STATE OF CALIFORNIA

DEPARTMENT OF MANAGED HEALTH CARE

FINANCIAL SOLVENCY STANDARDS BOARD (FSSB) MEETING

HYBRID IN-PERSON/ONLINE/TELECONFERENCE MEETING

DEPARTMENT OF MANAGED HEALTH CARE

980 9TH STREET, CONFERENCE ROOM 2nd FLOOR

SACRAMENTO, CALIFORNIA

THURSDAY, MAY 19, 2022

10:00 A.M.

Reported by: Ramona Cota

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APPEARANCES

BOARD MEMBERS

Larry deGhetaldi, MD, Chair

Scott Coffin

Abbi Coursolle

Paul Durr

Theodore Mazer, MD

Jeff Rideout, MD

Mary Watanabe

Amy Yao

DMHC STAFF

Pritika Dutt, Deputy Director, Office of Financial Review

Jessica Petersen, Assistant Chief Counsel

Daniel Rubinstein, Associate Governmental Program Analyst

Michelle Yamanaka, Supervising Examiner, Office of Financial Review

ALSO PRESENTING/COMMENTING

Lindy Harrington, Deputy Director
Department of Health Care Services, Health Care Financing

William "Bill" Barcellona
America's Physician Groups

Kimberly Carey
MedPOINT Management

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PROCEEDINGS

10:01 a.m.

CHAIR DEGHETALDI: Welcome, everybody, to the first in-person meeting since I think February of 2020 so this is exciting. We have four board members in the room and three virtually attending. This is Larry DeGhetaldi, the Board Chair. Mary and I would like to start, before introductions, with housekeeping notes; and they are a little bit lengthy because we have this combined Zoom/in-person meeting.

This meeting is being conducted in hybrid format, with the opportunity for public participation in-person or virtually through video conference or teleconference.

Please note the following for those joining us in-person today. There is a sanitation station located outside of the conference room where you will find masks and hand sanitizer. Masks are strongly encouraged. The women's restroom is located at the end of the corridor to the left, the men's bathroom is located just beyond the women's restroom on the other side of the catwalk. The entryway is near Suite 200. Both the men and women's restrooms can be accessed using code 5314. The code is also posted inside our conference room doors. Please remember to silence your cell phones.

For our Board Members here in-person please do not join the Zoom meeting with your computer audio. To ensure that you are heard online and in the room please use your mic in front of you and push the button on your microphone to turn it on and off. The green light will indicate that it is on, red will indicate that it is off. Please remember to turn off your microphone when you have finished. Please speak directly into the microphone and move it closer to

you if necessary to ensure that everyone can hear you.

Questions and comments will be taken after each agenda item, first from the Board Members and then from the public. For those who wish to make a comment please remember to state your name and organization you are representing. And as Board Members make comments please also state your name as you make a comment so you can keep that for the record. Any Board Member who has a question please use the Raise Hand feature. All questions and comments from Board Members will be taken in order in which raised hands appear, Jordan will keep me honest on that.

Public comment will be taken from individuals attending in person first. For those making public comment at the podium here in front of the room, please be sure to leave your business card or write your name down and title and leave it on the podium so that our transcriber can accurately capture your info. For those making public comment virtually, please use the Raise Hand feature.

For those joining online or via telephone please note the following. For our Board Members attending online, please remember to unmute yourselves when making a comment and mute yourselves when not speaking. Please state your name and organization. For our Board Members and the public attending online, as a reminder, you can join the Zoom meeting on your phone should you experience a connection issue with the Zoom.

For the attendees on the phone, if you would like to ask a question or make a comment please dial *9. State your name and the organization you are representing for the record. For attendees participating online with microphone capabilities, you may use the Raise Hand feature and you will be unmuted to ask your question or leave a comment. To raise your hand click on

the icon labeled Participants on the bottom of your screen, then click the button labeled Raise Hand. Once you have asked your question or provided a comment please click, Lower Hand.

As a reminder, the FSSB is subject to the Bagley-Keene Open Meeting Act. The Bagley-Keene Act requires the board meetings to be open to the public. As such, it is important that Board Members refrain from emailing, texting, or otherwise communicating with each other off the record during board meetings because such communications would not be open to the public and would violate the Act. We also ask that you not use the Zoom chat feature as these comments or questions may not be viewable by the public.

Likewise, the Bagley-Keene Act prohibits what are sometimes referred to as serial meetings. A serial meeting would occur if a majority of the Board Members email, text or spoke with each other outside of a public Health Equity and Quality meeting about matters within the Board's purview. Such communications would be impermissible, even if done asynchronously. For example, member one emails member two, who emails member three, et cetera. Accordingly, we ask that all members refrain from emailing or communicating with each other about board matters outside the comments of the public. Mary, did I miss anything?

MEMBER WATANABE: No, but I think any references to Health Equity Committee means FSSB. Sorry, we are re-purposing some of our talking points.

CHAIR DEGHETALDI: I understand.

MEMBER WATANABE: You're okay, yes.

CHAIR DEGHETALDI: I got it.

MEMBER WATANABE: You got it. It's a lot.

CHAIR DEGHETALDI: I thought that there was sort of a safe harbor if we participated in both of the meetings. Very good. Okay. Now let's do a round of Board Member introductions, I will start. Larry deGhetaldi, family physician from Santa Cruz and the Palo Alto Medical Foundation. I will start in the room with the Board Members. Amy, would you start?

MEMBER YAO: Amy Yao, I am the Senior VP and Chief Actuary from Blue Shield California.

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

CHAIR DEGHETALDI: Let's go then to Jeff Rideout.

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

CHAIR DEGHETALDI: And Ted Mazer.

MEMBER MAZER: Ted Mazer, ear, nose and throat physician, independent physician from San Diego.

CHAIR DEGHETALDI: And Abbi.

MEMBER COURSOLLE: Abbi Coursolle, she/her, Senior Attorney with the National Health Law Program in Los Angeles.

CHAIR DEGHETALDI: And Scott.

MEMBER COFFIN: Scott Coffin, CEO, Alameda Alliance for Health.

CHAIR DEGHETALDI: And then let me turn it over to Mary.

MEMBER WATANABE: Hi, good morning, Mary Watanabe, Director; and I think maybe I'll tee it up here for my team. Pritika?

MS. DUTT: Good morning, Pritika Dutt, Deputy Director for the Office of Financial Review. Michelle.

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

MS. PETERSEN: Jessica Petersen, Assistant Chief Counsel in the DMHC Office of Legal Services.

CHAIR DEGHETALDI: So let's go to the transcript from our last virtual meeting from February 23. Let me just ask rather than formally looking for an approval of the transcript, if any Board Members have any suggested changes or comments that they would like to add? Shaking heads. I can't see Dr. Mazer but I --

SPEAKER: He is shaking his head.

CHAIR DEGHETALDI: That's wonderful. (Laughter.) We understand that, Dr. Mazer.

Okay, then let's go to the next agenda item, Director's comments from Mary.

MEMBER WATANABE: All right. Well, good morning again. For those in the room, welcome to our first in-person FSSB meeting in a couple of years but it is also my first FSSB meeting as the Director where I am in-person so this is very unusual. For those joining remotely, we have two people that are DMHC staff in our audience; so everybody else is joining virtually, just to give you some sense of what our room looks like. But just appreciate everybody's flexibility, and, you know, willingness to adjust to these unusual circumstances of holding hybrid meetings.

I am going to start with a quick update on the governor's May

revise. I will just say that the DMHC does not have any budget items in the May revise this year so I am not going to spend a lot of time on this but I do want to highlight a few investments across our Health and Human Services Agency that may be of interest to the Board.

Governor Newsom submitted his May Revise Budget to the legislature last Friday. The $300.7 billion budget includes a projected budget surplus of 97.5 billion and this is an increase of I think about 55 billion from January. Lots of money, lots of one-time investments that are, that are in the budget. It includes 57 million to maintain and improve the availability of safe and accessible reproductive health care so there's a lot of investments happening in that space.

The budget also proposes 304 million to reinstitute California's premium subsidy program for middle-income Californians who do not qualify for subsidies under the Affordable Care Act prior to the enactment of the American Rescue Plan. And this is really in the event the health care subsidies are allowed to expire at the end of 2022. I know there has been a lot of concern about those subsidies continuing.

Last year's budget also established the Health and Human Services Data Exchange Framework to begin in July of this year. This is a really exciting work happening to create a single data-sharing agreement and common set of policies and procedures that will govern the exchange of Health and Human Services information. This is for health care as well as social services entities as well as government agencies. The goal here is to have timely and secure access to electronic information to address social and health needs. And the May revision includes grant funding to provide technical assistance to small or under-

resourced providers, particularly small physician practices, rural hospitals, community-based organizations, as well as education and technical assistance for entities new to health information exchange; so lots of exciting work there.

I will just say that we have had someone on our leadership team participating in these, the Data Exchange Framework meetings, and if there is interest from the Board we could consider having a presentation at an upcoming meeting about that. I know the Office of Health Care Affordability is on my ongoing list to have a presentation at a future meeting, too from our partners at the Health Care Access and Information depending on what happens with that proposal.

And then just finally, the May revision includes close to 300 million in one-time investment to address the urgent youth and mental health crisis. This is really to support the ongoing crisis we have with behavioral health while we are working on the Children and Youth Behavioral Health Initiative. The funding will establish a center for researching, evaluating and applying innovative new technologies to improve youth mental health. Other investments include suicide prevention programs, crisis response, wellness and mindfulness programs. And one I am excited about, a video series to educate parents to better support their children, because I think that is really needed.

Moving on to our Health Equity and Quality Committee update. We were actually in this room yesterday for our fourth Health Equity Committee meeting. I am really excited about the progress the committee is making. The last couple of meetings have really been focused on the committee making some initial recommendations on measures by focus area and these will need to be whittled down and probably voted on over the next couple of meetings. The

committee will submit their report to me by the end of September. The committee has two meetings scheduled in June. And so the next meeting is June 8. These are open to the public and you can find more information on our website.

Let's see, moving on. On April 25 we released guidance to the health plans on the implementation of SB 510, which took effect January 1 of this year. This bill requires health plans to cover costs associated with diagnostic and screening, testing and immunizations related to COVID, without cost-sharing, prior authorization, utilization management or in-network requirements. Health plans are prohibited from delegating such costs to providers without a renegotiation of contract terms and this provision is retroactive to March 4, 2020, the beginning of the public health emergency.

The All Plan Letter is incredibly detailed. I am not going to go into an overview of it, but it does provide guidance to health plans regarding the delegation of financial risk, payment for services rendered between the start of the public health emergency and the end of last year, reimbursement rates for COVID services, and coverage and reimbursement of at-home tests. So I would encourage you to take a look at our All Plan Letter. You can find it on our website, healthhelp.ca.gov, by just doing a search of All Plan Letters, it is the first one that will come up.

Moving on to enforcement actions. On March 4 the DMHC and the Department of Health Care Services announced a joint enforcement action related to LA Care, including a $35 million penalty from the DMHC and a $20 million sanction from DHCS. The enforcement actions were related to several operational failures at LA Care including handling of enrollee grievances, the

processing of requests for authorizations, delay in processing claims, and oversight of delegated entities related to timely access. Because this is related to litigation I really can't say much more than that but you can read our press release on the enforcement action on our website home page.

And then finally, since our last meeting the DMHC released our Measurement Year 2020 Timely Access Report. Health plans and health care providers had to rapidly make many transitions during 2020 to respond to the pandemic so this is the report that kind of looks at that first year of the pandemic. While there were concerns about the impacts of COVID on appointment availability and timely access, most plans that had concerns actually showed an increase in appointment availability compared to 2019. Health plans did have the flexibility to record the next available appointment offered by a provider regardless of whether that was available in-person or through a telehealth appointment.

As we have discussed, I think over the last year or more we have been in the process of amending our timely access regulation. The Office of Administrative Law approved those amendments in January and the regulation took effect in April of this year. Health plans will begin monitoring their networks under the new requirements of the regulation for Measurement Year 2023. That information will be reported to us on May 1, 2024. And so beginning with 2023 we will have a rate of compliance to which we will hold plans accountable for meeting. And again you can find that report on our website under public reports.

And then finally I just wanted to make a comment about something related to timely access that you are probably starting to hear about this week in the media and elsewhere, which is on Monday the DMHC notified Kaiser that we

will be conducting a non-routine survey to examine enrollees' access to behavioral health services. The Department conducts routine surveys or audits of health plan operations every three years but we conduct non-routine surveys when we have good cause to believe a health plan is violating the law.

This non-routine survey is based on complaints we received from enrollees, providers and other stakeholders concerning the plan's behavioral health operations. We also saw a 20% increase in behavioral health complaints to the Help Center from Kaiser enrollees in 2021 compared to 2020. This non-routine survey will look at Kaiser's behavioral health operations, including timely access to care, the process for intake and follow-up appointments, scheduling, among other things.

I will just note that ensuring all Californians have timely access to behavioral health services is my top priority as the Director. This is an issue that is very important to me. The pandemic has really highlighted the demand for behavioral health services. And this is an issue that is also very important to me personally; I have a lot of lived experience with behavioral health access.

So with that I am going to take a breath and I will pause and see if the Board has any questions for me.

