider community can get accurate information.

It seems to me, and yes, there will be some lag time obviously because of payment and adjudication of claims, but it seems to me that from the patient perspective at this point most people can go onto a website and look at their coverage, et cetera. And there ought to be a place saying as of such and such a date this is how much you have met. And on the provider side that kind of information should become available as well.

MS. REAM: Thank you, that is very helpful. I will make a note to make sure that we further engage with providers on that bill -- or that reg.

MEMBER MAZER: Thank you.

MEMBER DURR: I was just going to comment on the general risk regs and appreciate your re-looking at those based on the arrangements that you are finding because of the complexity. So I applaud you and the

Department for going in that direction and becoming more knowledgeable. I just wanted to echo my positive comments for that. Certainly any provider support that you need for that and under standing arrangements, we would be available for you.

MS. REAM: Thank you.

CHAIR GRGURINA: I would double Paul's comments on that.

MS. REAM: Okay, appreciate it.

MEMBER RIDEOUT: Just a point of information for the Department. We just released our most recent benchmarking for ACOs, commercial ACOs, and it covers about 100 unique plan ACO contracts in the state. And like we have seen in general, those organizations that take some or complete financial risk seem to perform better on both quality and total cost of care. So if that information would be helpful as you go through this reevaluation process we're happy to provide it.

MS. REAM: Thank you.

CHAIR GRGURINA: Jen.

MEMBER FLORY: On the out of pocket max tracking one of the oddities we see sometimes with Covered California plans is there are certain cost-sharing reduction plans that consumers have to change because their income changes during the year. And that adds -- most of the time we are able to work it through with the plan but it does come up with time to time. Most plans are treating that as the same even though it is not technically the same plan.

MEMBER DEGHETALDI: On the risk thing. Jeff's IHA has done amazing work demonstrating, Sarah, one of your earlier comments there. The more risk the better the quality, the lower the total cost of care. And this is really

true. It is really exciting. I think the next decade we are going to see organizations move more and more into risk and there will be better outcomes.

One thing I am worried about is how do we define population risk? And the myriad ways from Medicare Advantage to how the commercial ACOs may do it in a proprietary way. Transparency and understanding how we define risk, if we don't do that well I worry that we'll move to value and leave sicker populations uncared for; so that's my first point.

The other is, Washington will probably -- Congress will probably have some kind of a surprise billing solution coming within the next, probably by May. How that interfaces with AB 72, there is going to be confusion and frustration or it doesn't overlap. We have to watch this.

MEMBER RIDEOUT: Just a little technical nuance too. I just learned this last week because it came up at one of our committee meetings. We can measure not only whether people are taking capitation risk but whether they are taking upside or two-sided incentive risk on top of that. So there may be a subset analysis that could be done, which I think would make a big difference.

MS. REAM: I will be following up with you.

MEMBER MAZER: Just to respond to Larry, we are dealing with two different populations so the AB 72 really doesn't overlap. The question is, if the feds do something on federal programs how will California react to that. On the AB 72 I could open up a whole new discussion but we'll save that for another day (laughter).

MEMBER YAO: Just one comment. I think you mentioned about the dental matrix and working together with CDI on the standards, which is encouraging to hear. How about the large group rate review, are you guys

working with CDI as well on that one?

MS. DUTT: Yes.

MS. REAM: Yes.

MS. DUTT: We have a biweekly meeting with them.

MEMBER YAO: Okay. I want to make sure we have one standard not two.

MS. REAM: We have them on speed-dial (laughter).

MEMBER RIDEOUT: About the dental matrix.

MS. REAM: Yes.

MEMBER RIDEOUT: I think a few meetings ago we talked quite a bit about sort of the challenges of comparing --

MS. REAM: It is.

MEMBER RIDEOUT: -- cost ratios with different dental plans.

MS. REAM: Yes.

MEMBER RIDEOUT: Is the intent there that once we have that matrix you will be able to partition some of the financial information according to where people land on the matrix?

MS. REAM: I don't know. So the matrix is really, it's a --

MEMBER RIDEOUT: Consumer.

MS. REAM: It's a consumer-facing tool. It's two or three pages depending on how we space it, and it is really intended to allow consumers to -- when, for example, their employer presents them with four options, here are your dental, your dental plan options. The consumer can look at each matrix, they are uniform, they can see, okay, for Plan A, a crown, my cost-sharing will be $100. For this plan my cost-sharing could be, it's a percentage of charges so

who knows what it's going to be. So it allows them in the purchasing, in the choosing portion. But that's an interesting, it's an interesting thought to sort of look at that and parlay it into that analysis as well on MLR.

MEMBER RIDEOUT: Just because I think we were frustrated not knowing how to make sense of the range.

MS. REAM: Well we still have the reality that there are no defined benefits for dental, so that makes it difficult sometimes to do a true deep dive comparison of the different products.

MEMBER YAO: One more comment around the general licensure.

MS. REAM: Yes.

MEMBER YAO: So we are working on lots of innovations, especially around value-based payment. I do expect that type of value-based payment initiative is going to evolve really fast and how could we get ahead of it instead of keep discovering new arrangements and then figure out how to deal with it? Just a question. (Laughter).

MS. REAM: I need a crystal ball. It is, it's fascinating to see how -- just when I think I understand then something new comes along.

MEMBER YAO: Yes, yes.

MS. REAM: It's fascinating.

MEMBER RIDEOUT: Again, I am just one voice in this but we deal with the data a lot. I think it is important to say not every new change necessarily has the magnitude --

MS. REAM: Right.

MEMBER RIDEOUT: -- of some very structural --

MS. REAM: Right.

MEMBER RIDEOUT: -- decisions about whether to pay physicians fee-for-service or capitation or whether you organize in a certain way with an infrastructure for predictive modeling or not. So I think there are some, just some really basic facts. This came up yesterday, primary care spend. I mean, maybe that's a factor, maybe it's not, I don't know. But I think you could say once you get past a certain threshold then the nuances maybe don't matter as much.

MS. REAM: Right, right.

MEMBER DEGHETALDI: It's happening fast, as Amy said. The direct provider contracting Medicare AC option is huge.

MEMBER RIDEOUT: Yes.

MEMBER DEGHETALDI: And that's a capitated payment and it's very attractive. There are a lot of reasons why we may see that just explode in California over the next couple of years. And there's many different models. I think we need to understand. And the market is always going to pull a fast one and it is going to be because they are smarter than we are.

CHAIR GRGURINA: Any other comments from the Board Members?

Okay, do we have comments or questions from the audience? And if I could encourage that you move close to the microphone on the podium so that we can hear.

Hello, Anthony.

MR. WRIGHT: Hello. Anthony Wright, Executive Director of Health Access California. Thank you. And I think my main comment is just to thank the Department for all the work. This is a significant amount of work.

Some of these regulations are literally over a decade in the making. Timely access to care, the out of pocket tracking, rate review, other issues.

And they are incredibly important for consumers and so we just want to thank the Department for the work that they have done and the lot of work that they are planning to do this year; we are looking forward to bringing some of these regulations to final fruition. Again, timely access to care is a major priority for consumer advocacy groups.

