STATE OF CALIFORNIA

DEPARTMENT OF MANAGED HEALTH CARE

FINANCIAL SOLVENCY STANDARDS

BOARD (FSSB) MEETING

ONLINE/TELECONFERENCE MEETING

HOSTED BY THE

DEPARTMENT OF MANAGED HEALTH CARE

SACRAMENTO, CALIFORNIA

THURSDAY, MAY 27, 2021

10:00 A.M.

Reported by: Ramona Cota

APPEARANCES

BOARD MEMBERS

John Grgurina, Jr., Chair

Larry deGhetaldi, MD

Jen Flory

Theodore Mazer, MD

Jeff Rideout, MD

Mary Watanabe

DMHC STAFF

Sara Cain, Associate Governmental Program Analyst

Pritika Dutt, Deputy Director, Office of Financial Review

Amanda Levy, Deputy Director, Health Policy and Stakeholder Relations

Sara Ortiz, Staff Services Manager

Sarah Ream, General Counsel

Jordan Stout, Associate Governmental Program Analyst

Michelle Yamanaka, Supervising Examiner, Office of Financial Review

APPEARANCES

ALSO PRESENTING/COMMENTING

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

Sean Atha
River City Medical Group

Bill Barcellona
America's Physician Groups

Yasmin Peled
Health Access California

Janet Vadakkumcherry
Health Center Partners

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1 PROCEEDINGS

2 10:00 a.m.

3 CHAIR GRGURINA: Why don't we go ahead and get started; we'll
4 start with some housekeeping notes. So for our Board Members, please
5 remember to unmute yourselves when you are making a comment and mute
6 yourselves when you are not speaking. For our Board Members and the public,
7 as a reminder, you can join the Zoom meeting on your phone should you
8 experience any connection issues.

9 Questions and comments will be taken after the agenda items. For
10 the attendees on the phone, if you would like to ask a question or make a
11 comment please dial *9 and state your name and the organization you are
12 representing for the record. For attendees participating online with microphone
13 capabilities, you may use the Raise Hand feature and you will be unmuted to ask
14 your question or comment. To raise that hand click on the icon that is labeled
15 Participants on the bottom of your screen, then click the button labeled, Raise
16 Hand. Once you have asked your question or provided a comment then go
17 ahead and click lower the hand. All questions and comments will be taken in
18 order of the raised hands.

19 So with that why don't we go ahead and get started and we will
20 start with some introductions. If I can have the Board Members introduce
21 themselves and the organizations they represent; and Jen, why don't you go first.

22 MEMBER FLORY: Hi, Jen Flory with Western Center on Law and
23 Poverty.

24 CHAIR GRGURINA: Thank you, Jen.

25 All right, Larry.

1 MEMBER DEGHETALDI: I am Larry deGhetaldi, family physician,
2 Palo Alto Medical Foundation, and barking dog in the background.
3 CHAIR GRGURINA: All right, thank you, Larry.
4 Ted.
5 MEMBER MAZER: Ted Mazer, independent physician in San
6 Diego.
7 CHAIR GRGURINA: Thank you, Ted.
8 Jeff, with the beautiful, purple background.
9 MEMBER RIDEOUT: Thank you. Jeff Rideout, Integrated
10 Healthcare Association.
11 CHAIR GRGURINA: All right. And I am John Grgurina with the
12 San Francisco Health Plan.
13 Mary, as the ongoing, permanent Executive Director of DMHC why
14 don't you start and then have your team introduce themselves?
15 MEMBER WATANABE: Great, thank you, I'm glad it's official.
16 Mary Watanabe, Director of the Department of Managed Health Care. Let's see.
17 Let's go to Pritika.
18 MS. DUTT: Hi, Pritika Dutt, Deputy Director for the Office of
19 Financial Review.
20 MEMBER WATANABE: Sarah Ream?
21 MS. REAM: Hello, Sara Ream, Chief Counsel for the Department.
22 MEMBER WATANABE: Michelle?
23 MS. YAMANAKA: Michelle Yamanaka, Supervising Examiner.
24 MEMBER WATANABE: I will just quickly give a shout out to our
25 admin team with Sara Ortiz, Jordan Stout and Sarah Cain that are going to keep

