STATE OF CALIFORNIA

DEPARTMENT OF MANAGED HEALTH CARE

FINANCIAL SOLVENCY STANDARDS BOARD (FSSB) MEETING

ONLINE/TELECONFERENCE MEETING

HOSTED BY THE

DEPARTMENT OF MANAGED HEALTH CARE

SACRAMENTO, CALIFORNIA

WEDNESDAY, FEBRUARY 24, 2021

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

Mary Watanabe

Amy Yao

DMHC STAFF

Sara Cain, Associate Governmental Program Analyst

Pritika Dutt, Deputy Director, Office of Financial Review

Amanda Levy, Deputy Director, Health Policy and Stakeholder Relations

Sara Ortiz, Staff Services Manager I

Sarah Ream, General Counsel

Jordan Stout, Associate Governmental Program Analyst

Michelle Yamanaka, Supervising Examiner, Office of Financial Review

APPEARANCES

ALSO PRESENTING/COMMENTING

René Mollow, Deputy Director
Department of Health Care Services, Health Care Benefits and Eligibility

Jeff Album
Delta Dental of California

Bill Barcellona
America's Physician Groups

Yasmin Peled
Health Access California

Janet Vadakkumcherry
Health Center Partners

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PROCEEDINGS

10:00 a.m.

CHAIR GRGURINA: Welcome to the Financial Solvency Standards Board February 24th meeting. So before we start I do have some housekeeping notes for everyone. So first of all for our Board Members, please remember to unmute yourselves when you are making a comment and mute yourselves when you are not speaking so we don't hear the background noise. For our Board Members and for members of the public, as a reminder, you can join the Zoom meeting on your phone if you have any technical difficulties with the connection issue.

Questions and comments will be taken after each agenda item. And for the attendees on the phone, if you would like to ask a question or make a comment please dial *9 and then when you are speaking state your name and the organization you are representing for the record. For attendees participating online with microphone capabilities, you could use the Raise Hand feature and you will be unmuted to ask your question. To raise your hand click on the icon that is labeled Participants at the bottom and then from there you click on the Raise Hand which is on the bottom right hand corner. Once you have asked your question or provided your comment if you can remember to lower your head so that we don't come back to you for another comment. All questions and comments will be taken in the order of the raised hands.

And then also please note all the documents are currently available online at the DMHC website in the Financial Solvency Standards Board section, in case you want to be able to better see them.

With that why don't we go ahead and have Welcome and

Introductions and we will start with the Bard Members if you can introduce yourself; and actually we will start with Paul.

MEMBER DURR: Hi, everybody. Paul Durr, CEO for Sharp Community Medical Group in San Diego. Welcome.

CHAIR GRGURINA: All right, thank you, Paul. You were the first one to join, that's why you got to go first.

Jen, do you want to go ahead and introduce yourself?

MEMBER FLORY: Hi, Jen Flory with Western Center on Law and Poverty, I'm a health policy advocate there.

CHAIR GRGURINA: Thank you, Jen.

Ted, can you introduce yourself, please?

MEMBER MAZER: Ted Mazer, I am an otolaryngologist ENT surgeon down in San Diego, past president of CMA.

CHAIR GRGURINA: All right, thank you, Ted.

Jeff, can you go next, please?

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

CHAIR GRGURINA: All right, thank you, Jeff.

Amy?

MEMBER YAO: Hi. I'm Amy Yao, I am the Chief Actuary at Blue Shield of California.

CHAIR GRGURINA: All right, thank you, Amy.

Larry?

MEMBER DEGHETALDI: Larry deGhetaldi, a family physician and CEO for Palo Alto Medical Foundation in Monterey Bay.

CHAIR GRGURINA: All right, great.

And then Mary, our new Executive Director, congratulations and please introduce yourself.

MEMBER WATANABE: Thank you. Yes, no, officially the Director of the Department of Managed Health Care and thrilled to be leading this team. Thank you, John.

CHAIR GRGURINA: All right. Mary, do you want to have any other introductions from DMHC staff?

MEMBER WATANABE: Sure, yes. We have a number of staff joining us to do presentations today. Maybe let's have -- we'll start with Pritika, do you want to introduce yourself?

MS. DUTT: Hi, I'm Pritika Dutt, Deputy Director of the Office of Financial Review.

MEMBER WATANABE: Thank you. And Sarah Ream?

MS. REAM: Hi, good morning. I am Sarah Ream, I am the Chief Counsel for the Department.

MEMBER WATANABE: And Amanda Levy?

MS. LEVY: Good morning, everyone. Amanda Levy, Deputy Director for Health Policy and Stakeholder Relations.

MEMBER WATANABE: Great. And Michelle, I don't know if you are able to unmute yourself.

MS. YAMANAKA: Hi, this is Michelle Yamanaka, Supervising Examiner in the Office of Financial Review.

MEMBER WATANABE: Thank you, Michelle.

And we do have Sarah Cain, Sarah Ortiz and Jordan Stout, our

admin support team. And René Mollow, I see you there from DHCS too, we will have a presentation later from René.

CHAIR GRGURINA: Very good. Well, thank you.

The next agenda item is the transcript and the meeting summary from the November 18th meeting in 2020. So I would ask, first of all, are there any comments or questions from the Board Members and if you could raise your hand if you have any?

Not seeing any, do we have a motion to move the transcript forward?

MEMBER WATANABE: Dr. Mazer has his hand up, John, and he's waving at you.

MEMBER MAZER: Both hands and in the Raise Hand thing. Yes, just a quick comment on the attendees. I was not able to attend on Zoom but I was present and sending questions through text so if I could be added to there on the Attendees, please.

CHAIR GRGURINA: If we can go ahead and make that one addition; thank you, Ted. Any other comments?

And just for Board Members to know, apparently, my Participant section, I didn't see your hand raised, Ted, so I am going to have to do the back and forth of finding hands being raised so I apologize if I am a little slow today. If there are no other comments do we have a motion to move the transcripts forward with the one change that Ted proposed?

MEMBER DEGHETALDI: So moved.

MEMBER YAO: Second.

CHAIR GRGURINA: I heard Amy with the second. All those in

favor?

(Ayes.)

CHAIR GRGURINA: Any opposed?

(No audible response.)

CHAIR GRGURINA: No. All right, well that passes. Thank you very much, folks.

MEMBER MAZER: John?

CHAIR GRGURINA: Okay, the next agenda item is Mary giving us her remarks and so, Mary, you are up.

MEMBER WATANABE: Yes. And, Dr. Mazer, did you want to add something really quick before I start?

MEMBER MAZER: Just so John knows, if you are looking at the hands up feature there's two columns, there's Attendees and Panelists and you may have to go back and forth between the two.

CHAIR GRGURINA: All right, thank you, thank you, Ted.

MEMBER WATANABE: And I will do my best to help John monitor that.

So, welcome everybody to our FSSB meeting. As John said, I was going to start with kind of the most exciting news, which is the changes you will see on our org chart; maybe let's go to our next slide here. I am just thrilled to have been appointed as the director for the Department. That happened in early December when the governor announced my official appointment. From my first month at the DMHC, it has been almost six years, I knew I had found a very special place to work. I have a tremendous amount of respect for our team, their dedication and commitment to our mission and I am really, again, just honored to

lead the department.

I also will mention a notable departure that was announced on the same day, which is that Elizabeth Landsberg, our former Help Center Deputy Director, was appointed as the new Director of the Office of Statewide Health Planning and Development. So really excited to have her at OSHPD and to be able to work very closely with her on a lot of the overlap in our work. But obviously it leaves a very big hole in our Help Center, she has just made some really positive improvements there, so that is one vacancy we're still working to fill.

At the end of December the governor announced the reappointment of Rachel Arrezola as the Deputy Director of Communications and Planning and the long, long-awaited official appointment of Sarah Ream as our Chief Counsel after acting I think for almost over two years.

I am also excited to announce the appointment of Christin Hemann, our new Deputy Director of Legislative Affairs, who was appointed by the governor also at the end of December and she officially started on January 25th. Prior to joining the DMHC Christin was the Associate Director and Executive Director of the California Association for Adult Day Services; she previously served as the Assistant Director of Legislation and Public Affairs at the California Department of Aging. So really excited to have Christin join the team. She wasn't able to join us today but we will have her probably participate in a future meeting.

And then lastly, we actually have some late breaking news related to one of our other Deputy Director positions. As of Monday, Jenny Phillips has been appointed as our new Deputy Director for the Office of Plan Licensing. You

may remember Jenny from her time as our former Deputy Director of Legislative Affairs and a senior attorney in our Office of Plan Licensing. So prior to returning to the DMHC, Jenny served as a special assistant to the California Attorney General advocating and testifying on healthcare issues in the California legislature and was the chief policy advisor to the AG on Medi-Cal fraud and elder abuse, hospital system consolidation, tobacco laws, CURES database and disability rights. So really excited to have Jenny back on the DMHC team.

As I mentioned earlier, I am really thrilled to see our leadership team really starting to take form. We have two more vacancies, including our Chief Deputy Director position; I am hoping by our next meeting we will have some announcements about those.

I did want to just take a moment to thank and acknowledge the numerous staff that we have had filling in in these acting positions. It is really a testament to the commitment to our mission that we have had a number of people that have stepped up in these acting roles for a year or longer, but they have really provided continuity and kept the work moving during this transition.

So moving on to just some quick highlights about the governor's fiscal year '21-22 budget. Governor Newsom submitted his $227.2 billion state budget proposal for fiscal year '21-22 to the Legislature on January 8th. The budget prioritizes funding for COVID response, provides relief to Californians facing job loss and eviction and provides support to small businesses and invests in schools. Thankfully, the economic downturn was less severe than anticipated and the economic outlook and revenue forecasts presented in the budget have improved dramatically.

I'll highlight just a few of the health and human services-related

items. The budget includes a $15.5 billion increase in total funds for the health and human services programs. This includes funding for the anticipated increase in Medi-Cal enrollment next year in the implementation of CalAIM, which I know René is going to talk about later.

The budget proposal also includes the establishment of a new Office of Health Care Affordability at OSHPD. This office will be charged with increasing transparency on cost and quality, developing cost targets for the healthcare industry, enforcing compliance through financial penalties and filling gaps in market oversight of transactions that may adversely impact market competition prices, quality access and the total cost of care.

There is also a proposal to recast OSHPD and the Office of Health Care Affordability under the umbrella of a new department called the Department of Health Care Affordability and Infrastructure. The department will be the dedicated entity within state government with subject matter expertise on healthcare affordability and infrastructure. So Elizabeth has got a lot on her plate as she is taking over that department.

There were also a number of budget items related to behavioral health. As you know the isolation, job losses, school closures caused by the pandemic have had a significant impact on mental health, I think particularly on our children and youth and young adults. The budget includes a number of investments to improve outcomes and to increase access to behavioral health services. This includes one-time funding of $400 million for the Department of Health Care Services to implement an incentive program through Medi-Cal managed care plans in coordination with county behavioral health departments and schools. There is also $25 million proposed for ongoing Prop. 98 general

fund to fund innovative partnerships with county behavioral health departments to support student mental health services; and there's a number of other proposals related to just increasing access and coordination of mental health with the county.

And then finally, as we all have been talking about, the pandemic has highlighted the systemic racism and discrimination that has created social, economic and health inequities contributing to higher infection and mortality rates for both chronic and infectious disease and so the governor's budget really highlights a number of proposals to address health inequities. The one that is of most interest I think probably for us is a proposal for the DMHC in collaboration with other entities to establish a priority set of standard quality measures for full service and behavioral health plans, including quality and health equity benchmark standards, and for us to take enforcement action against non-compliant health plans. I don't have much more that I can share about this proposal other than there will be more information available in the spring, so likely by our next board meeting we'll have more to share.

There is also the Administration is proposing steps to improve health equity through managed care plan procurements. So as Medi-Cal and Covered California plan contracts come up for renewal the Administration will work to include a focus on health disparities and cultural and language competency through health plan contract language.

And then finally the budget includes funding for the Health and Human Services Agency to conduct an analysis of the intersection of COVID-19 health disparities and health equity to help inform any future response.

I'll move on to an update on our response to COVID-19. We have

been very busy continuing to monitor and respond to the pandemic. Since March of last year we issued 31 All Plan letters related to COVID and two emergency regulations. Sarah will talk more about the emergency regulation we issued since our last meeting; but we did issue nine All Plan letters over the last three months and I'll highlight just a few.

In December we issued an All Plan letter reminding health plans that all qualified, approved COVID-19 vaccines must be provided with no cost-sharing for health plan enrollees, regardless of whether the enrollee receives a vaccine from an in-network or out-of-network provider. We also released a fact sheet that is available on our website and we have a specific link to a COVID-19 site.

We also issued an All Plan letter related to network stability. This APL was tied to the executive order issued by the governor in September and requires plans to report information to the Department regarding contracted primary care practices identified as what we call priority practices. They are also required to identify closures or sales of their contracted primary care practices and how these closures or sales may impact the plan's ongoing ability to provide services to enrollees; and we issued a similar All Plan letter and guidance to the dental plans.

We also issued an All Plan letter requiring health plans to report information to the Department to ensure plans are sufficiently supporting providers to make sure they have access to COVID-19 supplies such as PPE to make sure they can safely deliver services to enrollees.

In response to the surge in hospitalizations that we saw at the end of the year we issued an APL directing health plans to remove administrative

burdens on hospitals, including directing plans to make take immediate steps to reduce or remove unnecessary barriers to the efficient admission, transfer and discharge of health plan enrollees.

And then we issued an All Plan letter notifying health plans they may not prevent or delay the transfer of enrollees and must cover medically necessary costs associated with the transfer of their enrollees per the State Public Health Officer Order that was issued by the Department of Public Health on January 5th.

And then just finally I will mention that my first phone call of the new year was an announcement about another health plan merger. Centene has notified the Department of its intent to acquire Magellan Health Inc. for $2.2 billion. Centene in California has several DMHC-licensed health plans, most notably Health Net of California, and then Magellan has two DMHC-licensed health plans as well. This transaction is currently under review, so again, I can't tell you much more about the transaction, we are still reviewing that, more information to come. Just a reminder that our review process includes looking at organizational and corporate changes, financial projections, administrative capacity changes to how services will be delivered, how the plan contracts with other plans and other potential impacts to enrollees or the stability of the healthcare system. We will likely have more information to share with you at our next meeting.

That concludes my update; I'd be happy to answer any questions.

CHAIR GRGURINA: Any comments or questions from the Board Members? I can see all of you now. Larry.

MEMBER DEGHETALDI: Yes. So Mary, I'm really excited about

the shift and the focus on disparities, COVID has obviously made that very visible. We are not starting from scratch; IHA has been doing this work for a long time. There are geographic disparities, there are ethnic disparities, there are age disparities and hair class disparities (laughter). So I am really looking forward to that work, really looking forward to it.