The rate review piece, I think -- the rate review. The rate reporting from 546 is so successful that there is continued interest to see if we can do it, not just for large groups but for individual and small groups to get a picture of the entire market.

On the SB 17 prescription drug reg we hope that, you know, given all the interest, you know, in the Governor's budget and elsewhere with regard to prescription drug purchasing that there is, that regulation takes into account interfacing with OSHPD as well as with maybe DHCS and the other entities that are using these reports that you are getting, the data that you are getting here at Department of Managed Health Care to inform the negotiations that DHCS is doing. That maybe -- maybe bring together work to make sure that there is consistent information that is coming from the drug companies at OSHPD and the insurers at DMHC, that kind of work.

And then I think just on the out of pocket max tracking. I appreciate that there are difficulties with regard to getting things in real-time, but the more that we can get this to be as useful for consumers where people know what is actually -- what their experience is so they actually can make decisions on what their plan says, the better.

The final thing I will just simply say since I would be remiss if I just didn't, just put a memory and a thought for Beth Abbott who served, you know, this realm of work. On this board for many years, both as a representative of Health Access and then obviously represented at this board when she was at the Office of the Patient Advocate. She passed away last week unexpectedly. We think of her and I know she wishes this work to continue well. Timely access to care was one of the things she worked on really hard so I think that it's in her legacy that we are going to continue it. Thank you.

MEMBER ROUILLARD: Anthony, thank you for mentioning that. When you got up I thought, I need to say something about Beth because she has been a major force in health care for a long time. I have worked with her over the years in a number of different capacities and always enjoyed her wit and her charm and her, you know, real consumer focus. She is definitely going to be missed. Thank you for bringing that up.

MR. WRIGHT: Thank you.

CHAIR GRGURINA: Any other comments, questions, from members of the audience?

If not, comments, questions from folks on the phone?

THE OPERATOR: No, no questions on the phone.

CHAIR GRGURINA: All right, thank you.

All right, thank you, Sarah. And we will now hear from you on the federal update.

MS. REAM: Yes. This is going to be much shorter than the regulations (laughter). That is not reflective of what is happening at the federal level. But primarily because there is so much happening at the federal level and

there is so much churn right now and so little finality to anything that I am actually only going to speak briefly about one topic. We'd be here all day otherwise.

As you may have been following the federal government, CMS and HHS, put out a rule that would require or that does require QHPs to issue two premium bills to enrollees. One bill has to be at least $1 and must cover the abortion-related services provided by the plan; the other premium bill covers everything else. Initially the feds had proposed that these bills would have to be sent out in two envelopes. They rolled that back a bit. They may be sent in two envelopes. If it's sent via email it has to be sent via two emails.

Apart from the administrative burdens on the plans the major concern with this is that people are going to be very, very confused. Why the heck am I getting two bills for my premium? Also, what happens when someone pays one bill but not the other? They pay the almost-full amount, don't pay the $1. Under current law a plan could terminate their enrollment because of that failure to pay $1.

So last week our AG and AGs from a number of other states across the nation filed suit against the feds to enjoin that rule. It will be very interesting to see what happens with this. It is one of many lawsuits that our AG has filed against the feds. This one is one to watch because it could, it could very much disrupt -- at least for the QHPs it could cause a lot of heartache for enrollees who are being -- having their coverage terminated because of a $1 payment.

You will also -- and I can't go into detail on this one but I'm sure you saw on the news that the federal government Office of Civil Rights engaged in

some correspondence with DMHC and our state government about the DMHC's position with respect to abortion coverage for California health plans. We are still analyzing that situation and deciding what next steps are.

CHAIR GRGURINA: The last presentation was probably a little more interesting (laughter).

MS. REAM: Sorry.

CHAIR GRGURINA: You're doing your job, Sarah.

Questions, comments from the Board Members?

MEMBER DEGHETALDI: *Texas v. Azar*.

MS. REAM: Yes.

MEMBER DEGHETALDI: Where? What? I mean, how do you -- yeah (laughter).

MS. REAM: Well, we'll see. I don't know. It's got a long way to go still, there's a long road ahead.

CHAIR GRGURINA: Ted.

MEMBER MAZER: On the proposed changes in matching funds for FMAP. We talked about it briefly before and organized medicine has been crazy about this, I was proud to get AMA to jump on top of comments. But are there any legal grounds for stopping the matching for the MCO tax and for other means by which California and other states have been able to generate more matching funds?

MS. REAM: So you mean the -- so MCO, I mean, legal grounds for us to challenge it or?

MEMBER MAZER: To challenge it on a legal basis rather than a regular tort.

MS. REAM: I don't know, and if I stretch my neck out too far there I'm sure to say something that is inaccurate on this one. I think we are still looking into that, the state is still looking into that to see what our options are.

CHAIR GRGURINA: Not mentioned but coming on the heels of the MCO is the MFAR regulations in a few months, so there's plenty of activity happening.

MEMBER ROUILLARD: What does that stand for?

CHAIR GRGURINA: It is the Fiscal Accountability. Basically what it means is I taking your money away.

MEMBER MAZER: It's MCO and everything else that has been used --

CHAIR GRGURINA: It's all the provider taxes. It's a huge, giant number and it's not just impacting California. There are many states, including many red states, where they have been using these opportunities for additional funds inside their Medicaid program. So that comes up I believe in May. So we will be here prior to that but that is a, from a budgeting standpoint, a complete upheaval of all of the things that the Governor and the Administration and the Legislature are looking to do on CalAIM, Healthy California for All, that will put us in a different world, so we'll have to see where we end up.

And Sarah is right, those were only just a couple of many that sit inside this world. Other questions, comments from the Board Members for Sarah?

Any questions, comments from members of the audience?

Questions, comments from folks on the phone?

THE OPERATOR: No comments on the phone.

CHAIR GRGURINA: All right, thank you.

All right, thank you, Sarah.

MS. REAM: Thank you.

CHAIR GRGURINA: Next up, Pritika. We are going to talk about the Dental Medical Loss Ratio.

MS. DUTT: Good morning. I am Pritika Dutt, Deputy Director for the Office of Financial Review. I will provide you an overview of the 2018 Dental Medical Loss Ratio, the Dental MLR reports that we received from health plans on July 31st, 2019. For this presentation please refer to the 2018 Dental Medical Loss Ratio Summary Report that was included as part of the meeting handouts.

Health plans that offered commercial dental coverage and contract directly with enrollees or employer groups are required to file the annual dental MLR reporting form. The annual dental MLR report is organized by product type, which is Dental HMO and Dental PPO; and by market type, Individual, Small Group and Large Group. Plans submit their annual MLR report to either DMHC or CDI based on which department has jurisdiction over those plans.

And like the full-service commercial health plans who are required to meet the minimum MLR requirement and pay rebates if they fail to meet the MLR requirement, there is no standard MLR requirement for dental plans. And we discussed the federal MLR for the full-service plans at the last meeting so that is available on our public website.

For reporting year 2018, 19 plans submitted their dental MLR filings that covered 6.2 million dental enrollees.

We'll move on to page 2 of the report.

So this table here shows the dental MLR for plans that offered

dental HMO and dental PPO products in the individual market. Fifteen plans offered DHMO products to 475,000 enrollees. The dental MLR for the dental plans that offered DHMO products ranged from 14 percent to 87 percent. The weighted average MLR was 60.4 percent.