CHAIR DEGHETALDI: As yet I don't see any hands raised. Any questions from within the room? Oh, I'm sorry, I'm missing that. Amy, please start.

MEMBER YAO: I don't have a question, I just wanted to make a comment. Really appreciate the governor's office will continue the Affordability Act subsidy. It is really important for the low-income people to have access to health care, especially during the COVID, it is a difficult time, so I just want to

make that comment.

And also I think another initiative that is important is the data exchange. I am glad to see the state is moving that forward. If we really want to transform the health care delivery system that is really the foundation. I just want to say those are really great initiatives from the state, thank you.

CHAIR DEGHETALDI: Abbi, you are next.

MEMBER COURSOLLE: Thank you. First, thank you, Mary, for that report. It is really helpful to hear all of the things you all have going on.

Just on the last point you raised about the non-routine Kaiser survey. I was wondering if you could give us a sense of the timing and when we will sort of know the results of that survey and any corrective action that the Department determines is necessary?

MEMBER WATANABE: Yes, no, thank you for the question. I don't have a specific time frame that I can share with you now other than we have notified Kaiser, we will be starting that process here in the next couple of weeks. This will take time, there's a lot that goes into our surveys, but as soon as we can make something public we will. We can probably, we may be able to share more about time frames in a future meeting but for now that's about all I can share.

CHAIR DEGHETALDI: And Paul.

MEMBER DURR: Thank you, Mary for a great update. I truly appreciate your commitment to behavioral health issues because I think it is so important to the impact on the medical side. I am wondering if there's any coordinated effort? Because what we are seeing on the provider side is the same thing that you are seeing, access to behavioral health is a challenge

because of funding and opportunities to recruit new providers into that space and I don't know if there is any coordinated effort that money could be aside, put aside from the governor and the surplus to reinvest in training, educating, recruiting new people into behavioral health in California.

MEMBER WATANABE: And I will say that there are a number of investments happening with the Health Care Access and Information department. I forget specifically if there are items in the May revise to address workforce. But I know even with the Children and Youth Behavioral Health Initiative there's a lot of innovative approaches and workforce investments to really make sure we are trying to speed up the pipeline to get providers into the field and helping consumers. But acknowledge that that's a challenge but it doesn't relieve the health plans of their obligation to meet the very strong consumer protections and timely access requirements we have in the law too.

I will just reiterate too, it is very important to me that if any consumer is having a problem accessing care timely or if there's barriers, our Help Center is absolutely available to assist. You can go to our website, healthhelp.ca.gov. Part of what is really critical about consumers coming to our Help Center, this is how we know where the barriers are and when there's issues because that helps to inform the other work we do. But thank you for the question; note about workforce, Paul.

CHAIR DEGHETALDI: Amy, your hand is up again?

MEMBER YAO: Hi, this is Amy. Mary, I do have a question around SB 510. So first I will say, I haven't read the All Plan Letter so maybe it is addressed in the letter so I apologize up front. But right before this meeting I was chit-chatting with Larry about COVID testing. We have seen huge costs on

COVID testing, but when we dig into it there's really concentrated on field labs and they're really over-billing. An average per test is like $250 and it counts come for almost like 80% of COVID test costs we have incurred. So I don't know whether DMHC is looking into it because this is not just a hurting us, it is really hurting all the members, right. That is going to translate into premium in the future for everybody because of a few bad behaviors here, so I just want to raise that issue.

MEMBER WATANABE: Sure, yes. And Jessica can jump in here if she has anything to add but we did address the reimbursement amounts and kind of gave some guidance in the APL about that so I would encourage you to take a look at that. But, Jessica, anything you want to add on that?

MS. PETERSEN: Just that we have addressed that topic in detail in our APL 22-014. It includes both a chart about whether the CARES Act federal reimbursement standard or the SB 510 standard applies, and it also addresses some specific lab issues. I hesitate to get into the weeds but I would say that that is definitely addressed in the APL.

MEMBER YAO: Thank you. I definitely am going to read it tonight.

CHAIR DEGHETALDI: Thank you, Jessica. And I have a couple of comments. First on the provider workforce. In our medical groups there are two providers -- we love to hire primary care physicians. The two providers that bring us absolutely great joy, child psychiatrists, nurse practitioners with behavioral health training who are bilingual/bicultural. So if we wanted to focus on any workforce needs, those are the two providers that our patients need most.

I do have one comment on, well, two quick comments on May revise. I still see the commitment of the state of California to cover all

undocumented, income-eligible Californians by January 1, 2024. And, you know, May 1 we added all patients over at the age of 50. It seemed to pass unnoticed but it was a, that was a great thing. So May revise, that's good news.

The other thing in the May revise that I am really excited about, over $300 million earmarked for population health management. Accessing data. Essentially knowing the 40 million Californians and not just their clinical conditions that drive to clinical risk but their social determinants, so that's, that's a brave new world as well. Really excited about that.

MS. PETERSEN: Great. Thank you, Larry.

CHAIR DEGHETALDI: So do we have, Jordan, any comments from the public? Not at this time.

So we will -- and I think we have Lindy on. Lindy, thank you for coming back again. Your update is fascinating so looking forward to it, thank you.

MS. HARRINGTON: Well, thank you for the buildup. I hope I can live up to that, to that, to that wonderful buildup. So to start, if we can move to the next slide, we will just do kind of a budget update for DHCS.

So I think hopefully everyone saw that we released our comprehensive Unwinding Plan for the COVID-19 public health emergency earlier this week. As part of that plan it overviews what we will be doing; but in order to update and match that plan we did have some May revision updates.

Specifically, we are continuing the separate billing for federally qualified health centers for COVID-19 vaccine administration when they do that outside of a visit. So that would have ended with the public health emergency. The Department is proposing to allow that to continue.

We are also proposing to continue presumptive eligibility for individuals 65 and older as well as our blind or disabled populations.

We are proposing to continue the 10% COVID increase that was provided to our intermediate care facilities for the developmentally disabled for their rates.

We are also proposing to continue to reimburse for oxygen and respiratory durable medical equipment at the 100% of Medicare rate that we have done during the public health emergency.

You will also see updates associated with additional, with the anticipated additional quarter of the increased FMAP percentage that we are collecting during the public health emergency as well as updates for caseload and redeterminations based on changing expectations for the end of the public health emergency.

You will see that we have proposed new retention payments for hospital and skilled nursing facility health care workers. So the May revision proposes $933 million for one-time payments to approximately 600,000 California hospital and nursing facility workers who have been at the front lines of delivering care to the most acute patients during the COVID-19 pandemic.

We are proposing to extend the nursing facility financing methodology, so what was previously known as AB 1629. As well as replacing the QWASP (phonetic) program with a new Workforce and Quality Incentive Program, as well as providing new accountability authority to the Department of Health Care Services to ensure quality services are being provided to Medi-Cal beneficiaries. So we have released updates in our November estimate as well as there will be trailer bill associated with that proposal.

The Department has updated our proposal associated with the Medi-Cal direct contract with Kaiser and as part of that updated proposal we are proposing the following changes to our trailer bill language:

We will be clarifying that former foster youth are included in the enrollment provisions related to foster youth.

Updated and added a default enrollment as part of the growth in the Medi-Cal enrollment.

Specifying that Kaiser cannot deny or dis-enroll any individual that meets the specified enrollment or default criteria

Specifying that Kaiser is subject to all the same standards and requirements except those related to beneficiary enrollment as required for other Medi-Cal managed care plans, including all of the requirements pursuant to CalAIM.

It is also updating to require that DHCS and Kaiser enter into a memorandum of understanding describing the requirements that are different than those imposed on other Medi-Cal managed care plans. And that MOU shall include but not be limited to the commitment of Kaiser to increase its enrollment of new Medi-Cal members over the course of the contract and requirements related to Kaiser's collaboration with safety net providers, including federally qualified health centers. It will require that DHCS post this MOU and publish a report describing the implementation of the requirements imposed by the MOU.

It would provide that Kaiser shall implement the California Children's Services Whole Child Model in its applicable counties.

And ensure that Kaiser maintains Knox-Keene licensure from DMHC.

The May revision also proposes to add an additional $300 million total fund to the equity and practice transformation payments, bringing the total combined funds to $700 million. These equity and practice transformation payments will advance equity, address gaps in preventative, maternity and behavioral health care measures, reduce COVID-19-driven disparities, support upstream interventions, social drivers of health and improve early childhood outcomes, as well as prepare practices to accept risk-based contracts and move towards value-based care.

We are also included in the budget, grants to support wellness and build resilience of children and youth and parents. So many young people have been negatively impacted by the trauma, stress and social isolation of the COVID-19 pandemic. Supporting them to rebuild connection and regain a sense of belonging is critical to their well-being now and in the future. To do so DHCS would provide additional Children and Youth Behavioral Health Initiative grants to schools, cities, counties, tribes and/or community-based organizations.

And so the budget includes $85 million in general fund under the California Health and Human Services Agency budget and these grants would include the following options: So well-being and mindfulness programs. So we would be supporting programs provided in K-12 school or in community-based settings that teach wellness and mindfulness practices to teachers and students as well as parent support and training programs. So expand community-based support, community-based parent support, and training programs that build knowledge and capacity of parents to address their children's behavioral health needs, including evidence-based programs such as PPP, Know the Signs and Mental Health First Aid training.

We are also proposing an update to our doula benefit and so we would be shifting the implementation date for the doula benefit from July of 2022 to January of 2023.

We are also proposing an updated reimbursement methodology for doula services and that is increasing the average estimated cost per labor from $450 to just under $1,100.

You will see as part of our update that the May revision includes an update to our AB 97 eliminations trailer bill. And that was because we updated the trailer bill at May revision to include a multitude of news services that had recently been implemented to ensure that those are not subject to the previous AB 97 reductions. There is no impact to our budget as we had assumed that there would be no AB 97 10% reduction associated with these new services but this just clarifies that within the trailer bill.

We are also proposing an additional $60 million of total funds starting in July of 2022 for health enrollment, for the health enrollment navigators project through fiscal year 2025-26. And really to continue that project activities with an emphasis on our COVID-19 public health emergency-related activities. Specifically helping beneficiaries maintain Medi-Cal coverage by assisting with annual renewals, reporting updated contact information and engaging in outreach application assistance, enrollment and retention of our difficult-to-reach target populations. And support for more focused targeted outreach and enrollment for the Medi-Cal program. And benefit expansions including the expansion of full scope Medi-Cal to all income-eligible individuals aged 26 to 59, regardless of immigration status.

Updates from the budget associated with our CalAIM initiative. So

the budget includes a delay of the transition of ICF DDs and pediatric subacute care facilities into managed care from January 1 of 2023 to July 1 of 2023 in order to provide more time to adequately prepare for the transition, while the remainder of long-term care facility benefits for skilled nursing facilities will transition to managed care on January 1 of 2023.

Our population health management service is now anticipated to go live in July of 2023 with additional PHM service capabilities incrementally phased in thereafter.

As part of our transitions to manage care, various populations are shifting into managed care as their primary delivery system. Some populations transitioned in January of 2022, so beneficiaries with other health care coverage, beneficiaries in rural ZIP Codes and others, while other populations are scheduled to transition in January of 2023. So those will be our dual and non-dual individuals eligible for long-term care services; and all remaining partial and full dual eligibles except for those with a share of cost.

But however, while we were implementing these transitions, we also identified additional individuals subject to the transition to mandatory managed care that were initially assumed to already be subject to mandatory managed care, so the Department continues to work carefully to identify which additional individuals will need to transition. And once that work is completed and proper noticing is provided to both the Medi-Cal managed care plans and members, those additional individuals will transition to mandatory managed care in January of 2023.

There was an update to our justice package to reflect that our in-rate pre-release program would have an inclusion of expanded pharmacy

services as part of the package of benefits provided up to 90 days pre-release specific to pharmacy services. Our previous estimate only included the cost of medication assisted treatment and psychotherapeutic medications during pre-release period and a supply of medications post-release. Now we are proposing to cover medications consistent with the full scope of covered outpatient drugs under a Medi-Cal state plan as part of the 90 day pre-release services.

We are proposing as part of the May revision budget bill language to use monetary sanctions collected in the budget year to grant awards to qualifying nonprofit legal aid programs and organizations that serve Medi-Cal managed care enrollees in Los Angeles County or other impacted counties as determined by the Department for the purposes of improving access to care in the Medi-Cal program.

And then you will see other various updates to the budget to reflect caseload updates, timing updates, and all those wonderful things. So if we can go ahead and move to the next slide.

As we move through, not a big update on the managed care procurement as we are right in the middle of that procurement, but if we can go to the next slide.

So just a reminder that we are really transforming Medi-Cal managed care through our multiple efforts that are slated to take effect in January of 2024. So really looking at a new mix of high quality managed care plans that will be available to members.

So we have the procurement of commercial managed care plans. So our competitive proposal process for those commercial plans, statewide in counties with a model that includes those commercial plans.

We have the model change happening in select counties. So we have provided conditional approval for 17 counties to change their Medi-Cal managed care model. This will be subject to federal approval and includes a new single plan model and expansion of the COHS model.