MEMBER WATANABE: Thank you, Larry.

CHAIR GRGURINA: Other comments, questions?

MEMBER WATANABE: Jeff has his hand up, at least that I can see.

CHAIR GRGURINA: Jeff.

MEMBER RIDEOUT: I was just going to, I guess, piggyback on what Larry said. We are now experimenting with a claims-based geo-descriptor that reflects potentially disparities based on ZIP Code-based income. It is obviously not the same thing as having data that identifies people by social determinants but it is potentially a proxy that we can apply to our existing data set, including our quality measures, so Mary, I think that's something we can explore with you. The measure was actually developed through Rand so it has some legs to it, I think, from a validity point of view.

MEMBER WATANABE: That's helpful, thank you, Jeff.

CHAIR GRGURINA: Other comments from Board Members?

MEMBER YAO: Yes.

CHAIR GRGURINA: Go ahead, Amy.

MEMBER YAO: This is Amy. I have one question, it is related to the OSHPD, the new organization. It is a really good move that we establish an organization to focus on affordability, that is definitely very important for all

members. The question is, how will OSHPD, they are going to be coordinating with DMHC, DHCS, et cetera? Is that going to be a regulatory agency or is it more a research agency?

MEMBER WATANABE: No, good question and I think there's a lot more information that will come out in the spring around the Office of Healthcare Affordability too. But I think the intent is to coordinate with all of these kind of sister agencies within the Health and Human Services and obviously, with the other purchasers in the state too. So again, I am really excited to see Elizabeth heading up that organization. I think she is well aware of what we do at DMHC and how that might fit and be coordinated. There is, as you can imagine, a lot of overlap and a lot of ways I think that we could coordinate along with the other departments within the state as well. So again, more information, I think about that office and what it will be doing and their charge in the spring as well.

CHAIR GRGURINA: Okay. Mary, I would also add that, obviously, as you have given your update, there is a tremendous amount of important work that is there. It was pleasing at the beginning to see as you move into the role and other roles are being hired that there is not so many folks with Acting because there is obviously a lot to get done, so we appreciate that you have the talent behind you to get done what needs to be done.

MEMBER WATANABE: Thank you, John. No, I've got a great team. I am hoping by the next meeting I will have one job and one title only so that would be great.

CHAIR GRGURINA: Okay. We will look forward to hearing that from you in May.

Okay, why don't we go ahead and let's move on to the next topic,

which is the FSSB Board Member selection and I will turn that over to you, Mary.

MEMBER WATANABE: Great. This may be a little anticlimactic, seeing that you are kind of looking at our Board. But I do just want to acknowledge that as I mentioned at our last meeting, we reissued our solicitation for board members and we did receive a good response, but after careful consideration I made the decision to reappoint our five board members. I am thankful you were all interested and willing to continue on the board. I really have valued your diverse perspectives but you also bring kind of a very diverse representation of both our geography and the areas of the healthcare delivery system that you represent. So I am excited for you all to continue another three year term.

And I also will just announce that John has agreed to continue as our Board Chair for the remainder of the year, which I really have appreciated working with John. I think that continuity, at least as we are likely going to continue to meet virtually for the rest of the year, so I think having John continue in this role will be great. We can revisit the selection of a new chair at the end of the year if either John is done or one of you really would like to take on that job.

So again, just appreciate your continued commitment to the board. And with that, I'll turn it back to you, John.

CHAIR GRGURINA: Okay, just one piece of clarity there. Mary, you said the reappointment of five members. So just important for others to know there are seven positions but two members still had time remaining on their clock.

MEMBER WATANABE: Correct.

CHAIR GRGURINA: So thank you to the five members who have

agreed to continue to serve forward and we appreciate that.

So with that, why don't we go ahead and let's move on to the Department of Health Care Services update with René Mollow. Welcome, René.

MS. MOLLOW: Thank you so much. I am very happy to be here this morning to provide you all with the update from the Department of Health Care Services. And I am going to -- my remarks today will be to provide some updates in terms of our Medi-Cal budget, CalAIM, Medi-Cal Rx, and then COVID-19. Next slide, please.

In terms of the Medi-Cal budget, just a couple of highlights that I wanted to point out. The governor's budget that was released in January proposes $126.3 billion for the Medi-Cal program and within that budget there's three major areas that we are focusing on for this year.

First is our COVID-19 response. There's approximately $7 billion in total funds that are identified for our response to COVID-19 and this reflects issues around increased caseload, which we are projecting for the budget year to be approximately 14 million individuals, also vaccine administration costs and then other COVID-19 response impacts. And also it is reflective of increased federal funding that we are able to receive given our COVID response and the requirements that we have for maintaining continuous coverage of our Medi-Cal enrolled beneficiaries.

Also in terms of CalAIM, and I'll give a little bit more detail on CalAIM in my upcoming slides, but CalAIM has been fully funded for '21-22 and approximately $1.1 billion in total funds have been proposed for this investment, which will provide for enhanced care management and in lieu of services. It will also promote necessary infrastructure to expand the whole person care

approaches statewide, build upon existing dental initiatives and also promote greater consistency and the delivery systems where beneficiaries receive services.

In terms of our response in addressing health equity, we are also looking at the coverage of continuous glucose monitors. We have found that communities of color have a higher prevalence of diabetes than the general population, so to help improve diabetes management and outcomes the budget does include a $10.9 million investment in terms of adding continuous glucose monitoring systems for adults that are in our program with diabetes type 1. This new benefit would be effective January 1, 2022. I do want to note that currently because of the requirements under the early periodic screening, diagnostic and treatment benefit, which is a required mandatory benefit under Medicaid, these services are currently covered for children that are enrolled our program for individuals that are under the age of 21.

We are also looking at an investment of approximately $94.8 million total funds in terms of permanent telehealth flexibilities. So we are looking at once the public health emergency has ended, certain flexibilities that we have put in place during the public health emergency that will continue to exist post the public health emergency, with a goal of focusing on improving equitable access to our providers and also addressing inequities and disparities in care for all members.

In terms of the telehealth proposal that is on the table, I do want to note that California was ahead of the curve prior to the public health emergency in terms of our policies around telehealth. We are now looking at some additional flexibilities that we will maintain post the public health emergency and

in particular for the budget proposal. We are looking at adding remote patient monitoring, that was one aspect of telehealth, and it is not telehealth per se but it is really a service that is provided for our beneficiaries both in fee-for-service and in managed care, so we do have trailer bill language out in terms of the expansion of telehealth services as well as adding this new benefit under the Medi-Cal program. And again, the remote patient monitoring was not an aspect of what we had implemented either pre the public health emergency or during the public health emergency, but we do see the value add of that benefit of being added to the Medi-Cal program.

We also have an investment in behavioral health. There is an infrastructure investment of approximately $750 million in general fund. Over three years we are looking to invest in critical gaps across community-based behavioral health care, the behavioral health care continuum, and also looking at the addition of at least 5,000 beds or units or rooms to help expand capacity for behavioral health services and gaps in those services within community-based services that are provided under the Medi-Cal program.

We are also looking at student services and providing one-time funds of $400 million in total funds to implement an incentive programs through Medi-Cal managed care plans in coordination with county behavioral health departments and schools to build infrastructure partnerships and capacity statewide to help increase the number of students that are receiving preventative and early intervention behavioral health services. Next slide, please.

In terms of CalAIM, I know that at the last update that my colleague Lindy Harrington did touch on CalAIM so what I'd like to now call out is just kind of our status of where we are at with the CalAIM relaunch.

So we had first released our proposal in October of 2019 and we had planned implementation dates in 2021. But as you all know, we did, we were hit with the public health emergency.

With CalAIM, prior to the actual release of the proposal, we have had extensive stakeholder engagement that had occurred and with that engagement we had also received extensive written and in-person public comments on the proposal.

But as noted, the public health emergency then had an impact both in terms of our budget and our healthcare infrastructure so we did put CalAIM on hold for the duration of 2020.

So we have revised our original proposal and it does reflect learnings from the workgroup processes and the stakeholder input that we had received during 2020. During you know, the late part of 2019 and early part of 2020.

And then with ongoing policy development and then new implementation dates for our proposal. So on January 8th we did publish a revised CalAIM proposal along with an executive summary that also outlines what the key changes are.

And then we did host a public webinar on January 28th to walk individuals through our revised proposal and to also highlight key changes. Next slide please.

So with the relaunch I just wanted to note a couple of key implementation milestones. So we are looking, and this is for 2021, the work efforts that we have done. So we first launched our managed care long term -- our Managed Long-Term Services and Supports and Duals Integration

workgroup and we have also released a draft of the enhanced care management and in lieu of services model of care. I am sorry, I am losing my train of thought here, my apologies. So we have also released the draft of the model of care as well as contract language for managed care plans. And then we also, we had also released the enhanced care management and in lieu of services contract language to the managed care plans and to the provider standards for the managed care plans to adhere by. And then we also are releasing our Section 1115 and 1915(b) waiver public comment period will begin in March.

So through April to June we are going to be releasing draft rates for enhanced care management. There will be additional materials that will be going out for the enhanced care management and in lieu of services, including pricing guidance. And then we will be concluding the Foster Care Model of Care workgroup that has been convened over the course of last year. We will also form a county oversight and monitoring workgroup as well as develop auditing tools for oversight of CCS and our CHDP programs.

And then in July through December of this year the managed care plans will submit their model of care for whole person care and health home program counties for review and approval by DHCS. We will also begin the stakeholder process for county inmate pre-release application processes, as well as publish an update for monitoring and reporting on county performance standards. And the county performance standards, this deals with our oversight with our counties that do Medi-Cal eligibility determinations. And then we are also anticipating approval of our 1115 and 1915(b) waiver/renewal requests. Next slide please.

This just gives a highlight of the key implementation milestones for

CalAIM, again with a launch of January 1 of 2022, for those services that we have identified for CalAIM in terms of that first phase. I again want to remind people that CalAIM is a very important initiative to the department and it does have phased planned releases, so this is just the beginning part of that effort. So that does not mean that this is it in terms of CalAIM but these are going to be the major elements in terms of what we are looking at launching come January 1 of 2022. Next slide, please.

So Medi-Cal Rx. So I know that at the last board meeting my colleague Lindy Harrington did provide an update in terms of where we were at; and at the time that she had provided our update we were all in the process of moving towards our go-live date that was revised from January 1 to April 1 of 2021 and that we were in a green status at that time.

However, as Mary had alluded to in her earlier comments, the Department was notified regarding the proposed merger of Centene acquiring Magellan. We were not aware of this proposed merger until the time that we were notified by Magellan of this. So given this merger we did require and ask Magellan to provide us with a plan regarding conflicts of interest. Because in terms of the RFP that was released for this effort, we wanted to ensure that for any entity that was bidding on this proposal that there were no conflicts of interest by any entity that may be a participating managed care plan in our program or a pharmaceutical company or entity that contracts with the Medi-Cal program.

However, our contract does allow that should such conflicts exist that there has to be a conflict avoidance plan in place. Based upon the notification regarding this pending acquisition by Centene of Magellan we did

request a conflict avoidance plan to come to the department from Magellan. We did receive that plan but have determined that there is more work that is needed in terms of the review to help ensure that all of the appropriate firewalls are in place and to ensure that we do have strong protections in place in terms of the information and the data that Magellan currently handles on behalf of our program. We also learned through the conflict avoidance plan that Centene does also own some specialty pharmacies that also participate in our program. So given that collection of information we want to ensure that, again, we have strong protocols that are in place to help ensure that there are no unintended consequences or no inappropriate sharing of information and that all the necessary firewalls are in place.

So given all of this we did release a notice last week regarding a current delay in the effective date of Medi-Cal Rx. Our plan right now is to work with Magellan during this time period in terms of strengthening the conflict avoidance plan that they have submitted to us. We also recognize that there is still work that has to be done from a regulatory perspective in terms of the review and the approval of the acquisition. But it is imperative to us that we ensure and can provide assurances to all interested parties, health plans as well as our beneficiaries and the Legislature, that we have all the necessary protections that are in place for the information that Magellan does have regarding the Medi-Cal program as it relates to pharmacy services under our program.

So Medi-Cal RX does remain a very important initiative for us because it will be a tool that will be used to help standardize the pharmacy benefit statewide under one delivery system. It will also help with access in terms of pharmacy services for the Medi-Cal population that is enrolled in our

program. And so we will be working to, like I said, strengthen this conflict avoidance plan, and that we do plan to have an update in May in terms of where we're at.

I do want to note that given all that has transpired we have not yet identified a new go-live date. We want to make sure that all things are in place so that once we do announce what that go-live date is, that that will be the date that we will stick to. But in the interim time period we will continue to be working with both Magellan as well as our health plans in terms of respective roles and responsibilities and the work that they need to carry out on behalf of the Medi-Cal program. And ultimately our goal here is to help ensure the protection of our Medi-Cal beneficiaries as well as being sensitive to the work that our managed care plans are doing on our behalf in terms of meeting the needs of Medi-Cal beneficiaries. Next slide, please.

In terms of our COVID-19 updates, next slide, please. Just wanted to provide a couple of updates in terms of the public health emergency. So I think the last time when Lindy had presented she had shared that we have had an extension of the public health emergency. And now we did receive on January 7th a new extension of the public health emergency that goes through April of 2021.

However, since that time the Biden administration has also indicated that the public health emergency will likely go through the end of 2021 and that they intend to provide states with a 60 day prior notice prior to the end of the public health emergency. Previously, with the prior administration we really didn't have any particular due dates of when they may make changes with the public health emergency so this at least gives us a level of comfort in terms of

having some prior notification of that.

And we are going to continue to partner with CMS in terms of the flexibilities that they offer to us as we, you know, for the Medi-Cal program. Next slide please.

In terms of some recent flexibilities that we have requested of CMS:

We have put in a request to get COVID-19 testing for children in schools, with an effective date of February 1 of 2021. This is to help allow schools to reopen and to provide a means for doing mass testing of children that are Medi-Cal enrolled and to have a way to cover the costs of those tests for those students.

We have also requested federal approval to deliver the COVID-19 vaccine benefit exclusively through our fee-for-service delivery system; again, that is subject to CMS approval. And again, the goal behind that is to help ensure that the vaccine is available. It would be, as with other populations, free of cost to the Medi-Cal population, but also want to ensure that there are no issues in terms of individuals seeking vaccine administration if a person happens to go to an out-of-network provider.