This is a new table that we added from the last time we presented. Last year we presented and it was just a line graph. So this year we provided the actual MLR for the dental plans, and it also shows the enrollment that is in each plan. And there are two plans that offered dental PPO products to 110,000 enrollees. The dental MLR for the two plans that offered DPPO products was 61.2 percent and 74 percent, with a weighted average MLR based on enrollment of 68.7 percent.

On the next page, page 3 of the report, you can see the DHMO and DPPO products for the small group market.

So there are 19 plans that offered DHMO products to 434,000 enrollees. The dental MLR for the plans that sold DHMO products ranged from 34 percent to 88 percent, with a weighted average MLR of 53 percent.

And there were only 3 plans that offered dental PPO products to 451,000 enrollees. The dental MLR for the plans that offered DPPO products ranged from 61 percent to 74 percent and the weighted average MLR there was 61.5 percent.

Okay. On the next page, Table 3 over there, shows the dental MLR for plans that offered DHMO and DPPO products in the large group market.

Fifteen plans offered DHMO products to 1.9 million enrollees. The dental MLR for the plans that sold DHMO products ranged from 45 percent to 77 percent; the weighted average there was 65.3 percent.

And for the three plans that offered DPPO products to 2.8 million enrollees, their MLR ranged from 57.2 percent to 88.2 percent and the weighted average MLR was 88 percent. As you can notice from the table a majority of the enrollees were in Delta Dental's product, the MLR was higher at 88 percent there.

Okay, moving on to page 5. So this chart here shows the three year trend of plans that offered DHMO products in the individual market. The average MLR was 43 percent in 2016, 52 percent in 2017 and 53 percent in 2018. And this average is not weighted based on enrollment, it's a straight average across all plans. The weighted average MLR for 2018, as I had mentioned earlier for the DHMO individual market was 64 percent.

The chart on page 6 of the report shows the three year trend of plans that offered DHMO products in the small group market. The average MLR was 55 percent in 2016, 55 percent in 2017 and 55 percent in 2018. So there was no change so the results were pretty consistent from 2016 through 2018.

Okay, moving on to page 7. This chart here shows the three year trend of plans that offered DHMO products in the large group market. The average MLR here was 64 percent in 2016, 63 percent in 2017, with a slight decrease in 2018 at 61 percent.

Moving on to page 8. So this chart here shows a three year trend of plans that offered DPPO products in the individual market. The average MLR for 2016 was 66 percent, for 2017 it was 70 percent and 2018 it was 68 percent. So it kind of remained consistent from year to year when we looked at the three year trend.

On page 9. So this chart here shows the three year trend of DPPO

products in the small group market. The average MLR was 61 percent in 2016, 63 percent in 2017 and 67 percent in 2018, so it went up slightly in 2018 compared to the last two years.

Moving on to page 10. So Chart 6 again shows a three year trend for DPPO products in the large group market. The average MLR was 87 percent in 2016, 85 percent in 2017 and then it was 76 percent in 2018. Again, reminder that this was based, the average was based on the sum of the percentages and divided by the number of plans. The weighted average MLR for the plans that offered DPPO products for 2018 was 88 percent. So when you looked at the weighted average MLR based on enrollment it was higher for the DPPO large group market. There were three plans offering products in the DPPO large group market and the majority of the enrollees, as I mentioned earlier, were in Delta's product, that was at 88.2 percent MLR.

So we saw consistent results between 2017 and 2018. One of the things that I wanted to point out and as Sarah mentioned earlier was that there is no essential benefits in the dental market like there is for the full service plans. And there is a significant variance which in the plans, in the products that are offered by the dental plans, the premium can -- what we noticed is it was as low as $3 in some case and then went as high as $50, so there's different types of products and premium dollars out there. So it is primarily driven up by supply and demand. So, you know, that's what we have noted, that there's thousands of product designs out there.

And the previous slides on dental MLR we have presented for, I think this is the fourth or fifth presentation so they are all available on our public website.

Also as Sarah mentioned that SB 1008 had a requirement for plans to cover -- that cover dental services to utilize our uniform benefits coverage matrix and we are working with the stakeholders on that. So I think that including it with the dental MLR reporting provides greater transparency to consumers on what they are buying.

With that, that brings me to the end of this presentation, I will take any questions.

CHAIR GRGURINA: Jen.

MS. DUTT: Jen.

MEMBER FLORY: Is the drastic change or the variation in the individual market from like 14 percent to upwards of 85 percent, is that driven largely by a difference in premium amounts?

MS. DUTT: Yes, premium amount and then, again, type of benefits. The type of coverage an enrollee is getting.

MEMBER FLORY: Okay. Because it is almost like what are we even measuring and how useful is this?

MS. DUTT: Yes. So I think the matrix will be a good thing to kind of look at once it is out there. You know, what are they paying for?

MEMBER FLORY: Yes.

CHAIR GRGURINA: Ted.

MEMBER MAZER: The same kind of comment. It's like the wild, wild west.

MS. DUTT: Yes.

MEMBER ROUILLARD: What are we looking at and what is the consumer looking at here? And having gone through the era of California

imposing medical loss ratios on plans and then the ACA putting medical loss ratios on plans for medical care, I look at this and I think that this is -- in some ways you can interpret this as a farce that this is really even an insurance coverage. Or some companies, there is one I don't think we are supposed to mention by name but on each of the charts has some of the larger enrollments and some of the worst medical loss ratios. So I am encouraged that you are going to have a matrix of services to make some more applies to apples comparisons but I am wondering if this is really just a completely unregulated market, that is a consumer fraud.

SPEAKER: That's why we love you, Ted (laughter).

MEMBER MAZER: I don't mean to be blunt, but.

CHAIR GRGURINA: Jeff.

MEMBER RIDEOUT: So this may be circular math but in lieu of having the apples to apples based on benefits is there any value in doing a premium to MLR ratio of some sort? We need to normalize this so we understand what is within or out of normal because I don't know what to make of any of this.

MS. DUTT: We can go back and take a look at that. You know, the plans, what the average premiums are.

MEMBER RIDEOUT: You're making an assumption that premiums are reflective of benefits, which -- but it's better than kind of just noise.

CHAIR GRGURINA: Provides additional information. It's one thing if you're getting $3 per person or if you're getting 50. Or if in the health care it's 250 to 500, or the Medicare of 1,000. It changes what your administration is. But it gives you a better sense of why these are the way they are when you take

a look. You will notice it is much more divergent in the individual market than it is in the small group or the large group where the benefits are generally closer together. Larry.

MEMBER DEGHETALDI: This is the fifth time I have been confused and I'm feeling like (laughter). So basically, Ted, what we have seen is that the skinnier the benefits the worse the MLR and the more enrollees the better the MLR. I am still disturbed that the HMO is worse than the PPO side. Maybe that's benefit design. But I agree, consumers are probably buying dental coverage with inappropriately high administrative overhead, you know, and I don't know what we do with that.

CHAIR GRGURINA: Although, Larry, I would ask us to think that in somewhat similar to the situations we see when HMOs are stacked up against PPOs in a health arena, what you're finding is folks who are selecting the dental PPOs are doing so because they have a variety of needs that they want met. Whereon some of these DHMOs they are really limited benefits or they're figuring, I might have a crown or something else and I would prefer to have a wider network than what is offered there.