As well as a proposed direct contract with Kaiser for 32 counties, again, subject to state and federal approval, and leverages Kaiser's clinical expertise and integrated model to support underserved areas in partnership with FQHCs.

And so this will be restructured and a more robust contract will be implemented across all plans and all model types in all counties. And so really what we are looking for here is improved health equity, quality, access, accountability and transparency. We can go to the next slide.

So again, just a quick reminder of our key MCP contract content updates.

So additional and enhanced requirements to better align with our priorities, state and federal regulations, our All Plan Letters, previous California State Auditor report recommendations, and Medical Audit Findings.

Our new requirements for public posting of reporting, activities survey results, financial information and Memoranda of Understanding with third parties is to support transparency.

Strengthened quality requirements to align with the Department's Comprehensive Quality Strategy to achieve high quality care.

Increased expectations for providing access to care across a comprehensive array of person-centered health care and social services to align with CalAIM.

Improved requirements for systemic coordination of services and comprehensive care management to ensure the needs of the entire population are met.

Updated requirements for our managed care plans to partner with DHCS to increase health equity and reduce health disparities.

New requirements to support strategies that address unmet health-related social needs through community supports, population health management, care management and social drivers of health. We can go to the next slide.

We are looking for stronger provisions for network providers to better understand and meet community needs through local presence and engagement.

New requirements to support enhanced children's services.

Additional requirements to expand access to evidence-based behavioral health services.

Updated requirements to ensure that managed care plans have robust accountability, compliance, monitoring and oversight programs.

New requirements for emergency preparedness to ensure delivery of care and essential services during and after an emergency.

Additional requirements that build on current value-based payment efforts linking provider payments to value.

And expanded reporting requirements and strengthened performance requirements with penalties for non-compliance to support accountability and oversight.

Finally, just a reminder of the timeline.

So the RFP submissions have come in.

We have -- a Notice of Intent to Award will be, is targeted to happen in August of 2022.

And we will do our transition planning through 2022 and 2023.

And in late 2022-2023 we will have our Health Plan Readiness Period.

With the new managed care plan contracts implemented on January 1 of 2024.

Moving into our Medi-Cal Rx update.

So the Medi-Cal Rx has stabilized the call center and prior authorization operations. DHCS and our contractor have engaged in an intensive planning process for phase reinstatement of claim edits and prior authorization requirements.

As previously communicated, there will be no changes to the current processes or policy on May 1. Medi-Cal Rx is developing an approach for prior authorizations to support a more streamlined experience for our beneficiaries and providers. In addition, Medi-Cal Rx is refining claim edit messaging and implementing call center process improvements.

We will continue to engage with stakeholders to assess the impact of changes.

And Medi-Cal Rx will continue to utilize historical prior authorization and claim data for the transition policy beyond July 1, 2022.

DHCS and Magellan are evaluating the appropriate time to terminate the transition policy. Detailed information will be provided as part of the early communications approach in the coming weeks. If we can move to the

next slide. Can we jump back one, sorry about that.

So stakeholders will be given 90 day notification prior to the retirement of the 180 day transition policy.

As part of our change management process an internal communication plan is under development identifying 90, 60 and 30 day outreach and education activities.

And the Medi-Cal Rx program is developing a plan for prospective prior authorizations, the details of which will be shared with providers. In the interim, providers should not submit prospective provider authorizations.

As each phase of claim edits and prior authorization requirements are reinstated the Medi-Cal Rx program will assess for operational readiness to manage demand. Monitoring will continue post-reinstatement to ensure continued stability.

We have added special population clinical liaisons to the call center to provide additional targeted assistance.

And finally, Medi-Cal Rx is committed to delivering timely and safe pharmacy services to Medi-Cal beneficiaries and providers across California.

Then if we can move into CalAIM. So for our CalAIM updates.

Just a reminder, CalAIM is a multi-year initiative led by DHCS that aims to improve the quality of life and health outcomes of Medi-Cal beneficiaries by implementing delivery system and payment reforms across the program.

CalAIM leverages Medicaid as a tool to help address many of the complex challenges facing California's most vulnerable residents and taking a person-centered approach that targets social determinants of health and reduces disparities and inequities.

So again, our goals are to identify and manage member risk and need through Whole Person Care approaches and addressing social drivers of health.

Move Medi-Cal to a more consistent and seamless system by reducing complexity and increasing flexibility.

And improving quality outcomes, reducing health disparities, drive delivery system transformation and innovation through value-based initiatives, modernization of our systems and payment reform.

So as we think through I have several slides here that you all can look at, I think we have talked through many of these.

So really, you know, community supports and enhanced care management. The Department has adopted a list of 14 community supports. And by January 1 of 2022, 25 managed care plans in 47 counties began offering more than 520 community supports across the state. The Department anticipates about 40,000 members will be transitioned into community supports from Whole Person Care without interruption in service.

Enhanced care management was also implemented on January 1. Enhanced care management implemented in 25 counties that previously served Whole Person Care or Health Homes Program members. Approximately 95,000 individuals were transitioned into enhanced care management and our initial populations of focus included individuals and families experience (audio cut out), high-utilizer adults and adults with SMI and SUD. Jordan if we can go ahead and jump forward. Jump forward.

So kind of, you know, our core services here. So comprehensive assessment and care management plans, coordination of and referral to

community and social support services, enhanced coordination of care, member and family supports, health promotion, comprehensive transitional care, outreach and engagement.

Again, these were the whole person, the prior Whole Person Care and Health Homes pilot counties, so to help people identify where those have gone live. If we can go to the next slide.

Again, ECM is going live, occurring in stages, by our populations of focus.

Managed care plans offering the pre-approved community supports in all counties.

And every six months our managed care plans may add additional pre-approved community supports.

So again we had the, you know, particular populations of focus that went live in January of 2022 for those Whole Person Care and Health Homes pilot counties and we will go live in July of 2022 for all other counties.

We are proposing for our incarcerated and transitioning to the community, so for all other counties we will go live in January of 2023 along with are at risk for institutionalization and eligible for long-term care populations, our nursing facility residents transitioning to the community.

And then finally, in July of 2023 we'd have our children and youth population focus.

And again, more information on this timeline is also available on our website, there's lots of great information there.

So again, the community supports are really medically appropriate alternative services that can be provided to members in lieu of or to help avoid

more costly services such as hospital or skilled nursing facility admissions, discharge delays, or emergency department use.

They are optional for the Medi-Cal managed care plans to implement so these are not state plan benefits. It is optional for Medi-Cal managed care members to receive these services.

They must be medically appropriate and determined to be cost-effective for the member.

And they are available statewide beginning January 1, 2022, although the services will vary by county. And again, plans can add additional community support services every six months.

So our 14 pre-approved, potentially, medically appropriate and cost effective services that they may offer are listed here.

As well as we provided this chart, it is a little hard to see but we provided the link so you can all go there but it's on our website, that really details out by county, by managed care plan, whether or not the county has chosen to offer that particular community support. And if they are planning to offer it at a later date we have included that update there as well. So it is a really great resource for understanding what services are available in particular areas.

So another -- as part of our CalAIM initiative and to help ensure that our plans and communities are able to implement these we allocated $300 million for incentive payments in state fiscal year 2021-22, $600 million for state fiscal year 2022-23, and another $600 million for state fiscal year 2023-24.

So beginning in January 1 of this year we implemented the CalAIM Incentive Program. These are intended to complement and expand our enhanced care management and community supports by building appropriate

and sustainable capacity, driving managed care plan investment in necessary delivery system infrastructure, reducing health disparities and promoting health equity, achieving improvements in quality performance, and really incentivizing our managed care plans to take up enhanced care management and community supports.

So our funding priorities for the first year were delivery system infrastructure, enhanced care management provider capacity building, community supports capacity building and take-up.

We approved all Program Year 1 Payment 1 submissions from the managed care plans. Those IPP gap-filling plans will be released on the Department's website very soon. And Payment 1, our Program Year 1 Payment 2 submissions will be due later this year. So that's when plans will be able to demonstrate that they met those metrics that were laid out for the first year.

To complement those funds. We also have our PATH initiative. So as part of California's 1115 waiver demonstration renewal and amendment we requested funds for the Providing Access and Transforming Health or PATH Program.

This is bringing in, well, we are seeking $1.85 billion in federal funds to support, build and scale the capacity necessary to ensure successful implementation of CalAIM.

And these funds will be available to many types of entities, our Whole Person Care lead entities, counties, community-based organizations, providers, tribes. Our managed care plans are not eligible to receive the PATH funds.

There's really four main buckets associated.

So we have our Whole Person Care Services and Transition to Managed Care Mitigation Initiative. And so this is really for those services that were provided under Whole Person Care and are transitioning to community supports. But the managed care plans have an effective date later than January 1 of 2022; we are providing some transition service funding to allow those services to be continued to be provided in the community prior to the managed care plan picking up this service.

We have funding associated with technical assistance. So we will have a registration based Technical Assistance Program for counties, providers, CBOs, and others in defined domains.

We have our Collaborative Planning and Implementation Initiative. So support for collaborative planning efforts involving our managed care plans, counties, CBOs, providers, tribes and others.

And then finally what we are calling CITED, our Capacity and Infrastructure Transition Expansion and Development Initiative. And this is really where the bulk of the funding would be available to all counties, providers, CBOs, tribes and others to build and expand capacity and infrastructure necessary to support ECM and community supports.

So we have an updated timeline for our third-party administrator to support these PATH initiatives. So we really are looking to have kind of registration for the collaborative planning that will open hopefully in late June, with the launch and funds really starting to be disbursed in July.

For our CITED initiative launch we will have an application window that opens in June and closes in July. There will be a review of those applications with an expectation that we will launch and have those funds begin

to be disbursed in October.

Our marketplace is really looking that it will launch probably in December. And then we also have some justice-involved initiative launches.

So we have some of those funds are going out in Round 1 in this year, in May, or June, and then we will be looking for Round 2, 3 and 4 later in the year.

So really the next component we wanted to provide an update on is associated with our medical loss ratio or the MLR. We talked through our requirements in one of our previous agendas. But really, the biggest requirement is that we have our report due to CMS by July 1, 2022.

Regarding our implementation plan or our work plan for how we will operationalize those new requirements, the team has held multiple stakeholder meetings. The next stakeholder workgroup is next Wednesday on May 25th to further refine those requirements associated with our work plan.

Finally, we have several other managed care incentive payment programs that we are implementing. So we had our COVID-19 vaccine incentive program that ended February 28 of 2022, however, those funds will flow to the managed care plans post-reporting.

In next fiscal year we have our Behavioral Health Integration and Incentive Program. That ends December 31 of 2022 so mid, close to the end of that program.

We have our Housing and Homelessness Incentive Program, which will end December 31 of 2023 and we are in the early stages of implementing that.

As well as our Student Behavioral Health Incentive Program, which

ends December 31 of 2024.

And these are all managed care plan incentive arrangements that are implemented in accordance with federal regulations.

And again just some additional information on these programs. So the HHIP is really established in accordance with the Home and Community Based Services Spending Plan.

We are allocating $1.3 billion over two years.

It Is aiming to improve health outcomes and access to whole person care services by addressing housing insecurity and instability as a social determinant of health for our Medi-Cal population.

Our goals are to reduce and prevent homelessness and ensure managed care plans are developing the necessary capacity and partnerships to connect our members to needed housing services.

Program Year 1, so this calendar year, our deliverables are we received non-binding letters of intent from all managed care plans by April 4 of 2022. Our Local Homelessness Plans are due from the plans on June 30 of this year. And our reporting for the Measurement Period 1 will be May to December and will be due in early 2023.

I think going through the Student Behavioral Health Incentive Program again, this is a program that will have multi-years.

Our Program Year 1 deliverables. We received non-binding letters of intent from all managed care plans, we were really excited, at the end of January.

We received partner forms from all of our managed care plans in March.

Our initial interim payments will be issued to the plans later this month.

And our Accelerated Project Plans are due from the plans in at the beginning of June.

We have a needs assessment that will be due from our plans at the end of December.

And then again, Non-Accelerated Project Plans will also be due at the end of December.

So covered a lot of information in a short period of time but happy to take questions.

CHAIR DEGHETALDI: Lindy, dizzying is how I would describe your report. We do have an ENT doctor who may address that. I see him, perhaps to demonstrate the Epley maneuver, here to prescribe.

MEMBER MAZER: Am I on? Can you hear me?

CHAIR DEGHETALDI: We can hear you.

MS. HARRINGTON: Yes.

MEMBER MAZER: Okay. Lindy, thank you for that. And between dizzying and complex and wow, I don't know where to start. I probably have 50 questions but I will try to stick with two. One really concerns the transition timing, the planning for the procurement for January 2024. There's a lot of moving parts there. Your outline here says you have 17 counties looking to change their model, which worries me a bit, I don't know in what way that's going to change the number of plans that might be available in counties like San Diego, and you have already received RFPs.

So I am curious, how much change do you see in the delivery

networks in the various counties? Growth of number of plans or shrinkage of number of plans in counties with multiple plans? And how are we going to avoid some of the transition problems, continuity of care, understanding of where people go, what providers are still in which networks? In San Diego, we experienced a great disruption when we had mandatory dual enrollment many years ago and I kind of envision major problems with this transition by 2024. So that's question one.