We have also asked CMS approval for vaccine administration for our limited benefit populations. So this would include individuals that are in restricted scope Medi-Cal, individuals in our COVID-19 uninsured program, as well as individuals that are in our family planning -- our FPACT program. So we are still awaiting CMS approval on all of these requests that have been brought before CMS. We have had very active engagement with them and we are hoping that we will get approval soon on some of these very important initiatives.

And then we had also received CMS approval for some flexibilities

in terms of the timeliness for reinstatement of benefits following an appeal or a state fair hearing. So that was a flexibility that we had asked for and have received CMS approval on. Next slide, please.

Then the last thing I wanted to just highlight is CalHOPE. This is an effort that is funded through grant dollars through FEMA and this is to help provide services or resources to communities in terms of those communities dealing with the impacts of natural disasters. CalHOPE builds on community resiliency and does help people to recover from disasters through free outreach, crisis counseling and support services. Services under CalHOPE include individual and group crisis counseling and support, individual and public education, community networking and support, connection to resources and media and public service announcements. There is a county tool kit that can help communities implement messaging behind CalHOPE.

The one thing I do want to highlight with CalHOPE is that we do have a partnership with the San Francisco 49ers in terms of them actually promoting CalHOPE for the state of California. And then we also have a partnership with the Los Angeles Kings where they have actually been a helmet partner where the actual logo for CalHOPE is on the helmets of the Los Angeles Kings, so it helps to embrace the CalHOPE message from the executive level to the ice.

So some coming soon attractions with CalHOPE includes some support for virtual crisis counseling sessions through local partners, some students support and then also expansion of the CalHOPE warm line to 24/7. Next slide, please.

These are just some helpful resource links for COVID-19.

And that does conclude my update for the Department of Health Care Services and I welcome any questions that you all may have. Thank you.

CHAIR GRGURINA: All right, thank you very much, René, you covered quite a bit there.

Comments and questions from the Board Members? Larry.

MEMBER DEGHETALDI: René, that was a great and thorough report, I was really entertained, thank you. In the pre-COVID rollout of CalAIM, January 1st, 2023 stuck in my mind as sort of a pivotal day, particularly for duals. When is the next, when will duals go live in the CalAIM trajectory now? The same, has it changed?

MS. MOLLOW: Hold on. I can tell you that, hold on. I have -- I want to say the duals will go live -- 2023 seems to stick in my head as well but let me confirm that.

For duals, let's see. I am sorry, I am looking here through my pieces of paper.

CHAIR GRGURINA: Well actually, René, why don't we move on to some other questions and we'll give you some time to find it.

MS. MOLLOW: Yes, thank you.

CHAIR GRGURINA: I think '23 is correct and '25 was the latest for managed care plans to have a DSNP up and running to be able to cover those dual eligibles.

MS. MOLLOW: Yes. So in 2023 we would transition the mandatory enrollment of dual eligibles into managed care. And then for the long-term care services and support and the special needs plans, that has moved to 1/1/27.

CHAIR GRGURINA: Okay, thank you, René.

Ted and then Jen.

MEMBER MAZER: Thank you. René, great presentation, very comprehensive, and really enjoyed it as well.

A couple of comments on the remote monitoring. I think it's a wonderful thing to be doing, it is a vast improvement over where we have been and it is clearly going to grow and might have to go beyond just diabetes management. In the same vein, though, I think we need to be doing better in advancing tele-consults. This is twofold. One, it is necessary because it gets better care more promptly from the primary to the specialty level. But currently as a specialist what I am seeing is while we all lock down a lot of the -- I see primarily managed care Medi-Cal.

MS. MOLLOW: Mm-hmm.

MEMBER MAZER: But the FQHCs in particular and some of the primary care offices doing Medi-Cal work tend to be overdoing the consultations by having telehealth visits of very minimal basis and then immediately referring to specialty offices. Within the fee-for-service program that is a clear waste of resources and within the managed care eventually it is going to catch up as a waste of resources. So I think we need to be looking at both expanding the tele-consult as part of the program of remote monitoring, but also doing some kind of a look-back here as to whether during the COVID crisis, and as we come out of that, if we need to kind of review the idea of referrals to specialists without appropriate primary care for primary evaluations.

My other question to you and maybe beyond what you have got on your hands, under the Medi-Cal budget, what are the plans for Prop. 56 payments and is there any way -- I know under the legislation, the statutory

rulings on when they are paid, they don't have to be paid promptly. From an accounting standpoint it would be nice if there is a way to start getting concurrent payment of Prop. 56 funds rather than quarterly or semiannually and then it's kind of a mess going forward. Just to give you an example, I just got a payment from HealthNet for 2017 on Medi-Cal patients who were with Multicultural when they went out of business. That's a long ways out to try to figure out the accounting. So just some things that might be able to be looked at under Prop 56. Thanks.

MS. MOLLOW: No, thank you, thank you for those comments. So a couple of things. So e-consults is a component part of our telehealth proposal so that is included there. We do have on our DHCS website a, I think it's like a ten page document of our full proposal of what we are proposing pre- and post-the public health emergency. And there is a nice little cheat sheet chart that we all kind of call it that tells you what was happening pre-public health emergency and then post-public health emergency. And you will see that we are adding e-consults and then making sure that it's clear to people that e-consults are available.

I do want to make a clarification though. So the continuous glucose monitoring is like separate and apart from the remote patient monitoring. So the remote patient monitoring depending upon the needs of the Medi-Cal beneficiary will kind of dictate the types of services and supports that would be used and then we are looking at developing or looking at implementing appropriate CPT codes for the monitoring aspect of those services. So I wanted to let you know that they are kind of like separate and apart in terms of the work that we are looking to do from a health equity lens because we recognize the value of both of

those benefits. But on remote patient monitoring we have not relegated it to a certain set of services, it is really looking at people with chronic medical conditions who have a need for monitoring to help, you know, promote their safety, help them to be maintained in their home, and then to kind of obviate some of those needs for people having to come back and forth into the medical offices.

In terms of Prop. 56 payments, thank you for the comment on that respect. The budget does propose a further extension of the Prop. 56 payments. I do know that with the managed care delivery system it is a slightly different infrastructure in terms of how the payments are given to the plans, but the plans are required to then make those payments directly to the providers. But I can at least take back your comment to my colleagues on that front to see if there is any additional follow-up that can maybe be done with the health plans in terms of their responsibilities for ensuring that those payments do get out in a timely manner.

CHAIR GRGURINA: Thank you.

Jen.

MEMBER FLORY: Hi, René. And as you know, Western Center engages directly with DHCS on most of these issues so just two over-arching comments.

One with regards to the conversation about the governor's budget before and a focus on health disparities. Just wanted to flag that there was disappointment in the advocacy community when it was also stated at the same time that now is not the time to expand Medi-Cal. We know the populations that are excluded from Medi-Cal, whether it's due to their immigration status or

because there still continues to be an assets test on seniors, that lack of access to comprehensive, affordable health care is part of what does drive health disparities. So we just hope, as we see a shifting budget climate, that more consideration would be given for something that would concretely reduce health disparities.

And then the other piece, with regards to the people that are currently on Medi-Cal because the terminations were halted. First of all, big thanks to DHCS for all their work and engaging with us to make sure that people actually did stay on Medi-Cal. It wasn't as easy as flipping a switch so there is a lot of ongoing back end work that still needs to happen there. We are happy to hear that CMS is now engaging to give a little bit more lead time and I know colleagues are starting to have conversations with DHCS on what that will look like when we start to unwind that, given the fact that many Medi-Cal recipients, just like people of any other health plan, have not been getting as much health care during the COVID pandemic so there is a lot of also unmet health needs. And so just being thoughtful in how we are actually moving people through the renewal process, once that time comes, we look forward to continue to engage with you on that.

MS. MOLLOW: Thank you for that and appreciate those comments. And on the continuous coverage requirement, it is very critical that we do have sufficient time in terms of unwinding the public health emergency. Because to your point, it was not easy getting to that point and then unwinding it is equally daunting, especially given the length of time that has passed since the initiation of the public health emergency. So we do continue to advocate for as much time as possible with our CMS colleagues and we are hopeful, but do not

have any word yet in terms of their policy guidance and direction. But we will definitely be engaging with our stakeholder partners in terms of the efforts and our vision for what it might look like for the unwinding as it relates to the Medi-Cal enrollments. So thank you for those comments.

CHAIR GRGURINA: Other comments, questions?

MEMBER YAO: Yes, John. This is Amy, I have a question. First I want to echo everybody's comment, a great presentation. My questions, I think the first one is related to the eligibility redetermination; I think Jen kind of briefly mentioned about it. So can I interpret it as the redetermination will not restart during the public health emergency? So if the public health emergency got extended through the end of the year the earliest stage that could restart would be next year? So that's kind of my first question.

MS. MOLLOW: Yes.

MEMBER YAO: A second question. Oh, go ahead.

MS. MOLLOW: I am sorry, Amy, my apologies. Please, please continue.

MEMBER YAO: Hello?

MS. MOLLOW: Oh, yes. No, I'm sorry, Amy.

CHAIR GRGURINA: Ask your second question, Amy, René is going to answer them both at once.

MEMBER YAO: Oh, okay, okay. My second question is related to the vaccination so maybe I have two parts. I think you did mention that DHCS applied a federal waiver around, distributed the vaccines through the fee-for-service delivery system. So does that mean that a managed care plan does not have a role in that vaccination delivery? So even the managed care members,

they will receive the vaccinations through the fee-for-service delivery system, so that's one part.

The second part is about the cost of the vaccination. I think when you talked about the budget you did mention that there is a budget for not just for the vaccination itself but there is a budget for administration of the vaccination; so could I interpret it as the state actually will cover the full cost of vaccination of all members for both the vaccine itself and the administration?

Those are my questions.

MS. MOLLOW: Okay, thank you. So in terms of the renewals. So what is happening today, just to help manage the workload, counties are still processing renewals. But what is happening is there is a subset of renewals that can be reprocessed. They go through, there is no break in coverage, people can be automatically renewed. That's what we call ex parte. So the counties are relying on existing information that can then say that this person continues to be eligible, then they'll reset the renewal date a year in advance.

There's other individuals who historically when we have random renewals, where we may not have current information on them; in particular for some of our populations that may be subject to asset tests, that was a comment that Jen had mentioned earlier. So each year for those populations we have to verify, you know, the status of their assets and what they have. If we don't have that information available to us then the counties have to reach out and get that information.

So there is a subset of people that, you know, they may have to do some follow-up on, but in doing that follow-up and sending out additional requests for information, if the people respond the counties can take a look at the

information but they cannot take an action that would be a negative action on that person. Meaning, if the information comes back or they don't send the information back, the counties cannot disenroll those individuals because of the continuous coverage requirements under the public health emergency.

What we are looking at and having to work through is what that process will look like, post the public health emergency. We don't want to just wholesale discontinue people that, say, didn't return those packets. We do have an obligation to at least take one more look to then determine are these people still eligible or not. It's a matter of timing because the current guidance from CMS says we have six months to do that work and six months is not enough time to do that work. So right now everyone is staying enrolled in our program, with the exception of people who have raised their hand to be disenrolled from the program, if they are individuals who have moved out of state or if they have passed away. Those are the only legitimate reasons for disenrollment.

And then based upon some recent, a recent federal rule that came out towards the end of last year, if it was determined that a person was not validly enrolled those individuals can be disenrolled. However, we don't have additional guidance from CMS on that front and there was like a moratorium on rules that had come out from the prior administration. So we are, you know, continuing to assess that but right now people are not being disenrolled from the program. And so those, those the -- what people have historically known in terms of Medi-Cal disenrollments, those will occur once the public health emergency has been officially ended. Then we will execute a plan for resuming those renewals for individuals that we otherwise cannot renew during this time period.

In terms of the vaccines. So the vaccine itself is made free. So it's free to everyone, there is no cost to anyone for that. The federal government is paying for the vaccine so there is no cost to the state for the vaccine itself. However, for the actual administration of the vaccine we have put forward our request to CMS to pay at the Medicare rates based upon if it is a one dose or a two dose vaccine. That is similar to what we do today, say, for children in our program who receive their vaccines through the vaccines for children's program. Those vaccines are free to the state, all we pay for is an administration fee. So providers, pharmacies, they can get an administration fee. And so we have put in a request to CMS to have the vaccine administration carved out of our managed care plan. So all Medi-Cal beneficiaries, regardless of who they go to see, those providers will just bill the Medi-Cal fee-for-service program. So they won't bill managed care, but it's any enrolled provider in our program, clinic, physicians, pharmacy, wherever they may go to get their vaccine once they are eligible to receive the vaccine. They can then be reimbursed under our program, and it will be paid for, the administration fee. So it's just, it's just the delivery system in terms of where the payments will be executed but it's for all Medi-Cal beneficiaries regardless of their enrollment in managed care.

MEMBER YAO: Okay, thank you, thanks for the clarification.

MS. MOLLOW: You're welcome.

CHAIR GRGURINA: All right. So, René, I just have three comments for you, you don't need to respond. But the first one is joining Jen and Amy, really thanking DHCS's leadership on the continuous coverage as well as looking to the future of when the public health emergency ends, making sure that CMS is giving enough time for you to be able to go through those

redeterminations instead of just taking a lot of folks off of the program. As Jen said, probably looking for some pent up demand. So we really appreciate the leadership on that.

The second one is on the Rx. Obviously, you did not control, the Department did not control the Magellan-Centene merger. And no surprise what I am going to say is, I know you are looking to try and strengthen the conflicts of interest, we have concerns about that. But we'd also like to point out is when you come back in May and whatever any future date is, what we're saying is please don't push that day prior to January 1 of 2022. We have already been kind of through the motions of starting in January, stopping in January, starting in April, stopping in April. There needs to be enough time to get the systems ready to be able to give all the messages to the beneficiaries about the changes, so that's the second one.

And then the third one is just one for many of us who have been around for a long time, René. You started with talking about the budget and talking about it's a budget of $126 billion. I used to be at the State Department of Finance when it cracked 10 billion a long time ago. So it just goes to show how important the Medicaid program is in the state of California, how much it's grown, how many folks, as you said, up to 14 million Californians who are taken care of from that program. So thank you for your presentation. As I said earlier to Mary, there is a lot on DMHC's plate. You had slides of just the stuff for January of '22, you didn't even add the '23 and ' 24 or '25 where Larry took you to. So thank you for a very nice job. And with that, I see Larry, you have got another question?

MEMBER DEGHETALDI: Yes, just one.

MEMBER RIDEOUT: John, I had a primary question. I'm sorry, I

don't know if my hand is --

CHAIR GRGURINA: You know what, I can only see the virtual hands, I apologize. Why don't we have Jeff and then Larry.