1 us moving along here. Thank you.
2 CHAIR GRGURINA: All right, great. Thank you, Mary and team.
3 All right.
4 Our next item is the transcript and the meeting summary from our
5 February 24th, 2021 meeting. Any comments from the Board Members who
6 were present at that time?
7 I see just shaking of heads. Probably comments of, can't believe I
8 speak that way but they are taking dictation so that is the way it is.
9 So with that, can I have a motion to move the transcript from the
10 February 24 meeting?
11 MEMBER DEGHETALDI: So moved.
12 CHAIR GRGURINA: Larry put his hand up. A second? Ted, thank
13 you. All right, all those in favor, aye?
14 (Ayes.)
15 CHAIR GRGURINA: Any opposed?
16 Or any abstentions?
17 All right, great, unanimously passes. All right, thank you, folks.
18 All right, our next item is the Department of Health Care Services
19 update. This is René Mollow. We will recall that René was with us a while ago.
20 She was so popular that her section went way over between questions from the
21 Board Members, questions from the public. René did an awesome job last time,
22 we fully expect that here. There is a tremendous amount for her to cover and
23 René does have a hard stop, she does need to leave at a certain time so we will
24 have to be able to cut her loose. Obviously, there is a lot going on at DHCS so,
25 René, we really appreciate you taking the time with us and let me go ahead and

1 turn it over to you.

2 MS. MOLLOW: Thank you so much, John, and happy to be here

3 again today. I was asked to report out on a couple of items that are going on

4 here in the Department so I am going to do my best to get through the slides to

5 leave some time for questions that folks may have. So next slide, please.

6 Medi-Cal Rx; an update was asked of me on this effort. As of

7 today, we are still working with Magellan on a conflict avoidance plan. As you all

8 know that they were -- we were informed of Centene looking to acquire Magellan,

9 and one of the issues that we are working to address is the fact that Centene

10 does own participating Medi-Cal managed care plans as well as six specialty

11 pharmacies that participate in the Medi-Cal program. So we continue to do our

12 work with them in terms of an appropriate conflict avoidance plan, a conflict of

13 interest plan, I am sorry, and so I do not have anything further at this point in

14 time to share. But once we do have more information to share that is meaningful

15 we will then make sure that all interested parties are aware.

16 I do want to provide for everyone information about Medi-Cal Rx so

17 this slide gives you some helpful resources to help keep folks informed of the

18 work that we are doing outside of the work that is pertaining to the conflict of

19 interest plan. Next slide, please.

20 So, telehealth. So this is a big thing going on here in the

21 Department, so next slide, please.

22 So, I was asked to provide an update in terms of where we are at

23 and so this just kind of gives you a historical perspective of telehealth with the

24 Medi-Cal program. And just a couple of points that I want to note on this slide

25 here is that back in 2019 we undertook a significant engagement with

1 stakeholders in terms of looking at our telehealth policies and have made some
2 changes that afforded greater flexibility for our providers in our program. We
3 kind of removed certain codes that we said could be billed for purposes of
4 telehealth and really looked at the clinicians to determine if a covered benefit
5 was appropriate to be delivered via a telehealth modality.
6 And in the Medi-Cal program prior to the public health emergency
7 we did support the use of synchronous and asynchronous telehealth modalities,
8 both in our fee-for-service and managed care delivery systems. And one of the
9 things that we did in the policy updates that we had made were to identify what
10 we call modifiers in our claims system so that if a particular covered benefit were
11 delivered via a telehealth modality we would know that because of the use of the
12 modifier.
13 And prior to the public health emergency we had minimal use of
14 telehealth services -- of services being provided via telehealth modalities.
15 However, as you all know, we were hit with a public health emergency and in
16 response to that the federal government did offer states broad flexibilities in this
17 space. California did leverage those flexibilities in all aspects of our program and
18 the services that we deliver under our program. And for us, because of the work
19 we had done back in 2019, we felt it was then easier to then take on those
20 additional flexibilities because there was not a lot of work we had to do in terms
21 of our systems.
22 But we did work on providing extensive guidance to our provider
23 community and to our managed care plans in terms of the policies that we
24 implemented for purposes of the public health emergency. And for the way our
25 program works as it relates to telehealth, we leave it up to the clinician to