So we could see, as Amy knows so well, the PPOs generally receive the funding on the risk side of the house, with worse-risk versus the HMOs in Covered California. I would suspect thing it's the same thing here on the dental side of the house.

MEMBER YAO: Back on the 14 percent loss ratio. I think this issue came up a few years ago. It's really -- if you offer benefits there's always administrative overhead. There are certain basic things you had to set up, infrastructure, how to bill and et cetera. So that's cost. But it has become so

lean it's -- you see the phenomena like this.

MS. DUTT: Yes. The 14 percent is coming from the DHMO individual product and we saw that the premium range there was like $3.11 to $26.32. So the higher the premium the MLR goes up with that for the dental plans.

CHAIR GRGURINA: Jen.

MEMBER FLORY: It did strike me that even with a very low premium with that high of administrative costs, that most consumers would be better off negotiating with their dentist directly. Because a lot of dentists offer payment plans or things that you can do if you are not insured. This looks like an illusory benefit.

CHAIR GRGURINA: I think from years ago when this was brought before here and we looked at some of the variety of benefits, some of the incredibly low monthly premiums were basically just cleanings, coming in for cleanings. And then the question there would be, in the individual market there are some folks that say this is all I can afford and I want to be able to have that. And if they are not going in for the cleanings that then drives the medical loss ratio down. But it is a question of what are the benefits, how much are the premiums and that helps to describe what is going on with some of these really incredibly low loss ratios.

MEMBER YAO: But to add on to what you said, I haven't even seen benefits. It doesn't cover anything. All it has is, I will negotiate with your dentist to give you a discount, that's the benefit.

MEMBER DEGHETALDI: Just from a population health, having dental access for children and for at-risk homeless adults, that is really -- I mean,

this is all fine for the commercial market and for seniors certainly. Those are where the gaps are. So I'd rather look at access and capacity of the system to care for those populations.

CHAIR GRGURINA: Further questions or comments from Board Members?

Questions or comments from members of the audience?

MR. ALBUM: Hi, Jeff Album, Vice President, Public and Government Affairs for Delta Dental. And this is my annual pilgrimage (laughter) to talk to you about why dental loss ratios really give you no information whatsoever about a dental plan.

So last year when I did this I brought a tape measure. I had a prop and I was theatrical about it. And I told you I could walk around and measure all of those cups that you are now drinking from and when I was done measuring that I could tell you the exact measurement of each of those drinks. But I can tell you nothing about what you are drinking, what the quality of it is or anything else.

That is the situation you are in with this, in this case a regrettable law that requires the Department to do this and make this report. But if you don't have a uniform, standardized benefit that everyone is mandated to purchase this metric tells you nothing about it.

You asked a question, is this an unregulated market? This market is heavily regulated. We have to get our products filed and approved, we have to follow timely access, we have network, we have all of the same requirements, administrative requirements that a health plan does. But because there is no mandate to purchase us dental plans are trying to figure out what will people buy and at what price.

So the question on a 14 percent loss ratio product, it's not my product so I don't have to defend it, but I can. If that product is $3 a month and it does nothing but give you diagnostic and preventive services for the year, two visits to the dentist a year, that $3 product is saving you $600 a year. So the value of the dental plan is not the ratio of its admin to its premium, the value of a dental plan is the ratio of the premium to what it saves the consumer. So I'll quite there, I'll take questions, but again just make the point, you are using a tape measure to try and measure something on the inside and it is not doing you any good.

Oh, I know how I wanted to finish up. I wrote a top five list of ways I could lower my loss ratio to make my plan worse in the eyes of whoever thinks low is worse.

I could increase my call center staff so that I spend more time answering questions from dentists and patients and really talk them through stuff. That's going to drop my loss ratio.

I could spend more time identifying fraud waste and abuse. That is going to drop my loss ratio.

I could enhance my website, my online dental directory. I could add almost any technology that will help improve service to dentists and patients, that is going to drop my loss ratio.

I could spend more time with the dentists in my network, really ask them, survey them. Ask them how it's going for them, get to know their needs, that is going to drop my loss ratio.

And the final thing I can do, which I do do, is I could assign people in finance and accounting to present this report each year to the Department and

that drops the loss ratio.

Anyway, with that I am complete, thanks.

CHAIR GRGURINA: Thank you, Jeff. We'll look forward to the measure that comes back next year. Oh, Jen.

MEMBER FLORY: It did make me think, besides looking at just premiums, the medical loss ratio, that we would also consider the out of pockets and deductibles. Because I think in the example given, I don't want to assume that the plan at a 14 percent medical loss ratio is also giving services free. There could also be additional costs besides a $3 premium. It does cause me to question how helpful the medical loss ratio is but there should be other ways to help consumers see the true value of the plan.

CHAIR GRGURINA: Larry.

MEMBER DEGHETALDI: I had the same thought. If you spend $100 or $1 million, what percent is out of pocket? In dental it is very, very high. And I think we are looking at the share, at the DLR of the non-out-of-pocket expense. So we are really contributing very little to the dental cost the consumer pays, right?

MEMBER FLORY: Mm-hmm.

MEMBER DEGHETALDI: I think that's what I heard you say. I am curious as well.

MEMBER FLORY: Yes.

MS. DOUGLAS: Hello, Diana Douglas with Health Access California, the statewide health care consumer advocacy coalition. We wanted to express our deep concerns looking at the range of the medical loss ratios, particularly as has been noted many times, at the lower end, looking down

towards 14 percent but also noting how many of these percentages actually fall quite a bit below average.

From a consumer perspective we believe that there is a long way to go to ensure that the folks that we are advocating for are purchasing plans that are benefitting them adequately.

You know, another thing to note is that we see quite a few plans that are at the higher end of the range, up to 74 or 86 percent, so we know that there is definitely potential to do better and I hope that we will work towards that, thank you.

CHAIR GRGURINA: Any comments or questions from folks on the phone?

THE OPERATOR: No questions on the phone.

CHAIR GRGURINA: All right, thank you.

MS. DUTT: Thank you.

CHAIR GRGURINA: All right, thank you, Pritika.

Okay, Michelle, you are up with the provider solvency quarterly update.

MS. WATANABE: Thank you. Michelle Yamanaka, Supervising Examiner with the Office of Financial Review.

Today I am going to give you an update on risk bearing organization or RBO financial reporting for the quarter ended September 30th of 2019.

We have 185 RBOs filing with the Department. All RBOs are required to file annual survey reports. Annual survey reports are due 150 days after the RBO's fiscal year end. To date we have received 14 annual filings for

the quarters, fiscal year-ends March 31st and June 30th. September 30th is due at the end of this month. And a majority of our RBOs have fiscal year ends of December 31st, which are due at the end of May.

For quarterly reporting, this is the last quarter that we will have two types of filings. But there are for this quarter the Quarterly Survey Report, which are the financial statements as well as the calculation of the grading criteria, and a compliance statement, which is an attestation by the RBO stating that they met the grading criteria. So for the quarter ended September 30th we have 128 RBOs filing Quarterly Survey Reports and 57 RBOs filing Compliance Statements. We also have 6 RBOs that are filing monthly financial statements with the Department as a requirement of their corrective action plan or CAP.