And then all of the incentive programs that you have put out there, it's great that there's money for the incentive programs for the MCPs. But I worry about with the massive growth in the number of beneficiaries, particularly now with 50 and over and then potentially all workers who are qualified monetarily being into the Medi-Cal program. Is incentive enough or is it really time to look at the entire structure of the Medi-Cal Fee Schedule? Are we seeing transitions to more providers, fewer providers based upon the economics, and what does that look like for the future? So complex questions for your complex presentation, thanks.

MS. HARRINGTON: Sure. So I think taking the first question. So I think if we flip back to that slide that represents kind of the three types. So procurement for the, for the commercial plans. So those. When we look at the model changes in those select counties, so those 17 counties, Ted, are really moving to either the expansion of a county as joining COHS. So they are like, for example, they are joining the partnership plan so they are joining COHS, or they are moving to a single plan model to where there would be a single plan within that county that is under local operational control.

The remaining counties that are part of the commercial managed

care procurement, that is where we will then be -- as part of that RFP will be determining the plans that will be operating in those particular counties. And so, again, I don't have much more information to speak about what that may look like or who those plans are, I have no idea, because it is, it is part of the procurement process today.

As we start thinking about the incentive programs, I think one of the things that it is really important to identify is all of those funds are flowing to our managed care plans. But really the only way that our managed care plans can meet their metrics and the, and the requirements established by those incentive programs, is really working with their local communities and providers. And so the expectation is that those funds are flowing through the managed care plans and into the communities and providers in order to achieve the various requirements and metrics.

As far as the, you know, overall goal and review of the rate structure. I think it is always something that department is reviewing, analyzing, and as part of, you know, our annual process that we look at, and you know, are continuing to try to determine that we are updating our rates as we can as well as maintaining the fiduciary responsibility that we have within the state. So not really much more I can say specific to that.

MEMBER MAZER: Thank you. I would like to know if there is anybody following the numbers of physician providers in all of these networks as these changes are going to go forward to make sure that we are expanding, not shrinking, based on economics. But that will come in the future, thanks.

CHAIR DEGHETALDI: Thanks, Ted. We will have Amy, then Paul, then Jeff.

MEMBER YAO: Lindy, thank you, and gosh, you are a busy lady and DMHC is very busy as well. I am trying to do my best to follow all the updates so maybe my question, in comparison, is really not as significant but I do want to ask two questions.

One is I heard DHCS is very much concerned about the changes, transitions, the impact on member experience so it is trying to make everything as smooth as possible. So if you recall, I think starting this year, 1/1, DHCS transitioned transplant coverage from DHCS over to the managed care plans. I know it is still early in the year, but based on our initial kind of analysis we feel like the transplant rate that was established initially was insufficient, let's put it this way. So we don't want to end up creating more barriers, that's definitely not something we want to do, so we'd really appreciate it if the DHCS can review the transplant rates, the risk corridors and the rate itself. So that's one part of my question and ask.

And then the second piece of my question is on the PATH program. You mentioned that a managed care plan is not eligible but what kind of role does the managed care plan need to play here? Is that similar to the PATH 50 Stakes? A managed care plan will be kind of like, play the role of pass-through? Okay, good. You are shaking your head, that's good. I know PATH 50 Stakes we had lots of challenges. Okay.

My last question is on the medical loss ratio. So in today's rate-setting process I think there was like a 2% profit, about 7 or 8% admin costs, so it increased to about 90% loss ratio, but you mentioned about 85% will be the requirement. So will that requirement, will it also sync up with the medical rate-setting process? With the rate-setting will be also targeting 85% loss ratio? So

those are my questions.

MS. HARRINGTON: Sure, so kind of taking those in order. So for the first, the transplant rates that were established, for our hospitals were at the fee-for-service rates that they were receiving today to provide those services, so we are just maintaining that structure.

As we think about the PATH program, no, those funds will be going directly from the state through our third-party administrator to the awarded entities for those funds. Our managed care plans will be involved in ensuring that we don't have overlap in projects that could be funded through PATH and IPP so there will be some coordination there.

And then for the, for the MLR. There is not, again there, we continue to utilize our historical rate-setting methodology and this does not change our rate-setting methodologies.

MEMBER YAO: So, Lindy, maybe I'd just add one more comment on the transplant rate. Where we see where the cost is materially higher than what we anticipated is not about the transplant event or the surgery itself, it is the pre-care and post-care. We have to use the transplant center of excellence and those rates are materially higher than what we anticipated. So that's where the risk. So we wonder, when DHCS is setting the transplant payments can they include in the pre- and post-care. Looking at the rate for the whole episode of care instead of just the surgery itself. Thank you.

MS. HARRINGTON: Okay. I know the team has been working closely with the workgroup on the establishment of those structures. Paul, I think you were next.

MEMBER DURR: Yes, thank you, Lindy, for a great presentation. I

had a few questions and I will just give them to you in order that I ran through your presentation.

On the grant funding that is going to be made available, I was just curious how that is promoted or messaged to the smaller entities? Because I think you specifically mentioned that there was some specific grant funding for solo docs and, you know, smaller providers who may not have the skill set to be able to be aware of it, let alone submit a grant application. And it just made me curious as to how often do they do that and what's the funds that aren't spent? I would imagine they go back somewhere but how does that process work?

My other question is on the MCP requirements. It is great to have all those requirements, it looks like we are trying to do a better job of coordinating care for everyone. There were two things that came to mind in that regard. One is the health plan to take that responsibility and implement that probably is going to be an additional cost so I would hope that there would be funding for that.

But then also funding in your department to ensure, or someone to ensure, that those requirements are being met and the auditing process that you have established or are thinking to establish to make all that happen.

And my last one is related to the community supports. I think it's great. Again, it is the impact of the implementation of those communities supports, the oversight that you will have for that. And I didn't know if Scott wanted to comment and just curious about the effect of that. What has been the effect of implementing those community supports, because I see Alameda has implemented a number of them. I'm just curious if you are seeing a return on that? So thank you, Lindy.

MS. HARRINGTON: Sure. Paul, just real quick so I can make sure

because we talked about a lot of different grant funds. Are you talking about the practice transformation and equity grants?

MEMBER DURR: Yes, in particular.

MS. HARRINGTON: Okay.

MEMBER DURR: Thank you.

MS. HARRINGTON: Sure. So that, that grant program will be led out of our Quality and Population Health Management area within the Department. We will be working very closely with our managed care plans and partners to make sure that we are getting the information out, the requirements, what we are looking for, and ensuring that we are doing everything we can to really get those grants in the hands of the providers that need them. More information to come on the specifics about that.

Around the managed care requirements. As we develop rates for those future years these things will be taken into consideration, how they impact operations. And yes, we have put forward budget change proposals to ensure that we have resources within the Department to oversee this work.

And then for the community supports. I know it is really early in implementation so I am not sure that we are really able to speak to specifically outcomes at this point, but know that is something that the department is actively monitoring and watching.

CHAIR DEGHETALDI: Jeff then Abbi.

MEMBER RIDEOUT: Hey, Lindy, great report. Dizzying is a great word for it.

Are COHS plans going to be regulated by the Office of Healthcare Affordability, because I don't know that they are regulated in the same way by

DMHC. That's one question.

And second, do you or Mary know whether the Office of Affordability will use the same benchmarks for costs for Medi-Cal plans and providers that they will be applying to commercial and MA plans? I don't know if that is something in your purview or something Mary might want to comment on.

MS. HARRINGTON: I don't know that I have specifics about that. I am not sure, Mary, if you have anything at this point about that?

MEMBER WATANABE: I don't, I don't. We could, we could certainly try to follow up on that though, Jeff. But you are correct that we don't regulate the COHS in the same way.

MEMBER RIDEOUT: Yes. And that, just, Mary, a heads-up for you, that will come up probably at our Board meeting next week. A number of our members have brought that question forward.

CHAIR DEGHETALDI: So, Abbi, unmute, and there you go.

MEMBER COURSOLLE: Thanks. Lindy, thank you so much for the presentation, as my colleague have said.

I have a question that wasn't covered by your presentation so I don't know if you will be able to answer it but I thought I would ask. I know in Mary's presentation she wasn't able to give us much of an update on the fines imposed on LA Care back in March from the DMHC side and I was just wondering if there's any update from the DHCS side on those fines?

MS. HARRINGTON: I, Abbi, am not involved in overseeing that particular fine so I do not have a readily available update and I don't know where it is in the process so I don't know whether there's any information that the Department could update or not but I can take that back.

MEMBER COURSOLLE: Appreciate that. Thanks, Lindy.

CHAIR DEGHETALDI: And so, Lindy, it is my turn. Thank you so much for this. This is, this is, again, part of the meat of the meeting.

A couple of concerns that I have. I talked about celebrating expanded coverage. That does not translate to access. So a continued focus on an infrastructure. Or actually, I view CalAIM is going to be successful because California has for 30 years been in value-based care, probably leading the country. And I just, a couple of things that, the reasons why I think that we have been so successful in managed care, value-based care, half of the Medicare beneficiaries in the state are on MA and another growing percentage are in ACOs. Is that risk adjustment is transparent and embedded in the work that we do. And I just, this is a plea as we go forward into CalAIM. Our MCOs need to become well-versed in risk adjusting.

And I am worried about the other 14 million Medi-Cal beneficiaries, whether or not we are able to, and I see so many programs that are focused on what many of the MCO CEOs would say, 8% of our patients consume 80% of our resources. I just hope that we are mindful of that because if we don't appropriately risk adjust payments based on clinical risk and on social drivers, then the 8% will not have providers. And so that's just, that's my, if I could just highlight.

And frankly, I do need to mention, you know, the MLR requirement which will be solely imposed on groups that are in the Medi-Cal space, I just worry that there are a number of drivers that will erode access. And Ted's question is correct. We need to ensure that a maximum number of providers in California do accept, really do accept, not just be in networks, that we have a

welcoming program so that patients can have access.

MS. HARRINGTON: Appreciate that, Jeff (sic). I mean, I think one of the things that are -- Larry, sorry. I think one of the things that I would say on the risk adjustment and that, I think that is why we are so committed to our population health management program. I think that, you know, we believe that is going to be critical to being able to understand the needs of the population, what's there, what's happening. You know, just a broader focus. And all of that information is also critical to being able to identify from, you know, a risk adjustment perspective of what, you know, who is this beneficiary and what are their risks. So I think that is going to be key and why we are putting so much effort into ensuring that we get that population health management service right.

Again, also we are doing a lot of work just right now with our with our managed care plans. We have a workgroup associated really looking at risk adjustment. How do we improve, how we are utilizing risk adjustment, what, you know, what is our risk adjustment methodology that we use in our rate setting for our managed care plans. We are doing a lot of work today on that.

So I think we agree with you, it is important to ensure that we are getting the risk adjustments accurate and correct and so I think both of those things are big focuses of the Department right now. And I think -- and as we have committed to the plans as we have been working with them, you know, risk adjustment isn't a one and done thing. So we may, you know, make updates to our processes for rate-setting for this upcoming year. That doesn't mean we stop. That means we continue to evaluate, adjust, and make sure that we are keeping up with what is happening in our program and what is happening with our population.

So I think that is something that we are definitely doing on the MLR requirement. You know, a reminder to everyone this was a requirement from the federal government around ensuring that there was additional transparency. We have been working to, you know, make sure that we are meeting the requirements and not imposing undue burden, you know, when we get down.

So, you know, I think I want to make it clear that if I am a provider group and I am taking on risk but I am providing that service myself, we do not anticipate that those providers would be part of this MLR reporting, it is really about those entities that take on risk, and then further delegate the provision of those services and pay for someone else to provide those services.

So again, there's a lot of work happening in our MLR workgroups around those definitions but I do think that is important to make sure that we are also looking to make sure it's those, you know, delegated entities, it's those intermediary entities where we are gathering that information and trying to minimize impacts to the providers themselves that are taking on risk and providing those direct services. So I just want to make sure that that's clear and heard. Again, we will need to continue to work with the federal government on our definitions and what those look like but that's our goal.

CHAIR DEGHETALDI: And back to Amy.

MEMBER YAO: Larry, you know my favorite topic is always risk adjustment. Since you mentioned it I feel like I have to say something about risk adjustment. So based on our experience -- so risk adjustment, to make it successful, success, I think in Medi-Cal it is probably similar to ACA, it is relative to each other. So we definitely have seen providers with less technology or digital capabilities that are being disadvantaged. So I know in this budget DHCS

provides funding to FQHCs and other providers to, to invest in technology. It is so critically important. We really need to get a level playing field there before you truly have a meaningful or good population risk management. That's just a comment.

MS. HARRINGTON: Thank you.

CHAIR DEGHETALDI: Now, I think we can go to the public. We have Bill Barcellona.

MR. BARCELLONA: Thank you. Bill Barcellona with America's Physician Groups. Can you hear me okay?

MS. HARRINGTON: Yes.

MR. BARCELLONA: Good, thanks, all right. Lindy, thanks again, for the presentation. I have three questions. I am not going to ask them all at once so I will ask them one at a time so we can have a discussion.

First of all, you know, the purview of this committee, the FSSB is financial solvency of risk-bearing organizations. That's the, that's the target of what they are looking at. Can you -- do you have a sense of where things are going with the MLR standard in terms of the remittance requirement and how that will be applied to RBOs that are on the DMHC's watch list for financial solvency?