MEMBER RIDEOUT: Just quickly, René, add to the thanks for the great presentation. Are there any updates on the MCP procurement or reprocurement? That was one. And then I think to reinforce something John said on the Magellan contract, and maybe this is for Sarah Ream to consider, is there any statewide conflict avoidance guidelines or policies? Because I think as the state goes through a number of large procurements, HPD being another one, the consolidation on the for-profit side of things is going to keep popping up in one way or another. So I am just curious if every department figures that out for themselves, whether there is guidance on the front end versus the back end? Kind of a broad question.

MS. MOLLOW: So can you, can you ask me the first question again? I'm sorry.

MEMBER RIDEOUT: We got a fairly high-level overview of the reprocurement for managed care plans that is planned for this year; apart from CalAIM, obviously. Is there any update on that that you wanted to provide? I didn't hear anything specific to that.

MS. MOLLOW: Oh, no, I have nothing new to share on that front. We did, at our stakeholder advisory committee meeting there were some brief updates in that presentation on the managed care procurement. So I was just giving an update in terms of the timelines that we have been working on, but I did not have anything to share today in my presentation, so you did not miss that.

MEMBER RIDEOUT: Okay.

CHAIR GRGURINA: Larry?

MEMBER DEGHETALDI: Just a cautionary tone on the mass vaccination efforts underway in California. We have some experience that suggests that it costs about $50. The administration and documentation is expensive. While the vaccine may be free, we are going to be reimbursed about $10, so the economic burden of doing the right thing for all of us that are engaged in these activities will be quite significant. So it is well and good that we can reimburse for some of the administration, but it's a fraction of the cost.

MS. MOLLOW: No, understood. The vaccine for the COVID-19 vaccine is different than our existing vaccine administration rate so we are following and using the Medicare admin rates.

MEMBER DEGHETALDI: Right.

MS. MOLLOW: Administration rates, yes.

MEMBER DEGHETALDI: The Medicare reimbursement is about $15 and the --

MS. MOLLOW: So --

MEMBER DEGHETALDI: Yes. So --

MS. MOLLOW: So --

MEMBER DEGHETALDI: Go ahead.

MS. MOLLOW: Oh, no, I'm sorry, Larry, go ahead, please.

MEMBER DEGHETALDI: No, it's just the -- let's not, let's -- the economic realities are it is going to be very expensive for all organizations that are attempting to do the right thing for Californians. That there will be significant financial losses as we do this.

MS. MOLLOW: No, understood. And we pay, the vaccine

administration rates are based upon either if it's a one dose or a two dose vaccine, and then it's split because I think it's just under $50 between the two rates, I think. One is 16.94 and one is 28.34, I believe.

CHAIR GRGURINA: Okay, Ted, and then I think we are going to have to go to the public, we are running a little bit late; but we are having a very engaging conversation with René.

MEMBER MAZER: Just a quick comment because as you were talking about the reimbursement, regardless of where they went in-network out-of-network, I am operating out of the free clinic down here giving administration. I am thinking, we haven't even asked anybody if they have Medi-Cal. But as Larry said, the idea of doing that, to try to recoup some of the costs, it would probably cost us more to get the information and try to bill it to fee-for-service to Medi-Cal than we would be reimbursed. So it's a real negative number trying to deal with the reimbursement side.

MS. MOLLOW: No, thank you for that.

CHAIR GRGURINA: Thank you, Ted.

Do we have any comments from members of the public?

MS. ORTIZ: Yes, I am showing one. When prompted please unmute yourself, Janet, and state your full name and the organization.

MS. VADAKKUMCHERRY: Good morning, everyone. This is Janet Vadakkumcherry at Health Center Partners of Southern California from San Diego. Can you hear me okay?

MEMBER WATANABE: Yes.

CHAIR GRGURINA: Yes, we can.

MS. VADAKKUMCHERRY: Great, thank you. Thank you, René,

very much for the presentation and your valuable time to come and do that today and answer and field all these questions, which you're doing a great job of so thank you for that. I just had a couple of questions. I am noticing on the DHCS website under CalAIM, I know the documents, the executive summary and the proposal that revised on January 8th, but I noticed this week that the date is now showing updated as of February 17th. It's not immediately clear to me what may have changed, do you happen to have any insight as to that?

MS. MOLLOW: The only thing that I can think of is maybe the announcements of some of the upcoming stakeholder engagements and communications on the timelines for public comment and waiver submission, but the proposals themselves have not changed from what we had released back in January.

MS. VADAKKUMCHERRY: Okay, great, thank you.

And then I may have missed it because I had to take a call while you were speaking about Medi-Cal Rx. Did you say anything about the impact, the potential impact or anticipated impact of the delay in that rollout, be it this Summer or in 2022, with regard to the budget, the governor's budget and what might have to happen if he is banking, if he was counting on that money in 2021 that is not going to be realized to a later date? Any indications as to what the fallout might be if he has to -- I know we'll have the May revise, I guess that's maybe when some of that information will come out, but any line of sight onto potential changes due to the delay in the Medi-Cal Rx rollout?

MS. MOLLOW: Not at this time. I think your assumption is fair to say for May revise, but nothing at this point in time.

MS. VADAKKUMCHERRY: Okay, great. And then only because

of chiming in on what Larry and Ted said, for the FQHCs we are actually looking at $100 for the COVID vaccine, not only for the administration and documentation but the additional outreach and engagement that's needed and the infrastructure to support the types of populations, especially our federally qualified health centers work with. So we are actually just for the, you know. And I know DHCS knows this from our Primary Care Association, but the figure is closer to $100. I just wanted to make that comment and thank you all for letting me ask my questions.

MS. MOLLOW: Yes, thank you. Is it okay if I make a comment?

MS. VADAKKUMCHERRY: Sure.

CHAIR GRGURINA: Go ahead, René.

MS. MOLLOW: Okay, thank you. I want to make sure I am following process. So, Janet, thank you for your comments and your remarks. The one thing I will also add is that for one of those -- in that federal ask regarding the vaccines we have asked to see if we can have the cost of the administration. When someone is presenting, you know, at the FQHC it doesn't obviate what you just shared in terms of the cost impacts. But we have asked to have those services reimbursed separate and apart from the existing PPS rate for an FQHC or an RHC or if it's through a tribal clinic to the rate that we pay to our tribal clinics; so we are having ongoing discussions with CMS. However, if a person presents for a visit and it's an allowable visit and the COVID-19 vaccine is administered during that time, then the clinic will just be paid their corresponding PPS rate or the all-inclusive rate if it's a tribal clinic. So I did want to acknowledge that but do also acknowledge what you are sharing in terms of the additional costs, so thank you for that.

MS. VADAKKUMCHERRY: Good point. You're right, thank you.

MEMBER RIDEOUT: John? John? John?

CHAIR GRGURINA: Yes.

MEMBER RIDEOUT: I may be way off on this but I think the CARES Act keeps going until April and that theoretically would cover costs of COVID-related vaccines. But I don't know about all the qualification requirements, but that's something that's sticking in my head from another discussion I've had recently.

CHAIR GRGURINA: Okay, are there any other comments from members of the public?

MS. ORTIZ: We do have one more. When prompted please unmute yourself.

MR. BARCELLONA: Thank you, Sarah.

Hi, everybody, it's Bill Barcellona from America's Physician Groups. René, thank you for the presentation and for the great work DHCS has been doing all during 2020 on the pandemic.

My comment relates to an additional comment that John lodged on the Rx implementation. So I represent risk-bearing organizations, which are kind of the primary focus of this, this group. The carve-out that results from the implementation of Medi-Cal Rx hits these RBOs in their mid-contract cycle. When it's implemented, as John indicated, it would be less disruptive if it was implemented on a January 1, 2022 calendar date rather than mid-year. Even under that circumstance it would hit mid-contract for a number of RBOs across California and there are about, I think, 86 of them who are in the Medi-Cal program across the state.

And, you know, what we don't know, because of the lack of communication with plans over Medi-Cal Rx implementation, is what the amounts of the carve-out will be once risk is taken away from the RBOs for drugs, to their monthly PMPM payments that they receive from the plans. But bear in mind, during the pandemic they have seen $4 to $5 PMPMs for cost impacts related to COVID-19 testing and treatment costs already, so the implementation of the carve-out mid-contract cycle for these RBOs is going to be disruptive to their capitation payments and ultimately to their financial solvency compliance with the DMHC. So I just wanted to make you aware of that, thank you.

CHAIR GRGURINA: Thank you, Bill.

MS. MOLLOW: Thank you, Bill.

CHAIR GRGURINA: Any other questions or comments from members of the public?

MS. ORTIZ: Showing no raised hands at this time.

CHAIR GRGURINA: All right, thank you. Well, with that, René, thank you very much. Thank you for the extra time, we really appreciate it, and good luck with the rest of your day. Thank you again, René, we really appreciate it.

MS. MOLLOW: Thank you so much. You all take care now. Bye-bye.

CHAIR GRGURINA: All right. So next up is the legislation implementation with Amanda.

MS. LEVY: Good morning, everyone. I want to begin by briefly reminding you of the bills that we are working on implementation throughout 2021. Next slide.

Again, just reminding you of the requirements of each of these bills that I'll talk about and provide an update on the implementation of those requirements, starting with AB 731. AB 731, as you remember, established a rate review process for the large group market.

Starting in July 2020, health plans with large group products were required to file specified rate information with the DMHC annually or 120 days before implementing a rate change.

In addition, effective July 1st, 2020, health plans participating in the individual, small group and large group market were required to submit new geographic trend information to DMHC. Next slide, please.

Finally, effective July 1st, 2021, large group contract holders that meet certain criteria can request a review of their rate change.

There are two key implementation dates and activities associated with AB 731.

For the first phase the DMHC in collaboration with CDI developed the reporting templates for the health plans to submit their large group rate filings. Health plans submitted the first annual submission to the DMHC on September 2nd, 2020. We received 37 filings from 23 health plans. The filings were posted to the DMHC's premium rate review site on November 16th, 2020. The DMHC reviewed the health plans' methodology, factors and assumptions used to develop rates to determine whether they were unreasonable or not justified.

The DMHC is currently working on the second phase of AB 731, which is an online reporting form for the large group contract holders to request a rate review from DMHC starting July 1st, 2021. We are also reviewing

procedures in preparation for the July 1st deadline.

Our second bill that we are going to talk about, AB 1124, which authorizes the DMHC to approve two four-year pilot programs by May 1st, 2021 that would permit risk-bearing organizations or restricted health plans to undertake risk-bearing arrangements with either a qualifying voluntary employees' beneficiary association, or VEBA, or a qualifying trust fund. While these arrangements will not be subject to the full requirements of the Knox-Keene Act, specific categories of Knox-Keene consumer protections must be provided. The pilot program participants must annually report cost savings and clinical patient outcomes compared to a fee-for-service model and performance measurements for clinical patient outcomes and enrollee satisfaction. Next slide. Thank you.

The pilot programs will run from January 1st, 2022 through December 31st, 2025.

The DMHC will report on the program to the Legislature by January 1st, 2027.

And our update on this one, we are currently working with stakeholders on the application form and checklist that the VEBA or qualifying trust fund would need to complete to participate in the pilot program.

Our next bill, AB 2118, requires health plans in the individual and small group market to annually report specified rate information to the DMHC, similar to the information the health plans report on the large group market.

The DMHC is working with CDI on draft reporting templates and will be working with stakeholders to issue the final templates to health plans by July 1st, 2021. The first report will be due to DMHC on October 1st, 2021 for

measurement year 2021.

And the last bill that we will talk to you about today is SB 855, which amended California's mental health parity statute, requiring health plans in all markets to cover treatment for all medically necessary mental health and substance use disorders. The bill also defined medically necessary treatment.

SB 855 further expands health plans' responsibilities to help enrollees obtain out-of-network care when services are not available in-network within geographic and timely access standards.

Health plans are also required to use utilization review criteria and guidelines developed by nonprofit professional associations.

And our update on this bill: DMHC has issued initial guidance to plans and is reviewing compliance with the broader mental health and substance use disorder mandate, medical necessity definition and adoption of the nonprofit associations clinical care guidelines for utilization review.

The last update is DMHC is working on a regulation to be released later this year for SB 855.

And with that, that concludes my presentation. I thank you for your time and take any questions at this time.

CHAIR GRGURINA: All right, thank you, Amanda.

Any questions or comments from the Board Members?

MEMBER DURR: John, this is Paul, I have a question.

CHAIR GRGURINA: Go ahead, Paul.

MEMBER DURR: So Amanda, great presentation. My question has to do with when you are looking at the rate review process on the large group or even small group, do you have a team of actuaries that are available to

help with that process?

MS. DUTT: I can take that one, Paul.

MS. LEVY: I was just going to pass it off to Pritika, so perfect timing.

MS. DUTT: I think you have probably met Wayne Thomas before, he's our chief actuary. We have a team of five senior actuaries that report to Wayne. We conduct rate reviews in-house, we also have some consultants that we use that help us with the rate review process.

MEMBER DURR: Thank you.

MEMBER DEGHETALDI: Pritika, when we talk about regional rates are we talking about Covered California regions or some other geographic subdivision?

MS. DUTT: We are using, we are using the Covered California regions.

MEMBER DEGHETALDI: Thank you.

CHAIR GRGURINA: Amy, did you have a comment?

MEMBER YAO: Yes. I have a question related to the AB 2118 and on the IP and small group transparency. I thought today we are publishing the individual small group rates already so what is the difference? And I saw benefit information and cost sharing, but in California, actually Covered California defined the benefits, so all the health plans who participate are offering basically similar benefits and so the cost share will be similar. So what's the requirement under the AB 2118? What are we asking?

MS. DUTT: Amy, as part of the rate review process when plans file the individual and small group rate those are prospective, so we're looking

forward. For AB 2118 we will do a retrospective review similar to SB 546 requirements for large group currently so we get the aggregate information for the actual rates for the year. And also for the, you know, the benefit designs. Again, I know the Covered California piece is standardized; 2118 requires reporting on and off exchange product as well as grandfathered and non-grandfathered. These are the little nuances to AB 2118 that might not be captured in Covered California reporting.

MEMBER YAO: Okay, thank you.

CHAIR GRGURINA: Other comments or questions, Ted?

MEMBER MAZER: Yes, just -- maybe this is naive. Under the rate review you can make a determination of justifiable or unreasonable, non-justifiable; but what power outside of Covered California do you really have to change those recommended rates?

MS. DUTT: We do not have authority to reject any of the rate changes. However, through our rate review process we have been able to negotiate rate changes. We have been able to negotiate rate decreases with health plans because if we find a rate unreasonable then the plan has notification requirements; so they have to send notifications out to enrollees, employer groups about their rate being found unreasonable by the DMHC. You know, we'll publish it on our website. I think, you know, with just the transparent process we have been able to work with the plans on dropping the rates down when we find that, you know, the supporting documents do not justify the rate increases.