Moving on to the financial survey reports. The last column on the table contains the reporting results for the quarter ended September 30th, 2019. And this table shows that there were 182 RBOs that reported compliance with the grading criteria.

The Department has three categories that can be assigned to each filing, Superior, Compliant or Non-Compliant. For the quarter ended September 30th there were 42 RBOs or 23 percent of the RBOs that were capture in our Superior category. This includes 1 RBO on a corrective action plan. Eighty-three RBOs or 45 percent of the RBOs were captured in our compliant category. This includes 6 RBOs on a corrective action plan and 12 RBOs on our monitor closely list. And we have 3 RBOs or 1 percent of the RBOs that reported non-compliance with the grading criteria.

Moving on to corrective action plans or CAPs. Again, the last column of the table contains the reporting results for September 30th. We

currently have 14 active corrective action plans.

Twelve of the CAPs are continuing from the previous quarter and we have two new CAPs as of September 30th, the quarter ended September 30th. For the continuing CAPs 11 of the RBOs are improving from the previous quarter and there was one RBO that was not improving. For that RBO they needed additional time to meet their financial assumptions so they revised their projections and we are closely monitoring them on a monthly basis.

The handout titled Cap Review Summary is sorted by Management Services Organization, or MSO, and reflects the duration of our CAP monitoring. This table shows that there are 10 RBOs that filed 14 CAPs. Three RBOs had more than one active CAP at September 30th.

Of the 14 CAPs, 7 are approved and 2 of those approved CAPs were completed subsequent to our September 30th financial review, and there are 7 CAPs that are in review. Of those 7, 5 are continuing from the previous period and 2 are -- as I mentioned, 2 are new as of September 30th.

The Office of Financial Review also conducts an analysis of RBOs that have Medi-Cal lives assigned to them. At September 30th, the quarter ended September 30th, there were approximately 3.7 million lives assigned to 89 RBOs. Of the 89 RBOs we took the top 20 and they had approximately 2.8 million lives assigned to them, which is an average of 140,000 enrollees per RBO. The remaining 69 RBOs had approximately 975,000 Medi-Cal lives assigned to them, which is an average of 14,000 enrollees per RBO.

So for the top 20 RBOs that had approximately 2.8 million lives assigned to them, 3 of those RBOs were on a corrective action plan, 4 were on our monitor closely list and 13 had no financial concerns.

Looking at the remaining 69 RBOs that had approximately 975,000 Medi-Cal lives assigned to them, 4 RBOs were on a corrective action plan, 4 on our monitor closely list and 61 had no financial concerns.

The Office of Financial Review also conducts claims and provider dispute exams and financial exams. For the year 2019 we had 24 audits scheduled; 19 of them have been completed and we are wrapping up the last five. For the year 2020 we have 24 audits scheduled; 5 are in progress and have been scheduled and 19 are planned for the remainder of 2020.

And with that, are there any questions?

CHAIR GRGURINA: Paul.

MEMBER DURR: Just a clarification I think to better understand. You were mentioning the RBOs that were superior. That there were 23 percent that are superior but one is in a corrective action plan. And then that also plays into the compliant ones too. So maybe for us to better understand, you could be superior but yet be under a corrective action plan. It seems like it might be incongruent there.

MS. YAMANAKA: Sure, sure.

MEMBER DURR: You might want to clarify that.

MS. YAMANAKA: Sure. So for this, for this situation I believe the RBO was non-compliant a couple of quarters ago. So during the course over the year they improved their financial metrics. So currently at September 30th they do meet the superior, the superior metrics but we are just continuing to monitor them to ensure that they met their financial assumptions and they are tracking completion of their CAP. So that's part of it. So their metrics substantially improved over the course but we are on the monitoring of the corrective action

plan. And this specific CAP, it was completed just last month after we reviewed their September 30th filing.

CHAIR GRGURINA: Jeff.

MEMBER RIDEOUT: Michelle, has the Department thought about or done any work to try to connect the RBOs on CAP with any of the risk regulation work that is being done? Who is actually filing for approval and whether there is an out-sized commitment from some that probably shouldn't be filed?

MS. YAMANAKA: Sure. So within the Office of Financial Review Pritika brings -- we have the Division of Financial Oversight which reviews the applications. And during that, during that time sometimes they have a pre-filing conference. They bring us in if the applicant is an RBO or it has association with an RBO that is reporting to the Department. So yes, we are working closely.

MEMBER RIDEOUT: So a follow-up to that. Are those RBOs treated any differently because they have a CAP in terms of what they are requesting in terms of risk regulation?

MS. YAMANAKA: Let's say the applicant is on a corrective plan. We will look to, we will look at the financial solvency of that RBO to see how they will be assisting, if they will be assisting the health plan, to ensure that the RBO is financially sound. And I can't answer to the other side of the house with the applicant so I am going to let Pritika talk about that part. What do you look at?

MS. DUTT: I think you are asking about the risk regulation, the contracts we are getting in that are asking for exemption. So we are reviewing these contracts and then we are looking at what the RBO is currently reporting as their grading criteria. So that's some things we are looking at as we are

getting the data ready for Shelley to look at and for Sarah Ream to look at and weigh in on what the next steps would be for the risk regulation.

MEMBER ROUILLARD: So I expect to get a report on sort of what the landscape looks like as a result of the exemptions that have been requested in the next month or so and we will be deciding how to proceed from there.

CHAIR GRGURINA: Ted.

MEMBER MAZER: I'll express my naivete here. I look at the charts of the individual MSOs and their groups and many of them have been quarter after quarter after quarter. What is the general action that is taken if the corrective action plan is not bringing them up on a regular basis to get off after four, five, six quarters of report? Is there a protocol for when someone is told-forgetting about the SynerMed experience-this doesn't work?

MS. YAMANAKA: So first of all in the corrective action process it is a collaborative effort between the RBO and the health plan to arrive at a corrective action plan that can be approved by all parties. So we monitor that corrective action plan to ensure that the RBO is meeting their intended targets. In the event that the RBO has a setback where they aren't able to meet their corrective action plan then we will have a discussion with the RBO as well as the health plans to determine if there should be -- what the next steps are. If it is determined that the RBO is unable to meet their projections within a reasonable time frame then the Department has administrative action that can be taken which is, one, to freeze enrollment, or two, to delegate that risk.

So it is an ongoing monitoring. A majority of the RBOs do come into compliance with their approved CAP. However, there are some instances where the financial viability of the group just isn't there and so that's when we

would need to take that action.

MEMBER MAZER: And if I can follow on with that. When a provider is in one of these groups that is being monitored and there is the feeling that they are not, they are not going to be able to maintain their CAP, is there any role for notification of the providers within that group that they may be at risk if this group fails?

MS. YAMANAKA: So we work directly with the RBOs, the health plans are also involved. So at that point it would be worked out with the health plans and the RBOs. The Department doesn't have a listing of all the provider groups or at least that is submitted to our office to know which provider groups are available, yes.