There's 83 RBOs that are focused on Medi-Cal contracts and there has been a long history of those particular RBOs being on the watch list, sometimes chronically. The remittance, if it is imposed, could function like a kill shot for a small IPA and that could result in significant disruption of care to patients; and that is something that the DMHC has worked long and hard to avoid over the past 15 years and done it successfully.

But is there going to be coordination between the departments

when these remittances are imposed? Because a sudden remittance requirement by the DHCS could be surprising to the DMHC staff and could be very disruptive to the continued financial solvency of the organization and that could result in disruption of care to patients, it could also result in a significant disruption to the downstream physicians. Does that make sense?

MS. HARRINGTON: I think I hear what you are saying. I will have to take that back and have a conversation with the team about the level of interaction that is happening, but you know, excellent comment that we will, that we will take back and look into.

As for what the results will be. We don't have information about what those downstream results will look like and so -- and again, we are doing, you know. The first year will be reporting only before we move into remittance so there will be some time for organizations to have a sense of what things look like before we start with the remittance. And, you know, hoping that we are providing plenty of notice and information on what this looks like so that organizations are able to plan for it.

MR. BARCELLONA: Thank you, okay. Second question, I seem to recall that when you and I first talked back in December about the CalAIM orders that there was a requirement for the public transparency of DOFRs and I think I have emailed you about that; I can't find it now. Am I incorrect? Is that not going to be a policy of the DHCS and CalAIM?

MS. HARRINGTON: Bill, I'll have to take that back. I vaguely remember the conversation but I don't remember the result so I will have to take that back.

MR. BARCELLONA: Yes. Again, you know, each RBO's unique

situation with their DOFR, with their plans, bears heavily on how the MLR is applied.

And then my last question, Mary mentioned during her Director's Comments at the beginning about the Department's issuance of the SB 510 All Plan Letter. Do you have an estimate of when DHCS will be releasing its SB 510 All Plan Letter?

MS. HARRINGTON: I don't. That's outside of my purview so I will have to take that back.

MR. BARCELLONA: Who would be a good person to talk to about that?

MS. HARRINGTON: So that's, the All Plan Letter releases are overseen by the Health Care Delivery Systems team so Susan and, Susan Philip and Bambi Cisneros.

MR. BARCELLONA: Perfect. All right, thank you very much. Appreciate the presentation.

MS. HARRINGTON: Sure.

CHAIR DEGHETALDI: Any other questions from the public? Amy, your hand is up, did you have a follow-up question or no? Great.

Lindy, again thank you. The pace of change is amazing.

And now we are going to go, this agenda is perfect because we are going to go into Pritika's update on the Local Initiatives and COHS and they are going to be all over the state before long. (Laughter.)

MS. DUTT: Thank you, Larry. Good morning. I am Pritika Dutt, Deputy Director for the Office of Financial Review. I will provide you a quick update on the financial summary of the Medi-Cal managed care plans, a report

for the a quarter ended December 31, 2021. A copy of the report is available on our public website under the Financial Solvency Standards Board section.

This report is prepared by the DMHC on a quarterly basis and highlights enrollment and financial information for Local Initiatives, County Organized Health Systems and Non-Governmental Medi-Cal plans. As a reminder, the NGM plans, or Non-Governmental Medi-Cal plans, are plans that report greater than 50% Medi-Cal enrollment but are neither an LI or a COHS. The report is divided into three sections, first focusing on LIs then COHS and then Non-Governmental medical plans. And we present this report twice a year at a meeting.

There are nine Local Initiative plans that serve 5.8 million Medi-Cal beneficiaries in 13 counties. Total enrollment increased by 1.4% compared to prior quarter. Since September 2020 with all LIs, all LIs reported an increase in enrollment. LA Care, the largest LI plan with 2.4 million enrollees, had a 1.3% increase in enrollment over the last quarter. Overall, the LI plans' Medi-Cal enrollment increased by almost 80,000 from September 2021 to December 2021.

There was an increase in medical expenses due to increase in utilization of services. However, the increased medical expenses did not result in net losses for the LIs.

For the fourth quarter of 2021 the LIs reported total net income of $86 million. All LI plans reported net income except Alameda Alliance. All LIs met the DMHC's reserve requirement or tangible net equity. TNE to required TNE ranged from 491% to 789%.

There are six COHS plans that serve 22 counties. We receive financial reports from five of those COHS. Gold Coast does not report to the

DMHC. The five COHS that report to the DMHC serve over 2.2 million Medi-Cal enrollees. All COHS plans experienced enrollment growth for the last six quarters. CalOptima and Partnership Health Plan reported the highest enrollment numbers.

For the fourth quarter of 2021 the COHS plans reported total net income of $128 million. All COHS plans reported net income except CenCal Health. CenCal Health reported net losses of over 8.2 million. CenCal has reported six consecutive quarterly net losses due to increase in utilization and the main driver for them was the MCO tax.

CenCal has met the DMHC's reserve requirement or TNE requirement at all times during this time. CenCal's TNE to required TNE was 465% at December 31, 2021. All COHS plans reported 450% or higher TNE levels at December 31, 2021.

There are eight NGM plans that serve over 3.5 million Medi-Cal beneficiaries in 37 counties. All NGM plans reported an increase in Medi-Cal enrollment in December 2021 compared to the prior five quarters. For the fourth quarter of 2021 the NGM plans reported total net income of 145 million.

TNE to required TNE ranged from 177% to 834%.

Some of the takeaways from the report:

We have noticed that the enrollment in the Medi-Cal managed care plans continued to increase and this was attributed to the suspension of the annual Medi-Cal redetermination requirement during the public health emergency.

Most Medi-Cal plans reported net income in year 2021.

The Medi-Cal plans continue to meet the TNE requirements.

The DMHC will continue to monitor the enrollment trends and financial solvency of all Medi-Cal managed care plans. Additionally, the DMHC is working with DHCS on the implementation of CalAIM and Medi-Cal procurement to assess the financial impact of the changes on the Medi-Cal managed care plans.

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

CHAIR DEGHETALDI: I see no questions. There we are, Amy and then Paul.

MEMBER YAO: Pritika, I have a question on page 9. This is really about, like a mess. I couldn't make sense of it. Contra Costa Health Plan and Kern Health Systems, their medical loss ratio is over 100%, yet they have a net income positive. Is that because they had lots of investment income? Why?

MS. DUTT: So it does not account for the pass-throughs, the pass-through revenues and expenses that these Medi-Cal plans incur. So they get money from DHCS that gets directed to hospitals. And so -- but we did not make those adjustments. I think you are trying to get to the match.

MEMBER YAO: Yes --

(Member Yao and Ms. Dutt both speaking.)

MEMBER YAO: Then my other question is on page 20. For the COHS Health Plan of San Mateo. It looks like their financial performance has been quite volatile. If you look at the trend, next quarter they are going lose money. Do you understand what is going on there? Especially December '21, they make 30 million? It just seems a little -- I don't know what, do you have any insight?

MS. DUTT: So it is really driven by their medical expenses and, you know, utilization of services and net income. The other thing, we do track, keep track of is the TNE levels of the plans. So if you look at page 21, San Mateo has a TNE of 910%. So their TNE has ranged between, you know, 826%. So they have a high TNE level so we do not have that much concern.

MEMBER YAO: Oh.

MS. DUTT: But we keep, we do ask questions when we see the fluctuations in their earnings.

MEMBER YAO: Yes.

MS. DUTT: So I will have to take that back and look into more detail on what was the driver for that particular plan.

MEMBER YAO: Thank you.

CHAIR DEGHETALDI: Paul.

MEMBER DURR: Yes, Pritika, it was a great presentation, thank you. My question had to do with more, it fascinated me on the TNE overage for the COHS plans compared to the other groups, that they are more significantly higher than LI or NGM and I didn't understand why that would be the case. When you look at, there's a number of them that are over 1,000, 900 on the COHS, percentage of TNE, versus the other ones seemed to be about 600 to 500. Any thoughts around why that is?

MS. DUTT: So not on the LIs versus COHS. But for the NGM versus COHS, the NGMs, they have publicly traded parents so there is some flow of those dividend payments at year-end. So you will see, they would have -- except for Community Health Group, which is a quasi-government plan, you will see dividend distributions at year-end and those types of payments happening at

some of the NGM plans.

As far as the LI versus COHS, I am not sure, we need to take that back and take a look at that. But for the COHS, they are the only plan in those particular counties so that could be one of the reasons. I don't know, Lindy, if you have any thoughts there.

MS. HARRINGTON: So I think the -- I mean, I think one of the questions would be is, I think it may be just the timing of when the revenue comes in versus when the expenditure happens. Because we, you know, sometimes have to do the adjustments for the rate and it happens retroactively. So it may be some of that but we have to look more closely.

CHAIR DEGHETALDI: I appreciate the answers on that. I guess what always intrigues me is that with over 1,000%, you know, when you look at CalOptima, it is just increasing, for the most part. And many of them, it is like, I always thinks about the provider reimbursement side because we know that the providers are suffering and the ones that do take care of Medi-Cal tend to get paid on the lower scale and so it always --

It is a balance of increasing your TNE in percentages and yet you have a provider shortage or lack of provider input and should there be a cap or should there be some sort of other parameter put in that you can't exceed X amount. And I know there's always got -- when John was here he educated me about rainy days because we all have that, but anyone that's taking risk has to manage that. But you know, when I see those levels it just is somewhat concerning about the provider side.

MS. DUTT: So, Paul, good point there, but the TNE is not an indicator of how much cash the plans are sitting on, because it does include their

buildings, all their assets, in the calculation. So it does not mean they have all that loose cash sitting there, right, they could be owning a building, which does tend to be valued higher. So something we could take back and look at, like how much cash levels are in the TNE levels.

CHAIR DEGHETALDI: Ted.

MEMBER MAZER: Thanks, Larry. And Pritika, thank you for the presentation, as always. You mentioned a little bit about Alameda Alliance. And just looking at the numbers yes, their TNE is still good, but of the quarters reported, three out of six quarters they were negative with a declining TNE. Are there concerns at this point given past history or is the Department comfortable that they are going to be okay going forward?

MS. DUTT: Ted, one of the things my team looks at is the performance. As soon as we get those financial statements, we dig into those. You know, the plans' performances and we send questions over to the plans if we see any issues with the performances. And then we also, like I said, we look at how high a plan's TNE is. But maybe, Scott, do you have any insight on, you know, if the plan is having any future net losses or if you have any thoughts on the topic?

MEMBER COFFIN: Yes, I do, thank you. There are a couple of aspects to consider. One, we measure regulatory compliance and where do we stand in terms of our operations day-to-day, the second is around the financials, and certainly your questions about the financial performance. We are projecting to end this fiscal year here at the end of June with a net income of about $10-15 million and so -- like many organizations, you know, we have experienced both some positive and negative months.

You know, we have been heavily involved in provider incentive programs and member incentive programs as well as an increase in membership. For example, since March of 2020 our membership in Medi-Cal has grown by 70,000 adults and children and so through that, through that growth we have experienced additional costs that often come with treating our members. So to that end, we are anticipating to finish the year favorable.

CHAIR DEGHETALDI: Thanks, Scott. Abbi.

MEMBER COURSOLLE: Yes, thanks, Scott. I just wanted to also note, maybe it is more of a comment, but that Alameda is one of the counties that proposed to move to one plan with Alameda Alliance being the only plan in that county so I think it is definitely worth paying very close attention to make sure, since all Medi-Cal enrollees in Alameda Alliance are projected to move into that plan, to make sure the plan is in good financial condition.

MEMBER COFFIN: I 100% agree and that is something we are, you know, closely monitoring. And, you know. And also to just to keep in mind for the commission here is, the Board, is we are a mission-driven organization so being part of the community we serve, that entails, you know, making some significant investments into the community and we have been working very closely with Alameda County agencies and Board of Supervisors to ensure that we maintain that pattern. But 100% agree with you on the solvency as well. As I mentioned earlier, the regulatory compliance are key, key assets that must be in the right place.

CHAIR DEGHETALDI: Thanks, Scott. I have been here a long time and I think that the COHS have largely outperformed the Local Initiatives in terms of TNE. I would just say that in any time of uncertainty, pandemic-driven

uncertainty about future rates, a CFO of a managed care organization is going to want their TNE to go up. That's good for the plan but it disincentivizes the plan to do what Scott just said, which is, member incentives, provider incentives around quality and access, and rates that are attractive, particularly to the specialists that patients need. So it's a balancing act. But when the plans don't know what the future will be with so much change, the impact of CalAIM. You know, Scott, I just think it would be natural to want to be very, very conservative with your expense management.

MEMBER COFFIN: Absolutely. You know, one thing I want to point out to the Board, and Lindy did a really fantastic job of outlining, is you see all the changes in policy that we are experiencing, both in 2022 and in 2023; and this change in policy also means change in risk. And so as we think about reserves management and how to measure reserves, we need to consider long-term care as an example, major organ transplant that went live this year. All of these services very expensive as well as we have to be mindful about managing quality and access at the same time. And so these are major changes that affect the bottom line.