MEMBER MAZER: Thanks.

CHAIR GRGURINA: Okay. Any other comments, questions from Board Members? I have one more for Amanda or Pritika which is, under AB 731

it states that, for the large group rates they have to be provided annually or 120 days before the rate change. If a plan is submitting annually on an ongoing basis does that meet the requirements or do they have to get it 120 days before the rate change is occurring?

MS. DUTT: It is a change in their methodology. So, we understand that through the negotiation process between a large group employer there would be some little variations from, you know, through the negotiation process. AB 731 authorizes us to review the methodology that plans used to develop rates so, you know. I think plans normally, what we have learned is, change those methodologies annually and they don't change it that frequently.

CHAIR GRGURINA: Okay, thank you, Pritika.

Do we have any comments from members of the public?

MS. ORTIZ: Yes, I have one. When prompted, please unmute yourself.

MS. PELED: Hi, this is Yasmin Peled with Health Access California. I just wanted to thank Pritika and her team for their work on implementation of AB 731 and AB 2118. Health Access was proud to cosponsor those measures and we really appreciate the work of the Department in implementing those bills, so thank you.

CHAIR GRGURINA: Thank you.

Any other comments from members of the public?

MS. ORTIZ: No, there are none, thank you.

CHAIR GRGURINA: All right, thank you, Sara.

Okay, thank you very much, Amanda, appreciate it.

So next up is the regulations update and, Sarah Ream, you are

up.

MS. REAM: Yes, thank you. Good morning. The department has been, we have been very busy with regulations over the past 12 months; working on regulations that we anticipated knew we were going to have to work on as well as a number of emergency regulations due to the COVID-19 crisis. So I am going to be starting off giving an overview of regulations we have enacted or that we have in formal rulemaking right now and then I will be moving on to regulations that we are working on internally or we have started the informal rulemaking process and we anticipate starting the formal rulemaking this year.

So first, the enacted or regulations that are in formal rulemaking: Timely access and network reporting. We have this reg in formal rulemaking, meaning we have provided notice to stakeholders, provided notice to the Office of Administrative Law that we are engaging in the rulemaking process. The reg provides a standardized methodology for how plans are meeting the timely access to care requirements and how they report their survey information and how they are complying with the law. The regulation codifies the methodology the plans must use as well as other compliance requirements.

So far we have had two public comment periods, we have received hundreds of public comments regarding this regulation. The second comment period ended on January 21st and my team is currently reviewing and responding to those comments. We have to prepare a written record of the comments and our responses thereto. We anticipate that we will be finalizing this regulation in the next several months. Once it is finalized we will submit it to the Office of Administrative Law for approval and publication so we expect to have this reg in place this year.

Next, we have the COVID-19 testing emergency regulation. I provided an overview of this reg back in August to this group. But just as an overview, this reg was intended to clarify when plans have to cover COVID-19 testing, particularly for asymptomatic essential workers, and provided requirements regarding in-network and out-of-network testing and the delegation of financial responsibility for COVID-19 testing. This regulation will stay in effect until May 14th of this year unless the Department moves to extend or make that regulation permanent. We are still looking, still considering whether that's going to be necessary.

Next we have the summary of dental benefits and coverage disclosure matrix regulation; this is a requirement of Senate Bill 1008 from 2018. The bill, SB 1008, requires the Department in conjunction with CDI and working with the California Dental Association And California Association of Dental Plans to develop a standard benefits and coverage disclosure matrix for plans to use to help inform enrollees and potential enrollees about what is covered by the dental plan. This is similar, this matrix is similar to what major medical and surgical plans already use.

We worked closely with the associations to develop the matrix and the regulation and SB 1008 directs us to adopt the reg on an emergency basis, which we did just a couple of months ago. So we are now working to adopt that regulation on a permanent basis and we will get that work done this year as well.

Finally, we, in January, adopted an emergency regulation regarding transfer of enrollees from hospitals per a public health order. It feels like a year ago but it was only in January that we were experiencing a frightening surge of COVID-19 cases and surge of hospitalizations, particularly down in Southern

California. As a result of that the Department of Public Health issued a state public health officer order that directed hospitals with no ICU capacity in regions where there was very limited ICU capacity to transfer patients when it was medically feasible to do so to hospitals with available space. Under those circumstances the public health order also required the receiving hospital to accept the transfer patients without regard to the patient's insurance status.

Our emergency regulation, which took effect on January 15th, essentially told plans that they can impose no administrative requirements, nothing that could get in the way of efficiently transferring patients per our public health order. Put another way, we wanted the transfers pursuant to these orders, these public health orders, to not be stalled or delayed by any type of health plan approval requirements, utilization management requirements, nothing; we wanted to be able to transfer these patients quickly.

Essentially the point was that in these types of dire situations we need to enable hospitals to transfer patients as quickly as possible when it is medically appropriate to make space for new incoming patients so that we don't have ambulances circling for eight hours or people being set up in the gift shop. This regulation will expire on November 13th. I think we are all really hopeful that we don't have to extend this reg; fingers crossed that we are through the worst of it by November. Next slide, please.

So now I am going to talk about the many regulations that we have in the works that are not yet in formal rulemaking but we are planning to get there shortly. I am going to run through these fairly quickly, I am happy to answer questions either as we go or at the end, probably at the end will be the easiest for the group.

So, SB 855, which Amanda had mentioned in her remarks. The Legislature enacted it last year. This was authored by Senator Wiener. Behavioral health is a very important subject for him. The bill essentially expands mental health parity in California and among other things prohibits plans from limiting treatments for mental health and substance use disorders to short-term or acute treatment. The bill also put guardrails on the UM criteria and guidelines the plans may use for mental health and substance use disorders. Specifically, plans must use the most recent criteria and guidelines developed by the nonprofit professional association for the relevant clinical specialty.

The DMHC is working on an implementing regulation to make specific the requirements in SB 855. We will also clarify and implement provisions in the law requiring the use of these nonprofit specialty association standards; because again, it was generally said in the law that plans must use those guidelines. We need to now work with stakeholders to develop, okay, well who are, who are the associations, what are the guidelines? We are already making good progress on this reg working with stakeholders and we intend to start the formal rulemaking process in the next several months. Our goal with this regulation is to have it submitted for approval from the Office of Administrative Law by the end of this year.

We are also working on the general licensure regulation. So we promulgated, you may recall, in 2019 a regulation that defined various terms including professional risk and global risk. This regulation also requires any entity that accepts any amount of global risk to either obtain a health plan license or an exception from health plan licensure.

So in the year and a half since the reg took effect we have learned

more about the types of entities that are accepting global risks out there in the market and we have a better idea about which entities that are accepting global risk should receive an exemption. The types of entities that don't necessarily need a full license from the department. Based on this information that we have collected we are intending to revise the regulation.

We plan to specify what types and levels of risk qualify an entity to receive an exemption on an expedited basis and which types and levels of risk may require a more thorough review of an exemption request or may even require licensure as a health plan. We are planning to start the formal rulemaking process regarding this regulation in mid- to late 2021, this year, with an effective date for the regulation by mid-2022.

When we first implemented the regulation to allow for a seamless and more smooth implementation process we implemented a phase-in period during which time entities that were accepting global risk but that did not feel they needed a full license could apply for an expedited exemption request. We reviewed those. It was essentially file and use; submit your contracts, submit some high level information to us, and the Department granted a short-term, no longer than two year, exemption for the contract. Because we are working on revising this reg we have extended the time period for that expedited exemption request process. So until our reg is in place, until it is in effect, we are continuing to have the expedited exemption request process for entities that wish to accept some amount of global risk without obtaining a full license.

Provider directories. That is another one that we have been working on for a while. This regulation will codify standards for the directories including standards for information the directories must include as well as

standards for searches and for plan updating of the regulation. We plan to start formal rulemaking on this regulation in May, and again, to submit the reg package to the Office of Administrative Law by the end of the year. We are keeping OAL very, very busy.

Rate reporting and review, so, individual and small group rate reporting as well as large group rate reporting. Amanda and Pritika also already talked about this to a certain extent. We are working on regs to implement these laws, update existing regulations, update forms, update reporting requirements. So regarding the small group and individual market rate reporting, we plan to start formal rulemaking in July and hope to submit the final reg to the Office of Administrative Law by February of 2022. For large group we also plan to start the formal rulemaking in July and hope to have the final regulation to the Office of Administrative Law by March of 2022. These are going to be likely separate reg packages but they are obviously related in that they both relate to rate review and rate filings. Next slide, please.

Grievances and appeals. This is mainly, it is really a cleanup regulation to bring our regulations regarding the Help Center's receipt and review of grievances and appeals, bring that up to where we and the plans are today. Revising some grievance forms and notices, also clarifying what it means to be presented, quote/unquote presented for a fair hearing at DHCS. This reg we plan to publish or start the formal rulemaking process this spring, with a goal of getting it to the Office of Administrative Law by November for finalization.

Deductibles and out-of-pocket maximums, this is also a reg and a topic we have been talking about and working on for quite a while. This regulation will require health plans to track enrollee out-of-pocket maximums and

deductible accumulations through the health plan's grievance process. Meaning that if an enrollee contacts a plan and says I need to know how much have I spent this year towards my out-of-pocket maximum, the plan will need to process and respond to those requests within the same timeframes as the plan would normally respond if it was a grievance. We don't want those languishing and enrollees not getting timely information. We plan to publish or move this regulation into formal rulemaking this spring as well with the goal, again, by the end of this year for it to take effect.

Prescription drug tiers and anti-discrimination. This regulation will provide specificity regarding health plan formulary tiering practices and will prohibit plans from having a formulary that discourages enrollments by individuals with health conditions. Also it will tell plans you cannot, and this is already in the law but will provide more specificity on this, tell plans they cannot reduce the benefits for enrollees with any particular health condition. We plan to start formal rulemaking on this regulation this summer, mid-2021, with the goal of having it published through OAL and finalized by March or April of next year.

Finally, Amanda had mentioned that there was a bill regarding, it is AB 1124, regarding the VEBA pilot program. That bill allows for the creation of two pilot programs, one in Southern California and one in Northern California. In those pilot programs the VEBA or a qualifying trust fund may undertake risk-bearing arrangements with providers. The VEBA and the providers participating in the pilot will have to report to the DMHC regarding any cost savings and clinical patient outcomes compared to a fee-for-service payment model. The goal is to implement the program in an efficient way while also ensuring that enrollees in these types of programs are afforded the Knox-Keene Act

protections. We plan to start formal rulemaking on this reg in June and a goal of having it finalized by the end of this year or January of 2022.

So that brings me to the end of my regulation presentation; happy to answer questions or provide further information.

CHAIR GRGURINA: Any comments or questions? Jeff, why don't you go ahead and go first.

MEMBER RIDEOUT: Yes, just a comment on the provider directory. We are now approaching 200,000 unique provider records, about two-thirds of those are MDs, and we are capturing, approaching 70% of the SB 137 data elements for those attested records. Really our focus is heavily now to get the health plans that have contracted to ingest that information and use it as part of their creation of their provider directory. So I just wanted to give people a chance to hear a little bit of good news. In spite of COVID I think both the plan and the provider community, you know, are still pedal to the metal on trying to get this information into the form it needs to be.

CHAIR GRGURINA: All right, Ted.

MEMBER MAZER: To trail on Jeff's comment, I just had to work a little bit with one of the managed care Medi-Cal plans with the directory because I could not find them in my profile to attest. So there are some -- there are some weaknesses there, too. It's working well but there is a need for improvement and the health plans don't seem to understand how to tell us as providers to find them in the directory system, even if we have already signed up before.

The other comment I had actually has to do with the deductible and out-of-pocket maximums. I am kind of shocked that that doesn't already exist for the patient to be able to find that. I know if we call to ask for a surgical

authorization we can find out instantaneously what their deductible is, how much they have met, what their out-of-pocket maximum is, what their co-pay is, once they have met the deductible. So I am kind of confused as to why the health plans can't already do all of that, with a regulation that's requiring them to do that?

MS. REAM: That's a great question. We have heard from consumer advocates time and again that this is actually an issue for enrollees. We hear that enrollees are keeping receipts in shoe boxes, adding them up on their calculator and taking it to the plan saying, my records say I have met my out-of-pocket max, your record say I haven't, what is happening here? And obviously it is something that we would we would hope the plans are doing already.

The reg, the purpose of the reg, though, is to make sure that for those plans or those instances where this is not happening, that it does happen, and also to make sure that an enrollee's request to its plan for a status of out-of-pocket accumulations is answered timely. We have had discussions about how quickly is it, what is a reasonable time frame? How real-time can the accumulation for the out-of-pocket max be tracked? Unfortunately, there are some issues with lag time between, you know, their. It is not instantaneous. It is not like swiping your credit card at the grocery store and immediately it is tagged into how much you owe on your credit card. There is a lag because providers, it takes time for a provider to in some instances put the claim into the health plans. So there is naturally going to be some time lag but we want to make sure that it happens as quickly as possible.

MEMBER MAZER: Just to follow on if I can, John. I think the lag

time is obvious and we have the same issue. But we can certainly, as should an enrollee be able to say, as of today this is what you have met, if you have had other services, take them into consideration.

The other issue may be the confusion between out-of-network and in-network out-of-pocket and whether it is being applied to a deductible and there may there may be some upcoming legislation on that issue.

CHAIR GRGURINA: Thank you, Ted.

Other comments from Board Members? Jen then Paul.

MEMBER FLORY: Just on that last issue. One of the complicating things we found in particular is for people who are enrolled in Covered California when they are enrolled in a CSR plan that is income-dependent. So they actually at times are required to change plans during the year as their income changes and that's where it gets really dicey figuring out whether somebody has met a deductible or not and it has been very challenging for consumers.

CHAIR GRGURINA: Paul.

MEMBER DURR: Yes. My comment is, I did want to thank Sarah for being open and listening to the provider community with regards to the general licensure requirement. I think she referenced the fact that they received a lot of comments, or where their eyes were open to all of the filings that were done, and that they are relooking at the reg. So I really want to compliment Sarah and her team for being open and being available to think how those regs could be written differently, I am very appreciative of that.

The other comment I wanted to make is, the COVID testing, which was great. We still have concerns on the provider side about the COVID administrative costs. That still is in debate with some of our health plans as to

whose responsibility that is, and you know, when patients are going wherever to get the COVID vaccine, which we certainly appreciate, but the plans are looking to delegated groups to be held responsible for paying for that administrative service, which we would say did not, was not contemplated when we developed the contracts with those health plans. So any relief that you can think about from a regulatory perspective would be helpful.

CHAIR GRGURINA: Thank you, Paul.

Any other comments from Board Members?