MEMBER MAZER: And there is no public access to a physician to say, I think my group may be in trouble, I can't look it up anywhere if they are under a -- we see it here but -- under a corrective action plan and how long they have been there.

MS. YAMANAKA: So there is information on the Department's website regarding -- there is information that is posted. We are allowed to post certain information regarding the financial solvency that is submitted to the Department. It has all of the financial requirements, the grading criteria, if the RBO has met the criteria or not and if they are on a corrective action plan. So that information is posted on a quarterly basis so that the public can review it.

MEMBER MAZER: Okay, thank you.

CHAIR GRGURINA: I would say, Ted, an example of one provider group that I'm familiar with who went through this. They were on for four, five or six quarters. And you would think, wow, that's a long time, but part of what they

needed to do was show that they were actually making money two out of three quarters going forward. So there was going to be a little while where they were going to be on that. But what it is it's the responsibility of the health plan in addition to that provider group to be looking and watching closely and figuring out, if this isn't going to work what are our backup plans to be able to help protect the members and then also the providers.

MEMBER DEGHETALDI: Jeff's question introduced a concept that -- can we assess overall viability? If we are moving more to risk, if the RBOs are looking at more opportunities, what is their credit rating, essentially, as we go forward? And another thing that we don't do, I firmly believe what Sarah said, what IHA has shown, that more risk, higher quality, lower cost. Is that always true? If the RBO is inadequately capitalized, doesn't have an adequate network, access is not good, quality is not a cultural feature? At some point we might ask whether those RBOs that are persistently on your CAP list are not performing to quality and to the total cost of care expectations. It's just a -- it's another feature. We have to measure quality access, all the components of value.

MEMBER ROUILLARD: To that point, Larry, a few years ago we got data from IHA regarding the poor performers quote/unquote of some of the physician organizations. And we did that correlation to see if any of those were on our corrective action or had financial issues and there was no real good correlation there. We found that fascinating. It is something that we should probably do again because it has been a few years since we did that.

The other thing I would just note is that on the review summary a year ago we had twenty-something RBOs on corrective action and that number has gone down, now we are at 14. So we are definitely going in the right

direction.

The other thing I would mention is that a number of RBOs are coming in to obtain restricted licenses, particularly in the Medicare Advantage world. This raises a concern for me because some of their enrollment is very small, a few thousand members, less than 10,000 enrollees, and whether they are really going to be able to make it or not is a concern. But what do we have, like 10 now, Pritika, in process?

MS. DUTT: Restricted licensing?

MEMBER ROUILLARD: Yes, for Medicare Advantage RBOs.

MS. DUTT: So we have 9 MA license applications.

MEMBER ROUILLARD: Right. So we have 9 medical groups that have come in for restricted Medicare licenses. So lots of changes.

CHAIR GRGURINA: Any other questions from the Board Members?

Any questions or comments from members of the audience?

Questions or comments from folks on the phone?

THE OPERATOR: No questions from the phone.

CHAIR GRGURINA: All right, thank you.

Thank you, Michelle.

MS. YAMANAKA: Thank you.

CHAIR GRGURINA: Okay, Pritika, you are back up for the health plan quarterly update.

MS. DUTT: Okay, good morning again.

So the purpose of this presentation is to provide you a status update of the financial conditions of the health plans at quarter ended

September 30th, 2019.

At January 6, 2020, that's the day we pulled the data, we had 127 licensed health plans, which is one more compared to the same period last year. We licensed 3 additional full service plans, 1 Medicare Advantage, one restricted Medicare and one restricted commercial. One vision plan and one discount plan surrendered its license so that brings us to 127.

We are currently reviewing 14 applications for licensure, 9 full service and 5 specialized. Of the 9 full service, 6 are seeking licensure to be Medicare Advantage plans where they are contracting directly with CMS and 3 are looking to get restricted Medicare Advantage licenses. So what the restricted licensing would be doing is they get licensed and then they get their enrollment through acting as a subcontractor with a fully licensed plan that contracts directly with CMS or enrollees. For the five specialized plans they are looking at getting licensed for dental, two are looking to get licensed for EAP and one restricted vision.

At September 30th, 2019 there were 26.56 million enrollees in full service plans licensed with the DMHC. Total commercial enrollment includes HMO, PPO and Medicare supplemental lives. As you can see in the table, compared to the same period last year, total full service enrollment decreased by 210,000 enrollees, which was less than 1 percent decrease. The decline was due to a slight decrease in Medi-Cal enrollment.

This slide shows the makeup of the HMO enrollment by market type. The large group HMO enrollment had the largest increase. So that kind of tells us that there are more enrollees that are receiving health care benefits through their employers. The small group enrollment also slightly increased; and

there was a slight decrease in individual enrollment, that dropped by about 10,000 lives. Overall HMO enrollment increased when compared to the same period last year.

This slide shows the makeup of PPO/EPO enrollment. As you can see on the table the total PPO enrollment has been on a declining trend. Over the last four years PPO enrollment has declined by 400,000 lives. However, as I mentioned earlier, even with the decrease in PPO enrollment commercial enrollment has been on an increasing trend and that is because of the HMO market going up.

This table shows the government enrollment, which is Medi-Cal and Medicare. Overall the government enrollment decreased. Medi-Cal enrollment decreased by 370,000 lives, while plans with Medicare enrollment experienced a slight increase, adding about 110,000 lives. We saw similar trends when we presented data for June 30th at the last FSSB meeting. And one thing I mentioned earlier, we have 9 applications for MA and restricted MA in review. So what we will see for our next year or so the Medicare enrollment may go up.

We are closely monitoring 35 health plans closely due to various reasons. The number jumped from 27 to 35 for the same period last year. The reasons we have them on the watch list are varied, some because of declining financial health, there might be issues with claims processing or plans going through claims system conversion so we watch those plans really closely. There are some times we see issues during our financial exams, the plans are newly licensed and they are going through their beginning operation stages, there's concerns with parent entities.

So when we look at our licensed plans we also pay attention to what's happening with their affiliated plans, their parents. So if there's any concerns there we put them on a watch list. And these plans with low enrollment we watch them closely. As I mentioned earlier, compared to last year we had more plans on a watch list. A majority of the restricted health plans are on a watch list because they were either recently licensed or because they have low enrollment. So we have 24 total restricted licensees and 15 of those are on a watch list right now.

The total enrollment for the closely monitored full service plans is 7.5 million lives. Of the 31 closely monitored full service plans, 15 are restricted. There are 4 restricted for Medi-Cal, 6 restricted for Medicare and 5 restricted for commercial. The total enrollment for the 4 specialized service plans is 159,000; 1 is a behavioral plan, 2 vision and 1 dental.

This slide shows the two plans that did not comply with the tangible net equity requirement. The TNE is a financial reserve requirement by the Knox-Keene Act. So there were two plans that reported non-compliance with the TNE requirement, one of them was Universal Care, the other one was Vitality Health Plan of California. Both plans are full service Medicare Advantage plans and they contract directly with CMS to get their enrollment. So total enrollment in those two plans were 51,000 lives.

For Universal Care they reported TNE deficiencies as a result of audit adjustments at year-end, so they were able to get the TNE deficiency corrected in a subsequent quarter so that has been corrected.