I know, speaking on behalf of the public health plans, we have a mission that we serve and it involves serving our communities. And it is very important. We have to maintain solvency to do that but there are a lot of changes happening in the Medi-Cal program, which we are excited about, but we are also, you know, having to think about how to manage financially.

CHAIR DEGHETALDI: Jeff.

MEMBER RIDEOUT: Yes, just a follow-up. Pritika, you had mentioned that you can report on cash as opposed to TNE. I think if we, and

maybe I am missing it on a quarterly basis, but given the volatility in the real estate market I think real estate assets are suspect at this point so it might be nice to see cash as well.

MS. DUTT: Jeff, we do get that data. All the financial statements that we get from the health plans are publicly available on our website. But I can take it back and see if we can summarize that information and include it in the report in the future. But thank you for your comments.

CHAIR DEGHETALDI: Great conversation. I don't believe we have anybody from the public with questions, Pritika, so you are temporarily off the hook.

And then we go to Jessica, who has been very patient, on federal updates.

MS. PETERSEN: Good morning. Yes. I am Jessica Petersen again with the OLS within the DMHC and I will provide a very quick update on two pieces of news on the federal front.

The first is the rollback of the federal Conscience Rule. The US Department of Health and Human Services, also known as HHS, indicated in April, which was last month, that it intends to repeal a regulation adopted in 2019 under the Trump administration. The title of that 2019 rule is Protecting Statutory Conscience Rights in Health Care but it is often simply called the Conscience Rule.

By way of background, the Conscience Rule broadened existing federal law that allowed providers and certain health care entities to refuse to perform services like abortion, sterilization or assisted suicide when doing so would conflict with the provider's religious or moral beliefs.

The Conscience Rule, among other things, expanded who could object to participating in a service. For instance, under that 2019 rule, a receptionist in a medical office could refuse to schedule an appointment for someone seeking sterilization if such a service conflicted with that receptionist's religious or moral beliefs. Providers and any employee of a provider could refuse to participate, even tangentially, in providing a host of other services which included HIV testing and treatment, gender affirming care and contraception.

Swiftly in response to that rule a number of states and organizations sued HHS to prevent the implementation of that rule. They argued that the rule went beyond HHS's authority and that implementing the rule would effectively bar access to essential health services, particularly for women and LGBTQ individuals. The court agreed with the plaintiffs and found that HHS did exceed its authority in promulgating that rule and the rule was vacated in its entirety, meaning the rule is not currently in effect; but the April announcement from HHS indicates that that rule will be taken off the regulatory books.

The second and final federal update that I will provide has to do with fixing the Family Glitch. The so-called Family Glitch arises when a person obtains affordable health care coverage from their employer, but the employer's plan may not be affordable for the enrollee's dependents.

In this scenario the dependent may want to purchase a product from Covered California and might otherwise qualify for premium tax credits if they purchased an on-exchange product, but the Family Glitch would prevent that dependent from qualifying for those tax credits. This is because premium tax credits are available only when affordable employer-based coverage is not available. And due to how that term 'affordable employer-based coverage' is

defined under the Affordable Care Act the whole family is deemed to have access to affordable employer-based coverage and therefore not have access to the tax credits, even if the coverage is affordable only for the employee and not the family overall.

And just to get into the weeds for one moment, that employer coverage is considered affordable for a family if the cost to cover the employee for self-only coverage is no more than 9.61% of the family's income. That current rule does not consider that the coverage of dependents may push the cost for family coverage over that percentage threshold.

This glitch has been a long-recognized problem and recently the IRS and Federal Department of the Treasury proposed a new rule to fix it. Under this rule family members can qualify for those tax credits if the employee is offered affordable employer-based coverage but the dependent coverage would not be affordable. The federal rule is currently in its public comment period, which closes early next month in June. And assuming the rule is finalized this year it would take effect for the 2023 plan products.

That's the end of my presentation. Happy to take any questions.

CHAIR DEGHETALDI: Looking for questions.

MEMBER WATANABE: I will just add on the family glitch issue. We recently celebrated the 10 year anniversary of Covered California. Jeff and I were there 10 years ago or longer when we had the first couple of open enrollments and the family glitch. It is awful to hear the stories of families who can't afford coverage because of the family glitch and we have had our fingers crossed that there would be action at the federal level to fix this. It is one of those that those of us that have been involved on the ground in the enrollment

efforts are really excited and fingers crossed that this gets fixed.

CHAIR DEGHETALDI: Any Board questions.

MEMBER RIDEOUT: Wonks that we are.

CHAIR DEGHETALDI: That's great, thank you. Any? Nothing from the public so thank you very much, I think you had to go. So then back to Pritika.

MS. DUTT: Thank you, Larry. Good morning. I will go over our findings from the 2021 large group, small group individual annual rate filings and also highlight some of the key findings from the Prescription Drug Transparency Report for Measurement Year 2020.

This is a condensed version of our presentation that was publicly done back in March in San Francisco. The DMHC has issued three reports that include more detailed information on the filings and these reports are included as part of the meeting materials and also available on the DMHC's public website.

Large group health plans must file aggregate rate information and specified information regarding health plan spending and year-over-year cost increases for covered prescription drugs annually. DMHC is required to conduct a public meeting in every even-numbered year to permit a public discussion regarding changes in rates, benefits and cost-sharing in the large group market. The information we are discussing today is for groups that renewed during calendar year 2021.

There were 23 plans that were required to file information with the Department. Of those, 8 were statewide plans that offered products in many regions, 10 were regional plans that mainly offered products in one region, and 5 local health plans that have in-home support services plans for their IHSS

workers.

The large group market covered over 7.9 million enrollees. And of those 7.9 million enrollees, 7.8 million enrollees were impacted by a rate change. Large group rates increased by 4.2% On average and the average premium per enrollee per member per month was $533.70.

Health plans are also required to include information on their renewal notices to employers that compares the rate change to those in Covered California, CalPERS and the average rate increase in the large group market. Covered California and CalPERS negotiate rates with the plans similar to large employers so it gives some comparison for large employers. You can see the average rate increases for calendar years 2017 to 2022. The spike for 2018 Covered California rate increase is due to the uncertainty of the cost-sharing reduction surcharge, and it was included in the 2018 Silver rates due to the lack of federal government funding of CR subsidies. Excluding the surcharge, the 2018 statewide average increase for Covered California plans was about 12.3%.

This chart shows the average premium per member per month by year from 2016 to 2021. From 2016 to 2021 the average premium per member per month increased by 17% for regional plans and 22% for statewide plans. The average premiums for statewide plans have been consistently lower compared to regional plans. The average premium continues to rise every year, which is consistent with the renewal increases shown on the prior slide.

This chart shows the average rate increases for 2016 to 2021 by percentages. Aside from 2019, over the most recent four year period it is clear the average increase for regional plans have been much lower than their statewide counterparts. However, as seen on the previous slide, the average

premium was lower for the statewide plans compared to regional plans.

As I mentioned previously, the average rate increase was 4.2% for all plans in the large group market and the average monthly premium was $534. We showed Kaiser separately here on this table since Kaiser represents the majority of the enrollment in the large group market with 66% of the total large group enrollment. Kaiser reported an average increase of 4.2% with average premium of $522.

This table shows the average, minimum, and maximum premium increase and monthly premium by product type. In 2021, PPO and POS had the highest premium with average premium of just over $600 per member per month. Overall, HMO plans experienced the second-lowest average rate increases with 4.2% increase and had the second-lowest average premium of $528 per member per month.

This table shows that number of covered lives by actuarial value. Actuarial value is the percentage of total average cost for covered health care services that are paid by the health plans. For example, if a plan had an actuarial value or AV of 70%, on average, an individual would be responsible for 30% of the cost of all covered healthcare services. Plans with a higher AV are generally considered to have richer benefits with lower cost-sharing. 85% of large group enrollees or 6.7 million were in HMO plans with higher actuarial value and therefore the richest benefits overall. In contrast, High Deductible Health Plans, or HDHP plans, tend to have give members a lower premium option with higher out-of-pocket costs.

Assembly Bill 731 extended the rate review practice that the state already had in place effective July 1, 2021. Upon receiving notice of a rate

change, a large group contract holder that has coverage that meets specific criteria can request the DMHC to review a rate change if the contract holder makes the request within 60 days of the receipt of the notice. A large group employer may request the DMHC for review of a rate change from the health plan licensed by the DMHC. Please visit the DMHC website to request a rate review or if you are interested in getting more information about the rate review process.

Now I will discuss the small group and individual market rates.

In 2020, California enacted Assembly Bill 2118 for the purpose of increasing transparency of rates in the individual and small group markets. AB 2118 requires health plans that offer commercial products in the individual and small group market to report specified information including premiums, cost-sharing, benefits, enrollment and trend factors to the DMHC by October 1, 2021 and annually thereafter.

Beginning in 2020 the DMHC is required to present, annually present the reported information at various public meetings, as specified in both the report and the DMHC's website, no later than December 15 of each year. This is the first time we are presenting this information at this meeting. In this next section we will summarize the aggregate rate information and weighted average rate increase on health plan premiums for small group coverage in measurement to 2021 and compare information between on-exchange, off-exchange and grandfathered products.

DMHC received small group rate filings from 15 health plans for measurement year 2021, including 7 statewide plans and 8 regional plans.

In 2021, 2.2 million enrollees had small group health care

coverage.

This table compares information between on-exchange, off-exchange and grandfathered products. Small group plans that offered on-exchange products covered 70,000 enrollees and had an average increase of 2%, with an average premium of $496. Off-exchange plans covered almost 2 million enrollees and had an average rate increase of 1.7%, with an average premium of $537. Grandfathered plans covered 167,000 enrollees and had an average rate increase of 3.7%, with an average premium of $504. Overall, the average rate for small group plans increased by 1.8%. The average premium across all plans was $533.

This table looks at the enrollment by metal tier for on-exchange plans. Over 90% of the enrollees had HMO or PPO plans. Gold plans led the market with the highest number of enrollees. Silver plans were ranked second and other products significantly trailing in the number of enrollees. This pattern was consistent between on-exchange and off-exchange plans.

This table here looks at the enrollment by metal tier for off-exchange small group plans. A majority of the small group enrollees are enrolled in the off-exchange. Almost 2 million enrollees were in the off-change plans in the small group market. And similar to the on-exchange table on the previous slide, the majority of the enrollees were in the off-exchange gold products and over 90% of the enrollees were in HMO and PPO products.

In this section here I will summarize the aggregate rate information and weighted average rate changes on health plan premiums for individual coverage in measurement Year 2021 as required by Assembly Bill 2118.

For measurement Year 2021 the DMHC received individual

markets aggregate rate filings from 12 health plans, including 4 statewide and 8 regional plans.

The 12 individual health plans covered over 2.4 million enrollees.

This table compares information between grandfathered and on- and off-exchange plans. The overall average monthly premium was $550.95, a decrease of .4% from 2020. Eleven health plans offered on-exchange products and covered 1.8 million enrollees with an average premium of $560. Twelve plans offered off-exchange products and covered almost 570,000 enrollees with an average premium of $515. Only two plans offered grandfathered plans and covered 55,000 enrollees with an average premium of $633.

The next two slides look at enrollment by metal tier for on- and off-exchange products.

Of the approximately 2.4 million enrollees on the individual market, 1.8 million enrollees purchased on-exchange products or products sold by Covered California. The majority of the enrollees selected a silver plan, which is one of the four metal coverages. About 70% of the enrollees were in silver or higher metal tiers in the individual market for both on- and off-exchange plans. The majority of the enrollees in the individual market chose HMO plans with higher actuarial value, which was the richest benefits overall. Another item here is a catastrophic plan. Catastrophic plans offer coverage in times of emergencies as well as coverage for preventative care. Catastrophic plans typically come with low monthly premiums and a high deductible.

This table looks at the enrollment by metal tier for off-exchange plans. Approximately 570,000 enrollees were enrolled with off-exchange plans.

And now I will briefly go over the Prescription Drug Cost

Transparency Report for Measurement Year 2020.

In 2017, California enacted Senate Bill 17 with the purpose of increasing transparency of prescription drug costs. SB 17 requires health plans that file rate information with the DMHC to report specific data related to prescription drugs beginning October 1 2018 and annually thereafter.

In addition, it also requires drug manufacturers to provide advance notice of significant prescription drug cost increases and make certain information associated with these increases -- so they need to file this information with Department of Health Care Access and Information, previously known as OSHPD.

SB 17 requires DMHC to issue an annual report that summarizes how prescription drug costs impact health plan premiums. Health plans must report to the DMHC information on their 25 most frequently prescribed drugs, the 25 most costly drugs by total annual spending, and 25 drugs with the highest year-over-year increase in total annual spending.

Some of the key findings from the report include:

Health plans paid more than $10.1 billion for prescription drug costs in 2020, an increase of almost $500 million from 2019, and $1.5 billion from 2017.

Prescription drug costs accounted for 12.7% of total health plan premiums in 2020, a slight decrease from 12.8% in 2019, with only a .1% decrease.

Health plans' prescription drug costs increased by 5% in 2020, whereas medical expenses increased by 3.7%. So compared to medical expenses, the prescription drug costs increased by a higher percentage. Overall,

health plans premiums increased by 5.9% from 2019 to 2020.