If not, any comments from members of the public?

MS. ORTIZ: Yes, I have one comment, question.

MS. PELED: Good afternoon; this is Yasmin Peled again from Health Access. On the issue of deductible and MOOP tracking, I want to thank Sarah and her team for their work on the regulations there. As was already stated, this is an issue for consumers and it is something that we have, you know, been following closely and we actually -- Health Access is sponsoring legislation in this area this year, just because of the issues we have heard from consumers and so we look forward to, you know, working with the Department on this issue as it moves forward.

CHAIR GRGURINA: Thank you.

Other comments from members of the public?

MS. ORTIZ: I show no other questions or comments?

CHAIR GRGURINA: All right, thank you very much.

Okay, Sarah, we are still with you on the federal update.

MS. REAM: Yes. Next slide, please. There have been, obviously, a lot of changes at the federal level, a lot of changes in the works, but not a lot of

changes that have actually taken effect yet. But, obviously, I am going to talk about one that has, the new special enrollment period for individuals and families.

The federal government has opened a new special enrollment period for people to get coverage during this time of crisis. The federal special enrollment period runs from February 15th through May 15th of this year.

Covered California has followed suit and opened a special enrollment period as well, that enrollment period started on February 1st and runs through May 15th.

The DMHC also announced a special enrollment period for individual products sold off-exchange; so we have open enrollment now for -- special enrollment for both Covered California products and off-exchange products. That special enrollment period tracks the Covered California period, runs from February 1st through May 15th. So our hope is that this will enable people who either don't have coverage or need to change coverage to do so during this tough time. Next slide, please.

Next I am going to talk about two presidential executive orders that President Biden issued in January. These orders really articulate the Biden Administration's goal to have a unified national approach to addressing COVID-19 and also to strengthening the Medicaid program nationally as well as strengthening the ACA and the implementation, the continued implementation of the ACA.

So regarding the January 1st EO or executive order, it does, among other things, directs the departments of Treasury, Health and Human Services, and Labor, to clarify the obligations of health plans and insurers to cover

COVID-19 testing. As you may recall, back in June of 2020 those departments, Treasury, Health and Human Services, and Labor, issued guidance stating plans had to cover COVID-19 testing only when an enrollee had symptoms of COVID-19 or suspected or known recent exposure to COVID-19. So this guidance issued in January, contradicted the plain language of the CARES Act and the Families First Coronavirus Response Act. This contradictory language really resulted in confusion nationwide about what health plans have to cover with respect to asymptomatic people.

Largely in response to that federal guidance the Department issued its emergency regulation on testing to ensure that we were able to continue to expand and offer robust testing in California and not just limited testing to people who thought they had been exposed or who had symptoms. We also wanted to make sure, obviously, that essential workers had ready access to COVID-19 testing. So that, it will be interesting to see what happens when those departments go back and relook at that, that guidance.

The January 28th guidance revokes, specifically revokes, and I think that René's presentation regarding DHCS alluded to this. The January 28th executive order revokes President Trump's executive orders issued in January of 2017 and October of 2017. Those previous orders had stated that it was the goal of the Trump Administration to repeal the ACA. The orders directed federal departments to waive or delay requirements of the ACA to the greatest extent possible under the law. The orders also directed departments to look at ways to loosen the rules around association health plans and short-term limited duration insurance and to expand the use of health reimbursement arrangements. So now President Biden's executive order from the 28th directs the federal

departments to evaluate all existing regulations, all orders, policies and similar documents, to identify those that are inconsistent with strengthening the ACA and strengthening the Medicaid program, and to cancel, revoke, otherwise terminate those orders that are not in line with the Biden Administration's direction regarding the ACA. Next slide, please.

And then finally, the pending fate of the ACA. So the Supreme Court's decision in *California v. Texas* is expected in June. The Biden administration directed the Department of Justice recently to -- the Department of Justice submitted to the Supreme Court a letter stating we now -- we have taken another look and we are not, we don't agree with the position we took previously regarding this litigation. That was mostly a symbolic letter, it was not a formal brief; whether the justices will consider it or not is unclear. The Supreme Court during the arguments signaled to a certain extent that they questioned the legal basis for undermining the ACA but it will still be -- it will be an interesting, it will be very interesting to see where they come out on the validity and the constitutionality of the ACA now that the mandate was taken to zero. It is going to be -- June will be here before we know it I am sure but I am anxious to hear what that decision is.

And with that I am happy to answer questions or provide more info.

CHAIR GRGURINA: Okay, comments or questions from the Board Members? Amy first then Larry.

MEMBER YAO: Okay, yes. Thanks, Sarah. I have a question around the strengthening of the ACA. I think I had read somewhere that as part of it there is an idea about expansion of the premium subsidies to some income levels currently not eligible. Is that correct or that is not part of the federal

strengthening of the ACA?

MS. REAM: I am not specifically aware of that. There have been, there has been a lot of discussion, though, so it may just be something that I missed. But I think the Biden Administration is really committed to doing what it can to expand coverage and strengthen the ACA so it wouldn't surprise me if that was one of the endeavors they are trying to achieve.

MEMBER YAO: Okay, thank you.

CHAIR GRGURINA: Larry.

MEMBER DEGHETALDI: Sarah, Congress after, it seemed forever, debate on federal balanced billing legislation did resolve this, I think in January. Who is responsible for implementing that and assuring that we have the, you know, the opportunities to resolve disputes and protect consumers?

MS. REAM: So, great question. The balanced billing legislation really will not impact California to all that great of an extent because we already have robust balanced billing protections in California; we had AB 72, which implemented, you know, balanced billing. The one area is ambulance balanced billing or air -- excuse me, air ambulance balanced billing was addressed in the federal law. That provides some more protections there in California although we also have some laws in that regard. The federal law specifically said that states with more protective laws regarding balanced billing, the federal law does not preempt those or set those aside. So, my office has looked at and we have analyzed the impact there. We don't foresee at this point any profound changes or impacts to California, just simply given the strength of our protections that already existed.

CHAIR GRGURINA: Okay, other comments, questions from the

Board?

MEMBER YAO: Hi, John, I just have one more question for Sarah. It is related to the transparency rule, so where California is at in terms of adopting that. I think this year the provider is required to publish their negotiated rates with the health plan for the CPT codes and the 300 elective procedures, and I heard that next year the health plans are required to publish those negotiated rates. So I am assuming there is some kind of workgroup at the state level around helping implement those requirements?

MS. REAM: So you are talking about the federal level, the transparency regarding --

MEMBER YAO: Right.

MS. REAM: Right, sure. No, we are tracking what is going on at the federal level. At this point my understanding is it is really not -- the states are not being asked to get involved with that at this point. That could change. But yes, that is something that we are tracking at the federal level.

CHAIR GRGURINA: Okay, other comments or questions from Board Members?

Comments or questions from members of the public?

MS. ORTIZ: There are currently no questions or comments.

CHAIR GRGURINA: All right. Well, thank you very much, Sarah, we appreciate it.

MS. REAM: Thank you.

CHAIR GRGURINA: Next on the agenda is the dental medical loss ratio with Pritika.

MS. DUTT: Good afternoon, I think it is afternoon now. I am Pritika

Dutt, Deputy Director of the Office of Financial Review. I will provide you an overview of the 2019 Dental medical loss ratio reports that were received from health plans back in July. In addition to the PowerPoint presentation we have also included the 2019 Dental Medical Loss Ratio Summary Report, that is included in the meeting handouts. The handouts provide the enrollment, dental MLR information for all plans that were subject to the reporting requirement; it also provides the three year MLR trend of dental plans.

Health Plans offering commercial dental coverage are required to file annual dental MLR reporting forms.

The DMHC, CDI, stakeholders, including consumer groups, collaborated on the creation of the dental MLR form and instructions for completion.

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.

Unlike the full service commercial health plans who are required to meet the MLR requirement and pay rebates if they fail to meet the MLR requirement, there is no standard MLR requirement for dental plans.

The plans first reported data in 2015 for calendar year 2014. Current data is for reporting year 2019. For reporting year 2019, 18 dental plans submitted their dental MLR filings that covered 6 million dental enrollees. Next slide.

For reporting year 2019 we had 18 plans that offered Dental HMO products. Last year we had 19 plans, so one dental plan surrendered its license last year and they were not subject to the reporting requirement for 2019.

Fourteen dental plans offered dental HMO products to 478,000 enrollees. The Dental HMO individual market MLR ranged from 13% to 78% and the weighted average MLR by enrollment was 60%. Around 75% of the enrollees in the HMO individual market were in products with MLR of around 60% or higher.

Eighteen plans offer DHMO products to 368,000 enrollees in the small group market. The small group market MLR ranged from 35% to 87% and the weighted average MLR by enrollment was 52%. And then 41% of the enrollees were in DHMO small group products with MLR of 50% or higher.

And then 15 plans offered DHMO products in the large group market and the MLR ranged from 40% to 75% and the weighted average MLR by enrollment was 64%. And here 94% or 1.8 million enrollees were in products with MLR of 57% or higher.

In 2019 the weighted average MLR by enrollment remained consistent compared to 2018 for individual market, small group market and large group market for the DHMO products. In reporting year 2019 for the individual market the weighted average MLR was 60%, for the small group market the weighted average MLR was 53%, and for the large group market the average MLR by enrollment was 65%, so it was pretty consistent when you compare the 2018 to 2019 MLR data. Next slide. Thank you, Jordan.

There were three DMHC plans that offered Dental PPO products for 2019. There were two PPO plans in the individual market with MLR 60% and 74%, with weighted average MLR of 67%. For the three plans in the small group market the MLR ranged from 57% to 62% and weighted average MLR by enrollment was 60%. And for the three plans in large group markets the dental MLR ranged from 47% to 89% and the weighted average MLR here was 88%.

And 98% or 2.7 million enrollees were in the large group products with MLR of 89%.

For reporting year 2018 the weighted average Dental PPO individual MLR was 69%, for small group it was 62% and for the large group market it was 88%. The reported MLR for dental plans varies widely among the product and market types due to the differences in benefit plans, premium structure and provider payment arrangements. And again, unlike -- as I mentioned earlier, unlike full service products, there is no standard benefit designs for the dental plans.

We saw consistent results between 2018 and 2019 Dental MLR data. Additionally, we have seen an increase in the MLR for dental plans over the years when the dental MLR used to be as low as 4%. As I mentioned before, there is no standard MLR requirement for the dental plans but the dental MLR report provides transparency for the dental market. For the previous presentations relating to the dental MLR data, please see the Financial Solvency Standards Board page on the DMHC's website.

With that, I will take any questions.

CHAIR GRGURINA: Questions or comments from the Board Members? Jen.

MEMBER FLORY: I think every year when we see these we are pretty shocked at the difference between the MLRs here and the ones for the full service health plans; and I understand that there aren't standard benefits. And I am happy to see that there aren't plans as low as 4% anymore but it does seem that some of these products should come with a warning to consumers because that just doesn't look like they are really getting value when we are still seeing

plans as low as 13%.

CHAIR GRGURINA: Thank you, Jen. Ted.

MEMBER MAZER: Yes, I just want to second Jen's comments because I am looking at these, and I recognize there is no statutory requirements, it took a long time to get them on the medical side, I think it's high time that we get them on the dental side. We saw what happened in the earlier part of the COVID outbreak where you had plans refunding people's premiums or portions of the premiums because they could see that their MLRs were going to be too low. And here we have dental plans, they may be better than they were, but they are not good. I am not sure what role we can play in that, maybe, you know. On our side, for the medical side, we pushed MLRs. Maybe the dentists don't want to push the MLRs, I don't quite understand the relationship, but there is a lot of money being made on the backs of consumers who think they are buying a product that is not delivering.

MS. DUTT: So one of the things we had shared previously in prior presentations, that some of the premiums in some of these lower MLR products can be as low as $4 per member per month. So with that $4 the plans still have to pay the administrative costs, maintain staffing, claims processing functions, et cetera. So those are some of the variations when you look at the dental products and full service medical products where the major difference in premiums and you know what's covered and what's not covered.

MEMBER MAZER: I get that, Pritika, and it is a different product. But if the plans can't make their profit on something that is basically taking an awful lot off the top of the consumer dollar, maybe there shouldn't be these plans.

CHAIR GRGURINA: Thank you, Ted. Larry, you had your hand

up.

MEMBER DEGHETALDI: As bad as it is in 2019 what is 2020 going to look like with so many patients forgoing dental care? And the same is true on the medical side, 2020 is going to demonstrate lots of holes in our health care delivery system. No analogy to dental caries there but, you know. I agree with every -- but we've been looking at this, Pritika, for a long time and now I understand why my medical group hates it when I give them data that they can do nothing about.

CHAIR GRGURINA: All right, any other comments or questions from the Board Members? All right.

MEMBER YAO: Maybe a comment.

CHAIR GRGURINA: Go ahead, Amy.

MEMBER YAO: Okay, maybe just a comment. Yes, I think on the medical side lots of work has been done around limiting the limited medical benefit, because they really don't provide lots of protections to the consumers. I think the same -- on the dental side. The reason lots of plans with such a low medical loss ratio, because they really don't offer much benefit to the consumers. Those are the type of plans with a really low dental loss ratio as well. So if we want to do something around the dental loss ratio maybe we need to start from the benefit side. Maybe look at it, the value of the benefit first. Really you are just offering the member a discount card, it doesn't really provide a lot of value to the consumers.

CHAIR GRGURINA: All right, thank you, Amy.

Any comments or questions from members of the public?

MS. ORTIZ: Yes, I have one. Jeff, when prompted please unmute

yourself.

MR. ALBUM: Hi, Jeff Album, Delta Dental of California, Vice President of Public and Government Affairs. Once a year you guys look at this report and once a year I come here and try to make the point yet again that MLR is a worthless measurement mechanism for dental. For all of the reasons that make dental different from medical it is worthless. I think in 2017 when the first report came out I stood in front of you, those of you who were here, with a tape measurer and I said, with this tape measurer I can go around and measure every drink that's in front of you, most of you had bottled water, and I can measure exactly how tall that glass is, but I cannot tell you what quality the water is in any of your, any of your beverages.

And this is the same thing. This is the reason Congress did not call on dental plans to have a loss ratio. This is why this year the National Coalition of Insurance Legislators threw out the ADA proposal on a MLR for dental. It just doesn't work mathematically because of the tiny, tiny premium that is being used to provide these benefits.

And I sent to Pritika a five slide show that will show you that even with two dental plans offered today in Covered California with the exact same benefit design, one is a $13 per member per month plan, the other is a $57 per month plan. The plan with the much lower loss ratio saves the average consumer far more money in benefits then does the more expensive PPO program. A DLR punishes any plan that dares to offer a consumer a product of under 20, 15, $12 a month. It punishes it.