For Vitality, they reported their first TNE deficiency on December 31st, 2018, so that was as a result of audit adjustments. The plan is on a

corrective action plan and we are working on getting -- so they are providing weekly progress reports to the Department and we are working with our Office of Enforcement and CMS on this issue. So we are working with the plan directly getting weekly updates and trying to ensure that they comply with the TNE requirement. So currently they have about 10,000 lives in Vitality.

So this chart here shows the TNE of plans by enrollment category. Over half of the total licensed plans reported TNE of over 500 percent of required TNE.

This chart shows the TNE of health plans by line of business. A majority of the health plans with over 500 percent of required TNE are specialized health plans. As I had mentioned at the last meeting, the full service health plans, they take on more medical expenses, the risk is higher, therefore their required TNE is higher. That's why we see a higher percentage of TNE among specialized plans.

This chart shows the TNE by enrollment for plans that are being monitored closely. Three plans with over 300,000 lives have more than 500 percent of TNE. As I mentioned earlier, one of the things we look at for closely monitored plans is how they are doing overall in the compliance area. So they could be having a lot of money but there could be other compliance issues with these plans.

This chart shows the TNE by line of business for plans that are being closely monitored. Eight of the health plans on a watch list have greater than 500 percent of required TNE. Again, claims processing issues is the main reason these plans are on a watch list.

Currently we have 22 health plans on corrective action plans.

These plans are mainly on corrective action plans because of issues we identified during our financial examination. I know that the two plans that I mentioned earlier that had TNE deficiencies, they are on corrective action plans as well. So there are various things that we identify and then we get projections from these plans and monitor them closely as well.

So this slide shows the number of exams that we conduct for health plans. So on average we complete 47 exams per years. For fiscal year 2018-2019 we completed 47 routine exams. For the current fiscal year, 2019-2020, we plan to complete 48 exams. So far we have completed 18, 21 are currently in progress and 9 are scheduled to start sometime this year.

And that brings me to the end of my presentation. Do you have any questions? Jeff.

MEMBER RIDEOUT: Pritika, in the commercial enrollment shifts it looks to be all kind of in the individual market from PPO to HMO or close to it. How much of that do you think is part of Covered California changing its QHC expectations, or at all?

MS. DUTT: I'd need to go back and take a look at that, what's happening. Because we don't get on- and off-exchange enrollment so it's kind of hard to track that, but we can definitely reach out to Covered California to get some trends and look at that.

MEMBER RIDEOUT: I'm reacting to the notion that they have shifted from a more open access PPO offering to a more integrated care. So I am just wondering if that is somewhat reflective in the trends?

MEMBER YAO: Maybe I can help a little bit because we are the major one in the individual PPO space. Because when we introduced the Trio

product HMO we did see our open access PPO numbers did shift over to HMO.

CHAIR GRGURINA: Other questions from Board Members?

MEMBER YAO: Yes. As Shelley was talking about the restricted plans, out of the 24 are MA plans? Is that the majority of the restricted one?

MS. DUTT: The majority of them are MA plans. So we can provide further breakdown on that.

MEMBER YAO: That's one question. The other one is my observation on page 8. If you look at the number of lives under closely monitored plans, it's like 30 percent of the total numbers. Is that concerning, that percentage that high, or?

MS. DUTT: Yes, it is. So we are working with these plans. So like I had mentioned, some of these plans have higher TNE. They might be on a watch list because of claim system issues that identify during the exams. So we are working with these plans. And, you know, we have examinations scheduled so we can go and verify if they are meeting the compliance requirements for claims processing.

CHAIR GRGURINA: Jen.

MEMBER FLORY: Just one question on the formatting on page 7 and 8. Like in the future would it be possible to like after Medi-Cal and Medicare Advantage put like how many plans there are in each so we can of the plans how many are being closely monitored?

And then just a comment that, you know, with the Medi-Cal numbers going down we are disheartened to see them not being picked up on the commercial side. We worry about what's happening to folks. I have some ideas but --

(Several people speaking at once.)

CHAIR GRGURINA: Paul.

MEMBER DURR: Pritika, you had also mentioned on the restricted ones that are closely monitored, some of those are because they're new plans. Is there a way to tease out how many of those are new? I'm sure you have that but that might be helpful. Because is that a standard process that they are on that list because they are new?

MS. DUTT: Yes, and then we are tracking their enrollment. So they are new, they don't have -- they have a very small number of lives. So we are watching them closely because any significant increase in medical expenses could push them on a TNE deficiency situation.

MEMBER DURR: Right.

MS. DUTT: So based on their enrollment. And again, they are brand new so they wouldn't have --

MEMBER DURR: A history.

MS. DUTT: They will have small enrollment in the beginning so that's why we watch them closely.

MEMBER DURR: Okay. And my other comment was just quickly, it was on like Vitality and you're watching them with interim reports and all that. Because both them and Universal had audit adjustments, I know you being finance are looking at -- if those audit adjustments were made, obviously because of their auditors, are they ensuring that their weekly reporting to you incorporates the tenets of why those audit adjustments were made?

MS. DUTT: Yes. So that's something we look at when we -- so if it's to do with their claims liability, the IBNR, you know, their incurred but not

reported claims, we ask them to provide their policies and procedures; and if necessary we ask for actuarial certification of their IBNR on a more frequent basis.

CHAIR GRGURINA: Larry.

MEMBER DEGHETALDI: There is a -- I know we look at the managed Medi-Cal plans every other meeting. There is a natural business of feast and famine we have seen. There is declining enrollment, public charge. I worry, and I lived through the Alameda Alliance bit. I worry that the peaks and valleys may -- the valleys may be lower. All the conflicts with the feds between California, the fragility of the hospital fee program, 340B, DSH, all of that. I am just worried - and maybe I'm just being Chicken Little and should shut up, but I am worried about our ability to keep the managed Medi-Cal plans. I know San Francisco is very well run and they're doing okay but so many others are struggling.

CHAIR GRGURINA: I would say a couple of things. One is, I think for many of us when we see 'closely monitored' we're thinking, this thing is about ready to fall apart, and we are concerned because of some things we have seen in the past. So I think we need to listen carefully. And some of the comments that the Board Members made about teasing out, somebody is on because they are brand new and you want to watch it to make sure everything is okay. I think those kind of things will help some of us who when we see the words think, uh oh, this is a huge trouble.

The question I have, and maybe it's more for you, Shelley, is, when we have the chart that shows tangible net equity by plans and we have got the breakages, so it's less than 100, 100 to under 130, 130 to 249. My recollection

in history is back in the day you were pretty clear to the health plans that if they dipped below 200 percent that's when a phone call was being made, a visit to Sacramento was going to be made with the CEO and CFO and it was basically the Department saying, we need to start taking a look here and be able to see what you're doing. If that is still the case then perhaps should we break these out between 130 to 200 and show over 200? Because there are so many plans in this 130 to 249 bucket. That maybe all 28 are at 210 and you know what, that's okay.

MEMBER ROUILLARD: Right.

CHAIR GRGURINA: But it just gives us a better sense of what to look for. For me personally, this chart is where I look to see where there are some red flags going up for me. Folks that are under 100 percent of TNE, that's hugely problematic. You're at 100 to 130, that's a problem. When you're below that 200, what's the trend, what's it look like? And, you know, credit to the Department that they are looking at all kinds of things.