Manufacturer drug rebates totaled $1.4 billion in 2020 and this represents about 14.2% of the $10.1 billion spent on prescription drug costs.

While specialty drugs accounted for 1.6% of all prescription drugs dispensed, they accounted for 60.2% of total annual spending on prescription drugs.

Generic drugs accounted for 89.1% of prescription drugs, but only 18.1% of the total annual spending on prescription drugs.

That brings me to the end of my presentation; I will take any questions. So a lot of information. We have three very detailed reports that are available on our website if somebody is interested in getting more information but I will take any questions at this time.

CHAIR DEGHETALDI: Any questions from the Board?

Mary has a comment.

MEMBER WATANABE: Larry, to your point of having been around for a long time. I think I have been at the Department for seven years and I was remembering the amount of information we shared back then around rates. So just wanted to acknowledge to our consumer advocate partners who are on the phone that have given us this new authority and ability to collect a tremendous amount of information, the amount of transparency we are bringing to the cost of health care and premiums, it is not insignificant. So I just wanted to acknowledge that. I also wanted to take a moment to acknowledge Pritika and her team; I think Wayne Thomas, our Chief Actuary, is on the phone. This is just a small piece of the information that is in these public reports. The transparency is so important. But it is a tremendous amount of work for our team. I just wanted to

acknowledge the importance of this very technical information we just shared.

CHAIR DEGHETALDI: Jeff and Abbi.

MEMBER RIDEOUT: Yes. This is more a forward-thinking question a little bit. With the Office of Affordability looking at affordability, presumably through total cost of care, how will the Department kind of interface with that? Because I think we all understand premiums and MLRs are pretty poor proxies of total costs but I think there is something, there is a pony in here for really getting at what is driving the cost picture. Maybe that's for Mary again. I'm sorry, Mary, I keep putting you on the spot today. I am just curious if you have any thoughts about this.

MEMBER WATANABE: Yes, no, no, that's okay. And yes, I mean, I would say we have obviously been working pretty closely with our sister agency at HCAI. I think the amount of data shared and the overlap with the work that we are doing, we will have to kind of wait to see what happens with the legislation. Because we have a lot of experience with this work we have been trying to kind of share and advise. Pritika, I don't know if there's anything more you want to add?

MS. DUTT: Mary, to your point, we have been sharing information with HCAI. Also we have detailed information on rates available on our website and we are going to be working closely with HCAI on any data sharing and providing them technical assistance.

MEMBER COURSOLLE: Thank you, Pritika. This was so helpful and such a lot of information, as Mary said, presented in a really helpful way and I am sure a lot of work went into this.

I especially appreciated the review of the corrective action plans,

both for the RBOs and the plans. I was just wondering, for the RBOs it lets us know, the report lets us know when those CAPs were initiated but it doesn't look like we have similar information for the plans. I may be missing it but I was just wondering if that information is also available somewhere so we know how long the plans have been under those CAPs?

MS. DUTT: Abbi, I just went over the premium rates. Michelle is going to do a presentation on the provider solvency, then I will be providing another update on health plan finances. And we will discuss some of those plans that have been TNE deficient so we can go over it in that presentation.

MEMBER COURSOLLE: All right, sorry for getting ahead of myself. presentation.

CHAIR DEGHETALDI: Any other Board questions?

Have we studied geographic variation within the state? I know that health care premiums commercial are 35 to 40% higher in the Bay Area than LA. Have those trends increased? Have we looked at that?

MS. DUTT: We can take that question back and, again, have my team take a look at the data we have available. How much we can analyze and provide information at a follow-up meeting.

CHAIR DEGHETALDI: Because I think Jeff's point on how this informs the Office of Health Care Affordability is, we are really important for that.

MEMBER WATANABE: I will just add, I don't know that that's something we have looked at specifically with this data. Obviously, Covered California historically has done a lot of analysis and reports on the variations geographically as well. But we will take that back and see if there's something more we can share in the future.

CHAIR DEGHETALDI: I see Amy.

MEMBER YAO: yes. So I echo everybody's comments, it is a very helpful report. Actually the large group I never look at it this way, looking at the national plan versus regional plan. Actually, this is the aha moment. I always thought that a regional plan will have a lower cost just because of population, they are more geographically centered, the population they cover, maybe it would be more healthier, but actually it is the opposite. So more helpful information. I appreciate the different reports and different views with the insight that the local plans cost higher than the national plan. But anyway, that's.

MS. DUTT: Their premiums tend to be lower, Amy, over the a local plans. So that's one of the reasons, because they have their contract with the county.

Are you talking about the local plans as in the IHSS plans or?

MEMBER YAO: No, on page 5.

MS. DUTT: Page 5.

MEMBER YAO: The regional, the large groups, yes. Looking at their, the regional plans premium is higher than the statewide plan.

MS. DUTT: One of the items could be -- we can take back and look at it in more detail but, again, it is they don't have that many lives, they are more smaller scale. If you think about it, the larger plans, statewide plans, have more enrollees so the spread is higher.

CHAIR DEGHETALDI: Okay. And public comment I do see one hand raised. Is that Bill?

MR. BARCELLONA: Thank you, Bill Barcellona, APG. Pritika, I just had one quick question for you. On the filing forms there is, there is a

category for Physician Fee for Service Trend and Physician Capitated Trend. Can you, do you have the aggregate figures for those two categories broken down?

MS. DUTT: Bill, we do but we need to take that back and do some analysis and report back those figures, but we do have the data.

MR. BARCELLONA: Thanks. That's all I have, thank you.

MS. DUTT: Thank you.

CHAIR DEGHETALDI: Thank you, Bill.

Then we move to Michelle.

MS. YAMANAKA: Thank you, Larry. Good afternoon, Michelle Yamanaka, Supervising Examiner in the Office financial of Financial Review. Today I am going to give you an update on provider risk-bearing organization, or RBO, financial reporting for the quarter ended December 31, 2021.

We have 208 RBOs that were required to file quarterly survey reports. One RBO began reporting this quarter and two RBO accounts were inactivated, resulting in a net decrease of one RBO from the previous reporting period. We also have 13 RBOs on corrective action plans and I will discuss more information on a later slide regarding the CAPs.

The RBOs are also required to file annual survey reports. For the fiscal year-end March, June and September of 2021 we received 24 annual survey reports. The remaining reports are currently coming in and are due by the end of May. Several reports, about 150 more that are currently in process of coming in. We also review monthly financial statements that are filed by RBOs as a requirement of their corrective action plans. Next slide, please.

For the inactive RBOs, since we have been collecting information

there have been 121 RBO accounts that have been inactived for various reasons. We captured them in three categories, Financial Concerns, No Financial Concerns, and an Other category which is a catch-all consisting of examples like duplicate accounts, RBOs that didn't need to report, et cetera. So for the quarter ended December 31, 2021, there were two RBOs that became inactive, one RBO is represented in the Financial Concerns category, and one RBO in the No Financial Concerns category.

The enrollment assigned to the RBOs, we capture that as well. For the last survey report submitted, approximately 69% of these RBOs that have been inactivated had less than 10,000 lives assigned to them. For the quarter ended December 31 one of the two RBO accounts that were inactivated, one RBO is represented in the 0-5,000 category, one RBO is represented in the 10,000-30,000 category.

Moving on to the survey reports filed for quarter ended December 31. It shows that 195 RBOs are compliant and are meeting all grading criteria. This represents 94% of the RBOs. Within this category, there are 7 RBOs on our monitor closely list and there are 13 RBOs that are non-compliant and are on a corrective action plan.

Moving on to the corrective action plans. As I mentioned, there are 13 RBOs and we have active corrective action plans. Three RBOs have 2 CAPs that are active. Of those 16, 10 are continuing from the previous quarter and 6 are new as of December 31. Of those 10 continuing, 6 RBOs or 8 CAPs are improving from the previous quarter, and 2 RBOs are not. For those 2 RBOs, their March 31 financials came in and they are improving from the previous quarter and are tracking their corrective action plan. Of the 16 corrective action

plans, all 16 are approved so we are currently monitoring them.

For additional information on the CAPs we have a handout which includes the contracting health plans or RBOs, enrollment by ranges, the quarter the CAP was initiated, compliance, the compliance status with the final or approved, CAP and the grading criteria deficiencies.

Moving on to enrollment. The RBOs are required to file enrollment as part of their survey report. This slide represents that there are approximately 8.7 million lives assigned to the 208 RBOs and it is a slight decrease from the previous reporting period. Next slide please.

In addition to the enrollment the RBOs are required to report enrollment that is received from another RBO, which we call sub-delegated enrollment. We have identified 21 RBOs that received sub-delegated enrollment and this is approximately 155,000 enrollees that are sub-delegated. Of the 21 RBOs, 16 RBOs have less than 5,000 sub-delegated lives, 4 of the 21 only receive enrollment from another RBO, they do not have a contract with a health plan, and 1 of the RBOs is on a corrective action plan.

We also look at enrollment of Medi-Cal lives assigned to RBOs. At December 31 2021 there were approximately 5 million Medi-Cal lives assigned to 86 RBOs. This represents 57% of the total lives assigned to the 208 RBOs. Of the 86 RBOs, 72 have no financial concerns, 6 are on our monitor closely list and 8 RBOs are on corrective action plans.

Looking at the top 20 RBOs that have greater than 50% Medi-Cal lives assigned to them, the top 20 have approximately 3.7 million lives assigned to them, which represents approximately 43% of the total enrollment. 14 of these RBOs had no financial concerns, 4 where on the monitor closely list and 2 are on

corrective action plans.

With that, that concludes my presentation. I am here for any questions.

CHAIR DEGHETALDI: I don't see any Board hands raised. Any questions? Ted, hi.

MEMBER MAZER: Let me get off mute. In looking at the Review Summary page, and I have brought this up at pretty much every meeting when we get to this point, we have one MSO that continues to show quarter by quarter by quarter being in trouble. Compliant with the Final CAP is (inaudible). It is concerning to me that it is sort of the outstanding MSO on this entire chart. So I don't want to mention by name because I am not sure if this is all out there in public. But, are we concerned here about taking some action with this MSO and its delegated groups given a trend that seems to be non-ending?

MS. YAMANAKA: So, you know, the options to take action are to freeze enrollment or to de-delegate the claims risk, those are the two options. One of the things that we monitor very closely on a monthly as well as a quarterly basis is to look at, to ensure that the RBO is tracking their approved corrective action plan. If they are tracking, then unless there was another reason, we wouldn't look to enforcement action at that time. However, if there were financial difficulties or there are other concerns we may look at that option. So if an RBO is on a corrective action plan, they have been on there, if we see that they are tracking their CAP as we do, we are continuing to monitor them to see if there's any concerns, additional concerns.

MEMBER MAZER: Just in follow up. I understand that you are monitoring them and I understand they are compliant, but at what point in time do

you see financial solvency improving or that other interaction, maybe even freezing enrollment until they get there? Because some of these have significant enrollments of people.

MS. YAMANAKA: Correct, yes, you are correct, they are a significant enrollment. What I can tell you as is there are times that RBOs may need additional time to obtain compliance with the solvency criteria. And based on their corrective action plans, along with the approval of their contracting health plans, we may grant that time as long as they have a plan that is feasible, to show compliance.

One of the things we also do, what we do for the RBOs that are compliant and are meeting all criteria, especially when the annual financial survey reports are coming in, we will hold them to verify the 2021 or the previous year's financials because those are done by an independent auditor to verify the numbers as well as to go forward. So that may be part of the reason why some of these are still on there.

MEMBER MAZER: Okay. I do understand but I am just, some of these have been going on for over two years and it just seems like an inordinate amount of time waiting for a failure, thanks.

CHAIR DEGHETALDI: Amy.

MEMBER YAO: Yes, I had the same observation as Ted so my question would be a little bit different. Do we understand the root cause of the CAP? The CAP is with the RBOs or the CAP is was the MSO?

MS. YAMANAKA: So the CAP is with the RBO because that RBO needs to meet the grading criteria and demonstrate how they are going to become compliant with the grading criteria. The MSO may assist in preparing

the corrective action plan but we hold the RBO responsible.

CHAIR DEGHETALDI: Are these high Medi-Cal member plans?

MS. YAMANAKA: The information that we have, I don't believe we have that information posted so let me take, take that one back.

CHAIR DEGHETALDI: Thank you.

MEMBER WATANABE: If I can just add, and I know we have a couple of public comments that are probably going to address some of this as well. Just a reminder that we don't regulate MSOs. So we have financial oversight of the RBOs, we regulate the health plans, so those are our hooks. We have a number of tools. I think we have talked about this before. And, Ted appreciate that you continue to raise this, it is one of the first things that I look for when I get this report is where are the trends, where are the patterns, who is showing up again, who shows up a lot, repeatedly? But, you know, to freeze enrollment or to take some of the more progressive steps we can take can be very disruptive to that entity, to enrollees as well, so it is something that we do take very seriously. Michelle and her team monitor these corrective action plans. We have a goal of getting them back on the right path. But I know we have got a couple of public commenters that probably can add to that.

MEMBER MAZER: And speaking out of turn, I am looking at which plans these groups are with, and they are significantly with Medi-Cal managed care.