And here is the, here is the reason. Spending more on administration does not equal bad for the consumer; spending more on benefits

does not necessarily equal good for the consumer. There are plans that provide too much care because it is the wrong kind of care. There are plans that spend more money on quality, on call center, on customer service. In the case of a $13 plan, if you spend $1 more per person per month your DLR goes down by nearly 10%, something like 8 or 9 percentage points, because the, because the price is so cheap.

So as for the criticism, what value do these plans offer? Look at my slideshow. I will show you how the $13 plan delivering the exact same set of benefits as the higher DLR plan saves the consumer far more, nearly twice as much in an average year, based on consumption of services. Stop using the DLR to take your judgment about whether a dental plan is good for a consumer or not, it's the wrong measurement, it is a tape measurer trying to measure the quality of water.

CHAIR GRGURINA: Thank you, Jeff.

Other comments or questions from members of the public?

MS. ORTIZ: There are no further questions or comments.

CHAIR GRGURINA: All right, thank you, Pritika.

Let's go ahead and move on to the provider solvency quarterly update with Michelle.

MS. YAMANAKA: Hi, Michelle Yamanaka, Supervising Examiner in the Office of Financial Review; next slide please. Today I am going to give you an update of risk bearing organization or RBO financial reporting for the quarter ended September 30th, 2020. The update will include information regarding the status of RBOs, our analysis of inactive RBOs, as well as the status of corrective action plans.

For the quarter ended September 30th, 2020 the far right column represents the results. We have 199 RBOs that file quarterly surveys with us. This is an increase in RBOs. For the quarter there are 3 new RBOs included in this number. We had 2 RBOs that became inactive, which is a net increase of one RBO from the previous reporting period. RBOs are required to file quarterly survey information with us as well as annual reporting. To date we have received 15 annual filings from RBOs that have a fiscal year end of March 31st and June 30th. And as a reminder, the annual survey reports are due 150 days after the RBO's fiscal year end. Also, for the quarter ended September 30th we had 9 RBOs filing monthly financial reports with us as a requirement of their corrective action plan. Next slide please.

From the last presentation in November we provided an analysis of the RBO accounts that have been inactivated. We added the Quarter 3 2020 information as well as provided enrollment information that was requested. First, what we did is our analysis included going back to 2005 when we started receiving financial information from the RBOs. There have been 113 RBOs that have been inactivated; their accounts have been inactivated for several reasons. We tried to capture those reasons in three areas.

The first is Financial Concerns. These are RBOs that had financial concerns and were on a corrective action plan when they were inactivated, the accounts were inactivated. At September 30th there were 39 RBO accounts in this category.

No Financial Concerns category. These RBOs were compliant with all grading criteria and there were no financial concerns. As the quarter ended September 30th there were 54 RBO accounts in this category.

And then we have an Other category, which is kind of a catchall, which includes reasons such as RBO consolidation, duplicate RBO numbers. And as the quarter ended September 30th there are 20 RBO accounts in this category.

So as I mentioned, there were two RBO accounts that became inactive during the -- for this quarter and those RBOs are represented in the No Financial Concerns category.

Moving to the next slide. For the -- in the last FSSB meeting in November it was also asked if we could provide the enrollment that was associated with these accounts that have been inactive. So what we did is we went back, conducted an analysis with the three categories, Financial Concerns, No Financial Concerns and Other, and then we had enrollment ranges associated with each RBO account. As you can see, there are 79 RBO accounts that had less than 10,000 lives assigned to them when they were inactivated. Okay, moving to the next slide.

As part of the financial reports that we receive, RBOs are reporting enrollment information to us. This information is from the reports. As of quarter ended September 30th we have approximately 8.6 million enrollees assigned to 199 RBOs and this is an increase of 1% from the previous reporting period. Next slide please.

The most recent data is reported in the last column of this table and it represents there are 180 RBOs that are reporting compliance with the grading criteria. Within this category there are 16 RBOs on our monitor closely list and there are 19 RBOs that are reporting non-compliance and are on a corrective action plan.

Moving to corrective action plans. As I mentioned, there are 19 RBOs on corrective action plans and we have 23 CAPs, so there are four RBOs that have two corrective action plans active for the quarter ended September 30th. Of the 23 CAPs, 19 are continuing from the previous reporting period and we received 4 new CAPs for the quarter ended September 30th; and as I mentioned, 4 RBOs have 2 CAPs. Of these 19 continuing CAPs, 17 of the CAPs are meeting their approved projection projections and 2 CAPs or RBOs are not. With those 2 RBOs we are working with them and making a determination if they will be able to continue to meet or will be able to meet their approved projections.

Of the 23 approved CAPs, 21 are -- of the 23 CAPs, 21 are approved and 2 were in review. For those 2 we are working to get an approvable CAP. Moving forward with the September 30th -- wait, one slide back not quite done yet. Looking forward for these 23 CAPs after our review of the September 30th financial information, 12 of the 23 CAPs or 9 RBOs have been -- these CAPs have been completed, these RBOs successfully met the terms of their CAP. So going into fourth quarter we started with 11 CAPs that were continuing.

We also have a handout titled the CAP Review Summary as of September 30th and this has information that is sorted by the MSO if the RBO has contracted with them. But in addition to the previous reporting information that we have been presenting, we also added another column which has the contracted health plans, or RBOs, that are contracting with the RBO, so that information has been included in the handout. Moving to the next slide.

Effective October 1st, 2019, the RBO regulations were revised and went into effect. There was a new minimum requirement for TNE. Previously, it was positive, which was $1 or more. The revised regulations defined positive,

which is now a minimum of 1% of annualized healthcare revenues or 4% of annualized health care expenditures. There is a phase-in period with this requirement which went into effect on October 2nd of 2020.

Looking at the September 30th financials, there were 6 RBOs, which is represented in the column <100%. There were 6 -- as of September 30th, 2020, there were 6 RBOs that were not meeting the new TNE requirement. Of those 6, 2 are on a CAP and the remaining 4 were on our monitor closely list. Next slide please.

In addition to the revised regulations there was also a change to the cash-to-claims ratio. And we did the same analysis to determine at September 30th which RBOs did not meet the new reporting requirements. As of September 30th there was one RBO that did not meet the new requirement and they are currently on a corrective action plan. Next slide, please.

So last I want to talk about the RBOs that have Medi-Cal lives assigned to them. We conducted an analysis of these RBOs and for the quarter ended September 30th there were 4.8 million lives assigned to 86 RBOs. This represents approximately 56% of the total lives assigned to 199 RBOs. Of these 86, 65 RBOs had no financial concerns, 11 were on our monitor closely list and 10 of these RBOs were on a CAP.

We also looked at the top 20 RBOs, next slide, please, that had Medi-Cal lives, that had over 50% Medi-Cal lives assigned to them. And of those, the top 20, there were 3.7 of the 4.8 million lives assigned to these top 20 RBOs. For the top 20, 11 had no financial concerns, 4 are on our monitor closely list, and 5 are on corrective action plans.

And with that, that concludes my presentation and I want to open it

up to questions.

CHAIR GRGURINA: Comments or questions from Members of the Board? Ted.

MEMBER MAZER: Thank you for that presentation. It is great to see that there were two fewer RBOs under CAP right now than previous reported, although I wonder if those might be the inactive RBOs at this point, that's not clear. But when we look at slides 157 and 158 and we look at these RBOs with Medi-Cal lives we don't have the comparisons for RBOs without Medi-Cal lives. These numbers are a little bit worrisome when you are looking at those that have greater than 50% of Medi-Cal, almost 50% of those are on CAP right now; and overall with Medi-Cal lives, 25% of them are on CAP. I would like to If you can tell me how does that compare with the non-Medi-Cal RBOs and are we concerned about the fact the greater the number of Medi-Cal lives the more likely they are going to be on CAP?

MS. YAMANAKA: Let me get to that slide real quick. So when we are looking at the top 20, there were 5 out of 20 that are currently on a CAP. And overall -- we conducted an analysis where, yes, there are, there are RBOs that are on corrective action plans. But again, we have 199 RBOs and a majority of them, 90% of the RBOs are currently compliant with all solvency criteria. So while we are looking at the Medi-Cal lives, we also need to look at the reasons why they are on a CAP. Some of them may be on a CAP for claims timeliness, which may not, there may not be a financial reason for it. Those tend to be claims processing issues where we have seen that there have been system conversions to those. So we need to look at those a little bit more to determine the exact reason for these RBOs.

Now, let me remind you that of the 23 CAPs that we had, 12 were completed after receiving the September 30th financials, so that is not reflected in the Medi-Cal slides. We are talking about the 23, we are talking about the 23 CAPs. So a lot of those -- some of -- I want -- let me reverse. Some of those RBOs may have become compliant that have the Medi-Cal lives assigned to them.

MEMBER MAZER: Okay. And I did mis-speak when I said they were on CAP, they are either monitor closely or on CAP, so there are some issues with these different Medi-Cal RBOs. From that standpoint I think at the next presentation can we also see the RBOs with no Medi-Cal lives and see what those numbers look like as the comparison.

And then my final comment then I'll shut up. On the CAP review summary slides which you didn't present just now, it is great that you have added in the health plans and a chart to figure out which health plans are with which RBOs, but it looks like we have dropped the quarterly summary report that gave us the quick ability to see trends. How many quarters in a row has an individual plan been on a CAP? Can we get those reinserted in this chart, however you can figure it all out on one page or not, so that we can see those trends, not just the current numbers?

MEMBER WATANABE: Sure. It was getting quite busy with all of the X's so what we did is we included -- and we will take a look at that, we will take that back and take a look at it. But what we did is we included the quarter the CAP was initiated so then you could see the timeline from when it started and to current, yes.

MEMBER MAZER: I see that, but the visual was a lot easier to

quickly look at on the old charts.

MEMBER WATANABE: Okay, we will definitely take that back. The one other thing I wanted to mention was the two RBOs that the accounts were inactive for September 30th, those RBOs are reflected in the no financial concerns, so they were not on a corrective action plan when we inactivated the account.

MEMBER MAZER: Good to know, thank you.

MS. YAMANAKA: Okay.

CHAIR GRGURINA: If I could just add to Ted's comments. It may be that we will just have to have the two different charts in order to see the trend. But I do want to compliment, Michelle, you and the team at DHCS. This is, for folks in the public, it's on the website, it's called the Risk Bearing Organizations on a Corrective Action Plan. You can punch that up. And what they have done is they have taken into account board members and public members requests for more information. So it not only shows those on a CAP, but it lists who their MSO is, who they contract with, their enrollment, when was the CAP initiated, are they compliant with the final CAP, and what is their specific deficiency? This is a lot more information than we have had and what we requested and thank you very much, Michelle, to you and the team. And so as Ted said, I guess I would double down and say, if we can continue to have the old one that also had the pieces over time so we can see the trend, that's helpful as well. I don't know that we can quite get it on one chart, but just to the extent that we have access to it will be helpful. Larry.

MS. YAMANAKA: Okay.

MEMBER DEGHETALDI: Just holistically looking at the patients

that find themselves in plans that have CAPs. Is the clinical quality worse when plans are struggling, RBOs are struggling, in the care of patients? As we look at disparities. I would suspect as a clinician that if for whatever reason there is financial pressures on the payer that patients, you may see disparities in health, not just outcomes, but in cancer screening and hypertension management, go down the list. And that, we have never looked holistically at what happens to patients when their RBOs or their health plans are struggling financially.

MS. YAMANAKA: So one of the things that we do look at is we check with our Help Center that receives information regarding concerns or complaints to see, especially if we do see that there is a hardship with an RBO, to see if there have been any complaint submitted to the department, yes.

CHAIR GRGURINA: All right, any other comments or questions from the Board Members?

MEMBER YAO: I have a --

CHAIR GRGURINA: I saw Paul's hand first. Amy, can we have Paul first?

MEMBER DURR: No, Amy had raised her hand before, go ahead, Amy.

CHAIR GRGURINA: Okay. Go, Amy.

MEMBER YAO: Okay. Thank you. I have actually an observation. I do agree with the comments; it would be good to see more trend information. So maybe my interpretation may be wrong. You know, for 2020 there were lots of concerns about provider solvency given the COVID, the drop in the revenue for the providers. And at least looking at the information shared here on the surface I didn't really see the number of plans on CAPs or number of plans with a

very low TNE, has that materially increased from last year? So at least from that perspective I found it encouraging that most of our providers actually weathered the COVID fairly, fairly good. My observation may not be right but that's kind of my kind of a-ha moment. So I don't know whether, Michelle, that's a right observation or not?

MS. YAMANAKA: You know, as a September 30th, the grading criteria is pretty much what drives the compliance. And so there's 180 RBOs that are reporting compliance with the solvency criteria and we had 19 on corrective action plans. Really at quarter ended September 30th once we did our review that number dropped for the RBOs that were compliant because we closed 9 -- 11 of the -- -- 13. Hold on. Hold on a second, I want to make sure I get the number right. We closed or the RBOs completed, hold on a second, 12 of the CAPs, which represented 9 RBOs because these RBOs had -- the RBOs that completed the CAPs had -- 4 of them had two CAPs. So when you look at that, really there were more than 180 RBOs that were compliant. Add another 9 to it, it's 189 RBOs that were compliant at September 30th. So that's where we are at right now.

And so we do have, what did I mention, 16 RBOs on our monitor closely list. They are still compliant but we are just monitoring the trends in those, in those 16, so there could be additional non-compliance in the upcoming quarter. So we'll have -- we are working on that right now.

CHAIR GRGURINA: Paul.

MEMBER DURR: Michelle, great report, thank you. I echo everyone's comments about including the health plan on there. It was really good to see and it shows more accountability as to the oversight that those plans

should be doing. Looking at that report you can see consistency from certain health plans showing up multiple times would kind of give you an indication as to whether they are doing their oversight responsibility or not, so thank you for that.

As you mentioned, I think the other thing to note is that there is an improvement overall in RBOs and financial solvency so that is a great thing so I applaud the oversight that you have on that and how everything is improving and it's a very small number of groups that are more at risk.

Two questions though. One I feel from our group is that we are getting a lot more audit specificity with regards to claim timeliness. Our RBO has been very well positioned but I don't know if there is any regulation, new regulation, because we are getting it from multiple health plans asking for more detail on the claim timeliness audit. Didn't know if you had any insight into that?

And my other question for you is, you know, as the new solvency standards have gotten implemented, as you said they are on a tiered process, I think there were three maybe RBOs that might be falling short of the increase. Are you concerned about ever increasing, you know, where those requirements go and the ability of those RBOs who are failing now to continue to meet those or will they have a path forward to getting corrected?