And in some instances it is not that the overall finances of the organization are in trouble, it's some other things, as Pritika said. Maybe there was a claims system turnover and it is not working the way it should so the Department is in there closely monitoring. So it would just be helpful for us to maybe have this breakout for us to get a sense of where you have the bigger concerns on plans where there is a potential of a closure or, like you had done many years ago, stepping in to help write a plan.

MEMBER ROUILLARD: So, Pritika, is the -- when the plan hits 200 percent is there a phone call? What is your current practice right now?

MS. DUTT: So like John mentioned, we look at the trends. What's

happening if they are reporting net losses, what's driving that. We get on the phone with them and try to find out what's going on, what's the drivers. If we need projections we ask for that. You know, if a plan's TNE falls below 130 we put them on monthly reporting.

MEMBER ROUILLARD: Right.

MS. DUTT: But we can put them on monthly reporting before that. If we see a declining trend we try to put them on monthly reporting before the 130 mark is hit.

MEMBER ROUILLARD: Okay.

CHAIR GRGURINA: Okay.

MEMBER MAZER: John?

CHAIR GRGURINA: Yes.

MEMBER MAZER: Just following up on your comments from historical and having reviewed the 96 page transcript from the last meeting (laughter). I'm just wondering if the 200 percent number is the right number. From some of the conversation at the last meeting it appeared that that might not be the right number. And is that a number that ought to be set at a different level and be a trigger for a phone call, rather than 130 when things are kind of really getting close.

MS. DUTT: Right. So we don't necessarily will call somebody at 200. It could be they are at 500 when we'll call them. It depends on where they started at.

MEMBER ROUILLARD: Because if there's a trend.

MS. DUTT: Because if it's a declining trend then we -- because we get quarterly financial statements. So one of the things that our team looks at is

what is happening with net income, what is happening with their operating cash flows. Are they generating enough cash to be able to pay their expenses? Kind of looking at the month-over-month, quarter-over-quarter trend and that's when we start calling them. So it's not really at the 200 mark, we could call them sooner than that.

CHAIR GRGURINA: I think also, Ted, part of what was in the conversation from the previous meeting was about where should a plan have its TNE be.

MEMBER MAZER: Right.

CHAIR GRGURINA: And there isn't really where you would say, this is the absolute minimum and this is the maximum, it's for each plan to decide. But I know from the Department's standpoint over time and things change depending on what is going on, there is a number they are looking at or trends to say, you know what, we need a lot more information than just seeing the plan's quarterly financial filings. And yes, I have heard of turning monthly statements in, turning budgets in, showing reports of how are you going to turn this around, because the Department is doing their job by saying, you know what, we have some concerns we need to watch here before the thing becomes so bad that you are in a, we either need to close the plan or maybe the Department needs to step in and take over.

MEMBER MAZER: And I understand there's different things that the Department is going to look at to do that trigger. I am just asking the question of, TNE is a pretty important one, that's what is reported. Should there be a reasonable number at which point even one quarter says, okay, what's going on with you, can you explain why? And the trend is important but if there

is a sudden decline I think that should be a trigger as well.

MS. DUTT: Right. And we also look at what the TNE is made up of, what types of assets make up the TNE. Is it cash, receivables, building? Because we had a plan with 1,000 percent TNE but they had zero cash. So it's on the watch list because how do you pay your bills with --

(Several people talking at once.)

MS. DUTT: So we look at every single item on the balance sheet to kind of determine what is going on with the plan.

CHAIR GRGURINA: Any other comments or questions from the Board?

Comments or questions from members of the audience?

Comments or questions from folks on the phone?

THE OPERATOR: No questions on the phone.

CHAIR GRGURINA: All right, thank you very much.

Thank you, Pritika.

MS. DUTT: Thank you.

CHAIR GRGURINA: Okay, we have completed our scheduled agenda items. The next item is, is there any comment from members of the public that was not on the agenda today that you wanted to raise or discuss?

If not, any comments or questions from folks on the phone for items that were not on the agenda today?

THE OPERATOR: No questions on the phone.

CHAIR GRGURINA: Thank you.

Okay. Next up is agenda items for the future. So this is the opportunity for the Board Members to raise things they would like to see at future

meetings. And I see Amy is already jumping to that microphone; Amy, what would you like to see?

MEMBER YAO: There's lots going on with Medi-Cal. Could we get more topics around Medi-Cal like the payment reform, what is that going to look like, and also the MCO tax is going to be a big one.

MEMBER ROUILLARD: Okay.

CHAIR GRGURINA: Ted.

MEMBER MAZER: I know one of the more recent requirements on the Department was to receive provider grievances. And I am not sure whether there is anything really flowing in at this point in time because it is fairly new but at some point I would like to see what that might educate the Department to as to looking at particular plans. Whether it's complaints about adjudication of claims, timeliness of claims.

CHAIR GRGURINA: Others?

MEMBER DEGHETALDI: The January 1st, 2023 duals piece. There is a county in the Bay Area that 50 percent of its Medicare beneficiaries are duals. And how are we going to, what is that going to look like? How are we possibly -- it has been an invisible part of the population, Medicare primary for the most part. I think it's wonderful that we have this vision but I think many of the managed Medi-Cal plans are not ready for it. I'd like to better understand it. What risk, what's going to happen to these patients?

CHAIR GRGURINA: If I can add to Larry's comments. Given everything that is going on with Healthier California for All, I think most of us would like to continue to say CalAIM. Just to continue to have Jaycee or another representative from the Department here because there is so much activity that

we could --

MEMBER DEGHETALDI: We could put her name on that seat right there (laughter).

CHAIR GRGURINA: We could pull her right on up to the table here. I think having DHCS with us each quarter will be important given that there is so much there.

MEMBER ROUILLARD: Right. Agree.

CHAIR GRGURINA: Okay?

MEMBER MAZER: Just to follow on there also with the duals. The last time we came into mandatory dual enrollment there were issues with the federal government and I am not sure where that all stands at this point. So an update on how that would impact, whether there are waivers necessary. Taking away a Medicare beneficiary's right to choose.

And further, maybe a projection on what that would do to the requirement of network adequacy, where suddenly all of these Medicare populations that may have had managed care Medi-Cal secondary, are thrown into these groups.

CHAIR GRGURINA: Okay. With that just a reminder that our next meeting is May 13th from 10:00 to 1:00 in this room. Other than that we are closed. Thank you very much, folks.

(The meeting was adjourned at 12:06 p.m.)

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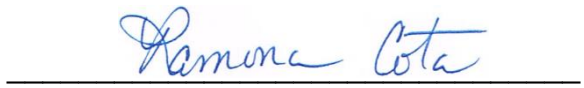
I, RAMONA COTA, an Electronic Reporter and Transcriber, do hereby certify:

That I am a disinterested person herein; that the foregoing Department of Managed Health Care, Financial Solvency Standards Board meeting was electronically reported by me and I thereafter transcribed it.

I further certify that I am not of counsel or attorney for any of the parties in this matter, or in any way interested in the outcome of this matter.

IN WITNESS WHEREOF, I have hereunto set my hand this 25th day of February, 2020.



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