CHAIR DEGHETALDI: Thanks, Ted. I think the Board is done, go to the -- I see, Bill, your hand up.

MR. BARCELLONA: Thank you, Bill Barcellona with APG. Just a couple of comments about this discussion. Again, I want to thank the

Department for starting to publish not just the MSO, but the contracted health plans. I am going to renew my request for the FSSB to perform an analysis of chronic CAP-ped groups that includes not only a discussion of their MSO affiliation but also their plan affiliations, because I think we should look at the premium rates that these groups have and whether there is variance within other groups.

I also think we should look at the historical performance of the MSOs. In my 20 year career with the Department and since I have left the Department I have noticed there are MSOs out there that can tank a group and there are MSOs out there that actively reform groups and keep them afloat. And so just the fact that you have five or six (inaudible) with a particular MSO in this Medi-Cal environment, I don't believe that's indicative that the MSO is under-performing, necessarily. So I think there is a lot more to this story that we should look at so that we don't revisit this at every meeting and kind of live in this Groundhog Day environment. Thank you.

CHAIR DEGHETALDI: Thank you, Bill.

Any other? I see Kimberly with the hand raised.

MS. CAREY: Hi, everyone. This is Kimberly Carey from MedPOINT Management. I believe that you have been referring to our MSO and I just wanted to say that our MSO, who is primarily focused on Medi-Cal, manages 20 or so different IPAs representing 1.6 million Medi-Cal members in the state. The two RBOs that are on a financial cap, both of which are I believe completed and are waiting for the final, have 92 and 95% Medi-Cal in their memberships. So I just would like to point that out. I think it is very important to note that.

The clients that we have that have experienced a majority membership with Medi-Cal have also had almost a hundred million dollars of COVID testing claims over the past (inaudible) that obviously, as you can imagine, has affected everyone's financial viability. We are hoping that with the help of the state there is success in recoupment of that Medi-Cal expense. So I wanted to make sure that we point those things out.

Lastly, I want to point out that the MSO does not take any financial risk, its job is to administer and perform the responsibilities delegated under the health plan contracts. So as you also know, we are at the whim of health plan funding and look forward to maybe helping. Maybe addressing that with the MLR might be able to highlight some of those areas. So thank you, that's all I wanted to say.

CHAIR DEGHETALDI: Thank you, Kimberly. Any other comments from the public? No? Well, thank you very much.

I think we go back now.

MS. DUTT: Thank you. Good afternoon. I am Pritika Dutt, Deputy Director of the Office of Financial Review. The purpose of this presentation is to provide you an update of the financial status of health plans at quarter ended December 31, 2021. We track the health plans' financials and enrollment trends very closely and work with the plans if we see any unusual trends that would raise concerns.

We also included a handout that shows the enrollment at December 31, 2022 (sic) by line of business and tangible net equity for five consecutive quarters for all health plans from December 31, 2020 through December 31, 2021. The information is broken into three categories. First we

have the full service plans, then we have the restricted full service plans and then we have the specialized plans.

As of April 6, 2022, we had 141 licensed health plans. We are currently reviewing 8 applications for licensure, which includes 5 full service and 3 specialized. Of the 5 full service, 2 are looking to get licensed for restricted Medicare Advantage, 3 restricted Medi-Cal. And for the 3 specialized they are looking to get into, for 2 of them they are looking to get into EAP business and 1 for dental health care services.

At December 31, 2021, there were 28.45 million enrollees in full service plans licensed by the DMHC. Total commercial enrollment includes HMO, PPO, EPO and Medicare Sup. As you can see on the table, compared to the previous quarter, total full service enrollment increased by 227,000 enrollees, and a majority of the increase was driven by Medi-Cal health managed care enrollment, or the government enrollment in this chart.

This chart shows the enrollment trend since 2017 for commercial and government enrollment for the DMHC licensed health plans. The gap between the commercial and government enrollment widened until 2019 where commercial was higher than government. And now since 2020, government enrollment surpassed commercial enrollment; and in 2021, the gap even widened further.

This slide shows the makeup of HMO enrollment by market type. HMO enrollment in all markets remained relatively stable compared to previous quarters.

This slide shows the makeup of PPO/EPO enrollment. As you can see on the table, there was a slight increase in PPO/EPO enrollment compared

to the previous quarter.

And this table shows the government enrollment, which is Medi-Cal and Medicare. Overall government enrollment increased. A majority is due to Medi-Cal enrollment, which increased by 162,000 lives. And this information is based on the financial statements received as of December 31, 2021.

There were about 4.6 million enrollees enrolled in the plans that were closely monitored by the DMHC. Of the 29 closely monitored full service plans, 15 are restricted licensees and had 472,000 enrollees. Of the restricted plans, 3 are restricted for Medi-Cal, 9 Medicare and 3 for commercial. The total enrollment for the 4 specialized plans is 224,000 lives. The specialized plan makeup was 1 vision, 2 dental and 1 behavioral. As a reminder, we have plans on the watch list for various reasons. We could have had an audit finding, TNE concerns, a decline in their net income, anything in the media that we are looking at, enforcement actions, so there are various reasons that we have a plan on the watch list.

Three health plans did not meet the DMHC's minimum financial reserve for TNE or tangible net equity requirement. CCA Health Plans of California, Inc., formerly known as Vitality Health plans. So CCA was TNE deficient at December 31, 2021. The plan was acquired by Commonwealth Care Alliance at December 31, 2021. The plan reported TNE deficiency and received funding from the parent company on January 4, so as of now the plan is compliant. And you might have seen Vitality on the reports quarter after quarter. The plan was purchased and now is compliant with the TNE requirement. So the plan had to file a bankruptcy. A new buyer purchased it through the bankruptcy court and now it is meeting the minimum TNE requirement.

The next plan is Golden State. The plan has not cured its TNE deficiency as of March 31, 2021.

On April 27, 2021 the DMHC issued a Cease and Desist Order that prohibits Golden State from accepting new members, effective May 1, 2021.

The DMHC issued an Accusation on July 1, 2021 to revoke Golden State's license and the plan requested a hearing.

On February 8, 2022 the DMHC entered into a stipulation with the Department. If the plan received funding by May 6, 2022 and the DMHC approved it, the Accusation may be dropped. If the plan does not receive this funding it will file a Surrender on June 1, 2022 to be effective August 1, 2022.

The plan was not able to secure funding as of May 6. The DMHC's Office of Enforcement is currently working with CMS and the health plan's attorneys on next steps. Per CMS, the plan has less than 2,000 enrollees as of May 1. So more to come on Golden State.

Premier Eye Care, Inc. So Premier Eye Care, Inc. was TNE deficient as of December 31, 2021 due to over -- there was some reporting issue with the administrative costs. They received funding from the affiliate parent and they were able to cure their deficiency as of March 31, 2022 so for the next quarter they would be compliant. Next slide.

This chart shows the TNE of health plans by line of business. A majority of the health plans with over 500% of required TNE me are specialized health plans. And I had mentioned this previously, but the TNE requirement for full plan plans is substantially higher when you compare it to specialized plans due to their higher level of medical risk.

Next slide.

This chart shows the TNE of full service plans by enrollment category. 59 health plans, or over half of the total licensed full service health plans, reported TNE of over 250% of required TNE.

This chart shows the 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 of their financial performance, which is TNE, net income, enrollment, their cash position, so these are the several criteria that we look at.

I also wanted to flag here that as of July 1, under the new health plan financial statement regulation update, the new monthly requirement for health plans to be placed on monthly reporting is 150% of required TNE. So we increased the number from 130% to 150%.

This chart shows the TNE of full service plans by quarter. And for detailed information on the health plan TNE levels and enrollment you can refer to the handout that was provided. It has more detailed information, as I mentioned previously, by enrollment, by line of business, as well as it shows TNE levels for each health plan.

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

CHAIR DEGHETALDI: Looking for questions from the Board. Amy.

MEMBER YAO: Yes. I have a question, Pritika. On page 9 you talked about the three plans but you didn't -- I am wondering, like the United Healthcare Benefit Plan of California, there's lots of covered lives associated with that plan. And United Healthcare, assuming a parent company, they should be,

their a financial shouldn't be an issue. Can you give a little bit of color on that one?

MS. DUTT: Which page are you on?

MEMBER YAO: Page nine on the slides.

(Several people talking about page number.)

MEMBER YAO: Yes. You talked about the first three.

MS. DUTT: I did talk about the first three.

(Pause.)

MEMBER MAZER: Are we still connected?

MEMBER COURSOLLE: Yes, I am not getting any audio.

MS. DUTT: I did not unmute my line, my apologies. So I was just talking to Amy here. United Healthcare Benefits Plan had a big loss at December 31 but they received additional funding from United Healthcare, which is their parent entity, and they were able to make them whole and they are TNE compliant as of the subsequent quarter.

MEMBER WATANABE: I will just add the importance of timely influxes of money from parents companies because if not you get on to our naughty list here in our FSSB meetings. (Laughter.)

MS. DUTT: And that is the difference between those government plans who have to hold on to their higher TNE versus the more commercial plans that has a parent backing.

CHAIR DEGHETALDI: Would you go back to slide 4, Jordan. It is the graph with the green line and the, there you go. This is important. The green line, the slope is going to accelerate with CalAIM, Medicare Advantage growing, with the expansion of the managed Medi-Cal plans into all 58 counties. This is

concerning because from the RBOs' perspective the blue line subsidizes the green line. So I am just, I just want to stress I am concerned about our ability to keep this fragile ecosystem intact. So that crossing the Rubicon back in 2020, we are never going to go back to the upside down, I don't think. Amen.

Any other comments from the public? I'm sorry, we lost you there for a little bit. Thank you.

So we go to public comments on matters not on the agenda. So I look for any comments or questions or topics of interest? I am seeing none. Okay.

And then agenda items. Maybe we can go around the Board and ask if there are any agenda items for future meetings? Jeff, thank you.

MEMBER RIDEOUT: Yes, Larry. Mary had mentioned the Office of Health Care Affordability assuming the trailer bill language gets through. I would like to see that one come up sooner rather than later, if that's possible.

MEMBER WATANABE: Shaking my head yes for anybody that can't see me. We will make sure that's on the list at the appropriate time and we will see if it makes sense for the next one.

MEMBER RIDEOUT: Thanks, Mary.

CHAIR DEGHETALDI: Mary, I am interested in the health equity work, particularly as we tie that work into risk adjustment, to ensure that the RBOs and plans who care for the most complex patients are going to be able to have a sustainable future. Paul.

MEMBER DURR: Yes, Larry, I was just thinking, you know, the MICRA settlement and that is certainly going to impact rates. And I don't know if there is anything that we can do on that but certainly that needs to be thought for

and consideration for plan filing on rates, because it will mean that providers are going to need additional revenue to cover those premium increases. I don't know if it is an agenda item, just maybe a comment for consideration on rate renewals.

CHAIR DEGHETALDI: And Abbi?

MEMBER COURSOLLE: Yes, I wanted to second the request on health equity. And then also, understanding there's uncertainty as to timing, but whenever the time is appropriate for an update on the LA Care fine situation I would appreciate that as well.

CHAIR DEGHETALDI: Jeff, your hand is up. I think that you're done?

MEMBER RIDEOUT: I had another request.

CHAIR DEGHETALDI: Great.

MEMBER RIDEOUT: Maybe just a bit of a primer on what DMHC does or doesn't regulate when it comes to plans versus RBOs; and then also what plans are not regulated. We picked up on COHS today, I am just wondering, sort of. I don't know enough about it, it would be great if there is just a little short update on that sometime.

MEMBER WATANABE: Yes, we can certainly do that. There's, I think, some medical groups that we also don't regulate. There are some nuances and things have changed over time so we will definitely add that to the list. MEMBER RIDEOUT: Thanks.

CHAIR DEGHETALDI: Amy.

MEMBER YAO: Yes. There is so much going on at DHCS so I don't know whether in three months there will be material movement on any of the topics, but maybe if we could have the regular update in a smaller chunk so I

can digest better. Thank you.

MEMBER WATANABE: You know, I actually had a note to take that back and maybe chat with Lindy and René. There is so much happening with DHCS and we want to make sure we are providing relevant information, particularly as it relates to financial solvency. But if you have any recommendations on what you would like to hear maybe at our next meeting so that we don't ask them to repeat an update on the budget and reprocurement and Medi-Cal Rx. So just if you have thoughts you can let us know now so we can help to tailor that presentation a little bit more.

CHAIR DEGHETALDI: Jeff, your hand is up?

MEMBER RIDEOUT: Sorry.

CHAIR DEGHETALDI: Thanks. yes, Let me just close. We are only four minutes over time. I am really impressed.

(Several speakers commenting on the time off microphone.)

CHAIR DEGHETALDI: Oh, we are ahead. Oh, my goodness. Well, this is amazing. I want to thank everybody for making it. I know some of our folks couldn't and I look forward to August when everybody will be in this room, maybe. So thank you to everyone. Great meeting.

(The meeting was adjourned at 12:45 p.m.)

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

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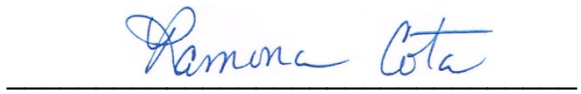

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