MS. YAMANAKA: Okay, so let me take your first question first regarding the claims timeliness. So, we did recently issue revised instructions for the claim settlement practices report. While the format hasn't changed, we tried to add some clarity to get some consistency in the reporting of those areas, so the instructions are more specific as to what needs be reported in each area. As for the health plans, we haven't heard the same comment where they are asking for more. I am not sure if it has to do with the revised instructions or if it is

something else. So, maybe we can talk a little bit more after to get a little bit of detail on that, if that works?

MEMBER DURR: Yes, thank you.

MS. YAMANAKA: Okay. Regarding the second area with the RBOs and the new reporting requirements. So, we did receive the December financials that came in. As we mentioned, there were six RBOs at September 30th that were not meeting this new TNE requirement. Of those six, two of the RBOs submitted corrective action plans and so we are working with them on that. As for the cash-to-claims, there is one RBO that is currently on a CAP and so within that CAP we are also addressing the new reporting requirements as well. So while there are concerns they have been addressed in the December 31st and the ongoing CAPs for the new revised requirements.

MEMBER DURR: Okay, thank you.

CHAIR GRGURINA: Okay, are there any comments or questions from members of the public?

MS. ORTIZ: There are no questions or comments at this time.

CHAIR GRGURINA: All right, thank you very much, Michelle.

MS. YAMANAKA: Thank you.

CHAIR GRGURINA: Next we have the health plan quarterly update, Pritika.

MS. DUTT: Thank you, John. The purpose of this presentation is to provide you an update of the financial status of health plans at quarter ended September 30th, 2020. We have been tracking the health plan financials and enrollment trends very closely and we are working with plans if we see any unusual trends or variations in their financials that would raise concerns.

As of January 5th, 2021 we had 134 licensed health plans. We licensed two additional health plans since the last FSSB meeting. We are currently reviewing 13 applications for licensure, 9 full service and 4 specialized. Of the 9 full service, 3 are seeking licensure to be Medicare Advantage plans and directly contract with CMS, 5 are looking to get licensed for restricted Medicare Advantage plans and 1 for restricted Medi-Cal. For the 4 specialized plans, 2 are looking to get licensed for dental and 2 are looking to get licensed for behavioral health and offer employee assistance program products.

At September 30th, 2020 there were 27.52 million enrollees in full service plans licensed with the DMHC. Total commercial enrollment includes HMO, PPO/EPO and Medicare supplement. As you can see on the table, compared to the previous quarter, total full service enrollment increased by 350,000 enrollees and that was driven by an increase in government enrollment. However, commercial enrollment experienced a slight decline in enrollment. An interesting observation to note on this table is that from December 31st, 2019 to March 31st, 2020, commercial enrollment had increased by 340,000, and after quarter one we started seeing a decline in commercial enrollment. Government enrollment, on the other hand, was declining prior to March 31st and then started increasing after March 31st and we saw an increase of 780,000 enrollees in government products since March 31st, 2020. Next slide.

This slide shows the makeup of the HMO enrollment by market type. There were 10.85 million enrollees in the HMO products at September 30th, 2020. As compared to quarter ended June 30th, 2020, HMO enrollment dropped by 50,000 lives. Enrollment in the large group market decreased by 70,000 lives, while individual market gained 20,000 more enrollees compared to

the previous quarter. Since the first quarter, which was March 31st, 2020, HMO enrollment decreased by 100,000 lives.

This slide shows the makeup of the PPO/EPO enrollment. As you can see on the table, the large group, small group and individual PPO enrollment remained consistent compared to the previous quarter. Similar to large group HMO products, large group PPO product experienced a slight decrease.

This table shows the government enrollment, which is Medi-Cal and Medicare. Overall the government enrollment increase in September 30th, 2020. Medi-Cal enrollment increased by 360,000 lives at September 30th, 2020 when compared to June 30th 2020. And as you can see on this table Medi-Cal enrollment has increased since March 31st, 2020. Medi-Cal enrollment has grown by 700,000 lives since the first quarter or during the pandemic. Medicare enrollment also increased slightly.

And as you saw on the previous two slides, for the second and third quarter we are seeing a decrease in large group commercial enrollment, which is not significant. One slide back, Jordan. Thank you. Also the individual and Medi-Cal enrollment has increased during the same period of time. However, we are not sure if the same enrollees from the large group market transitioned into individual and Medi-Cal products. Next slide.

We are currently monitoring 30 health plans closely due to various reasons, including but not limited to declining financial health issues with claims processing, plans going through a claim system conversion, issues identified during our financial audits, newly licensed plans, or concerned with their parent entity. There are 4.4 million enrollees enrolled in the 25 closely monitored full service plans. Of the 25 closely monitored full service plans, 12 are restricted

licensees and had less than 1 million enrollees. Next slide. Okay, thank you.

Vitality did not meet the Department's minimum financial reserve or TNE requirement. So as you may recall, Vitality has been showing up for a few quarters now. So, Vitality is a Medicare Advantage health plan that operates in Santa Clara and San Joaquin Counties. Vitality remains TNE deficient since it went operational in 2019 and we have been working very closely with CMS and DMHC's Office of Enforcement.

The DMHC issued a cease and desist order on June 30th, 2020 that prohibits Vitality from accepting new members effective July 2nd, 2020. CMS placed a similar sanction on Vitality based on the DMHC's C&D order. Due to the severity of Vitality's TNE deficiency and ongoing financial viability concerns the DMHC issued an accusation on July 31st, 2020 to revoke Vitality's license. Vitality had 15 days to request a hearing, which it did, and the Office of Administrative Hearings has scheduled a hearing date for April 26, 2021. Additionally, CMS issued a special enrollment period from September 1st to November 30th due to significant change in provider network for Vitality's members. So Vitality enrollees had a one-time special enrollment special opportunity to choose a different Medicare health plan or change to original Medicare.

At the end of December, Vitality notified the DMHC it has filed for Chapter 11 bankruptcy. Our Office of Enforcement has been in communication with Vitality's bankruptcy attorney on a regular basis. At January 1st, Vitality's enrollment had declined to 1,300 enrollees split evenly between Santa Clara and San Joaquin counties. We have been informed that the enrollment number has further dropped to 860 enrollees starting March 1st, 2020.

We have been in communications with Vitality's bankruptcy representatives who are looking for buyers that would be interested in purchasing Vitality. So, a lot of activities going on with our oversight for Vitality, a lot of coordination going on with CMS, because like I mentioned earlier, it is a Medicare Advantage plan. We license Medicare Advantage plans and oversee the financial solvency, all other oversight work happens at the CMS level so there is a lot of coordination happening here. Next slide. Thank you.

So this chart shows the TNE of health plans by line of business. A majority of the health plans with over 500% of TNE are specialized health plans. This is because the required TNE is higher for full service plans due to the medical expenses or risk being higher for these full service plans. For most plans the required TNE is driven by medical expenses. The higher the plan's medical expenses, the higher the reserve requirement for these plans are.

This chart shows the TNE of full service plans by enrollment category. Sixty-two health plans for over half of the total, licensed, full service health plans reported TNE of over 250% of required TNE.

This chart shows A breakdown of the 21 full service plans in the 130% to 250% range. If a health plan's TNE falls below 130% the plan is placed on monthly reporting. We also monitor the health plans closely if we observe a declining trend in their financial performance, which is TNE, net income, enrollment or concerns with the plan's parent or affiliated entities.

This chart shows the TNE by line of business for plans that are being closely monitored. As you can see, six plans with over 500% of TNE are being monitored closely; and this may be because of claims processing issues, declining financial performance, amongst other things. So, although 500% may

seem high, if we start seeing a plan at 1,000% and we start seeing their TNE trend dipping over quarter after quarter then we watch them closely to ensure that there is no further decline in the reserve requirements. Next slide.

We just received the fourth quarter financial statements. One of the things we will be adding for the next presentation would be the TNE and enrollment levels for each health plan.

That brings me to the end of my presentation. I will take any questions.

CHAIR GRGURINA: Comments or questions from the Board Members? Ted, then Jeff.

MEMBER MAZER: Two points. One on the Vitality issue. It's one of the reasons I keep on raising issues of enforcement. It looks like the patient enrollees were well managed, for the most part they went to other plans. Do we have any idea of the impact of payments on the providers as this was going south and whether the providers were significantly hit by not being paid or if the health plans are backing that up? That's number one. And I'll let you answer that then I'll go to number two quickly because I know we are short on time.

MS. DUTT: So for number one, we did hear from providers not getting paid. So, I know that they reached out to CMS on that as well. Like I said, the network piece is handled by CMS. Those now have to go through the bankruptcy process. They have to, you know, they are one of the creditors. They did have some unpaid claims liabilities on the books.

MEMBER MAZER: Okay. And again, from the provider standpoint, I think that is always the concern when enforcement isn't brought in early, it is often the providers left holding the bag.

Let me take you back to your slide number 55, the closely monitored plans, for a moment. Restricted plans, which I frankly still don't quite understand and maybe you can give me a sky high in 30 seconds or less, what constitutes a restricted plan. But of all of the closely monitored plans, restricted plans are three times the number of plans of commercial on closely monitored and over four times the enrollment. Is there something wrong with the restricted model or is there something else behind this?

MS. DUTT: So to define the restricted plan, so these are plans that get their enrollment through contracts with other plans that directly contract with enrollees. So restricted plans do not go and enter into contracts with DSCS, CMS or employer groups or individuals, they get their enrollment through, you know, acting as subcontractors to the fully licensed health plans. We have them on the monitor closely list because some of them are newer and then there could be low enrollment there where we are watching them closely, because, you know, just the low enrollment may cause some, you know, concerns for us because they might not have like enough enrollment to spread any losses, et cetera. The other thing is, most of them are newly licensed MA restricted plans there so we are watching them closely. They are new, just went into operation, so watching them closely there.

MEMBER MAZER: All right, thank you, Pritika, thanks.

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

MEMBER RIDEOUT: This for the plan and the RBO, just a general comment. We have talked a lot about the impact of COVID on normal patterns of care and utilization and payment. I am just wondering, and maybe not just for

Pritika, but is there a role that we see for this committee going forward to assess the accommodations for those changes in terms of our oversight of financial stability in particular? I know at IHA in a small way we have modified all of our performance measurements and looked at how provider groups can comply using new NCQA telehealth guidelines and stuff. I guess what I just don't want to do is start to see a lot of really strange things in the next couple of quarters and not know how we are going to process what we are seeing.

MEMBER WATANABE: Jeff, maybe I'll take that one. We have been keeping a very close eye on all of this, as you know, just as we hear from plans and providers but also as the financial reporting comes in. We are in the process of looking at the fourth quarter financials and so I think the next meeting, in the presentation we make then, I think we will have probably some new information to share.

One of the other pieces that I think we want to kind of revisit with the Board, as a preview for the next meeting, is just kind of the purpose of the meeting, and of the Board and if there are other things that we should be talking about and looking at. But I think in particular the impact of COVID on all of the work of the Department will continue to be something that we will want to engage with the Board and get your input on. So, a very valid and timely point, Jeff.

CHAIR GRGURINA: Larry.

MEMBER DEGHETALDI: Just to follow up on Jeff's question and, Mary, I love that opportunity to refocus or rethink this. COVID has really made visible disparities and we are now talking about that. And clearly, you know, providers that are paid Medicaid rates, which are lower than commercial rates, I am worried that when we have our quality data for 2020 that disparities will have

widened. And outcomes, we certainly know that COVID impacts communities, lower income communities far worse. I am worried that mammography rates or A1C control will have suffered and that will compound, you know, outcomes and COVID morbidities. So I am worried about where the managed Medi-Cal plans are going to be as this goes forward, I am worried about the impact on their patients, and I just want to keep sort of that holistic view of -- because there is an interrelationship between financial stressors and patient access and outcomes and we just have to, we can't be blind to that. Thanks.

CHAIR GRGURINA: Thank you, Larry.

MEMBER WATANABE: Thank you, Larry.

CHAIR GRGURINA: Other comments or questions from Board Members? Jen.

MEMBER FLORY: First of all, thanks for sharing all of the plan enrollment numbers. I think people have been very eager to look at that recently because we are concerned about what is happening to people, so it is with a bit of relief that we see that even though we have seen losses in the commercial market that we are seeing people picked up in other places. And I think, like Pritika mentioned, we don't know if these are one to one but we are seeing increases in the individual market and in Medi-Cal.

You know, one thing to flag, I think there have been a whole lot of stressors on people in terms of consumer debt and things like that, so as we do see moves to the individual market that is another, even though we are thrilled that people have gotten coverage, we do know that coverage can be more expensive for the consumer in that market.

And then the other piece, I mean, bearing in mind the totality of the

COVID world. And I think, you know, we are all very eager to see where the medical loss ratio ends up. You know, one of the things as I was looking at this I was wondering, you know, the presumption among consumer advocates has been that plans have been paying out less as people have had less access to care. So we are wondering if that is at all, like, helping some of these plans improve their tangible net equity and, you know, would that mean that fewer plans are on corrective action plans? And it looks like things are just kind of trending along as they have been so I don't know if there were any thoughts about that for things that we're not seeing in there?

MS. DUTT: So one of the things, we just got the fourth quarter financial statements so we are going to look at that very closely, compare it to 2019 fourth quarter information as well as some do some comparisons between 2019 and 2020 data. Preliminary, I am not -- we didn't see like plans reporting high profits for fourth quarter, right, so that's one of the things that was surprising to me was they didn't like report high profits for the fourth quarter. And then I think we have a couple more plans that went TNE deficient; again, we have to do a detailed analysis on that. We will be able to share something at the next meeting on that, Jen.

CHAIR GRGURINA: Okay, given the time why don't we see if there's any comments from the members of the public for Pritika?

MS. ORTIZ: There are none at this time.

CHAIR GRGURINA: All right. Why don't we go ahead and we -- we have an agenda item, public comments for any matters that are not on the agenda. Are there any comments?

MS. ORTIZ: There are currently no questions or comments at this

time.

CHAIR GRGURINA: Thank you, Sara. Okay. And then we have an agenda item, which is for the Board Members, do we have any future items we'd like for future meetings? We already heard about the COVID update, we have heard about the financials for the plans coming up, Mary talked about bringing back for us the focus of the Financial Solvency Standards Board going forward. Does anyone have anything else they would like to add for the next meeting? Seeing that, we are desperate to get to our one o'clock meetings that we all have.

So the last thing that we have in closing is a reminder that we have our next meeting May 12, 2021; it will obviously be video as we have here. And then just thank you, everyone, for your attendance and participation and we will look forward to seeing you on May 12. Thank you, everyone.

(The meeting was adjourned at 12:59 p.m.)

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CERTIFICATE OF REPORTER

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 11th day of March, 2021.

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