1 determine if the service provided, if it meets the intent of that particular
2 procedure code, and then based upon that, then they identify the modality uses.
3 So either it's a synchronous, you know, video visit, it could be asynchronous,
4 and/or it could be via a telephone modality, that could be provided.
5 For the public health emergency most of the services, the
6 modalities could be used for both new and established patients.
7 We also introduced more prominently in our program the use of
8 telephonic audio-only services for the first time, and did also allow for payment
9 parity across the various modalities.
10 And that payment parity was across provider types, including our
11 federally qualified health centers and well health centers. And the payment
12 parity was across the delivery systems, both for fee-for-service and for managed
13 care.
14 And then we also looked to waive site limitations for both providers
15 and our patients if they are being served by clinics or by other providers. So, the
16 providers could have been outside of their home offices and/or clinics as well as
17 the beneficiaries could have been in their home or in a different setting in terms
18 of receiving those services.
19 And then we also allowed expanded access through non-public
20 technology platforms that may not have otherwise met HIPAA compliance
21 requirements for protection and privacy of health information. So next slide,
22 please.
23 So this I just wanted to share. And there's a couple of slides in
24 here that kind of give information in terms of some data points. I did want to
25 share this data point just to give you the impact of the use of telehealth pre and

1 during the public health emergency. So this is preliminary data. We at the
2 Department are continuing to do our due diligence in looking at the impacts of
3 the public health emergency utilization of services. So this is just a snapshot of
4 information collected. Our data is lagged so I do want to let folks know that but
5 we are continuing to update this information. But this is just a snapshot of
6 showing what telehealth looked like in 2019 versus 2020. I do also want to
7 indicate that despite even these gains in terms of the use of telehealth services,
8 our visit utilization, generally speaking in the Medi-Cal program, was significantly
9 down because of the public health emergency and concerns going in to see
10 health care providers. But this did offer an opportunity for access to covered
11 services that people are entitled to under our program. Next slide, please.
12 So, in looking forward we have identified and have recommended
13 changes in terms of what we are going to be doing post the public health
14 emergency as it relates to the use of telehealth. We have put out a policy
15 document regarding our path forward for telehealth in the Medi-Cal program
16 once we get through the public health emergency. I do want folks to know that
17 up until the public health emergency has ended, the policies that we have put in
18 place for the public health emergency will remain in place.
19 We do believe our approach is reasonable and balanced because
20 we want to ensure equity in terms of the modalities that are used across the
21 delivery systems while protecting the integrity of the Medi-Cal program.
22 And we do want to ensure the use of the modalities are providing
23 for access to critically needed services in our program and then to adhere to
24 privacy requirements. Next slide please.
25 So in the policy paper, and I am going to kind of go through this a

1 little quickly because there is a detailed policy document, it is about 14 pages in
2 length I believe, maybe a little less, that does go through all of the
3 recommendations, but this is just a highlight of the recommendations that we
4 have put in.
5 So we would allow going forward, so again, after the public health
6 emergency is ended, in terms of allowing our clinic providers to establish a new
7 patient that's located in their federally designated service area through
8 synchronous telehealth modalities, and then to make permanent the removal of
9 site limitations. So that means that either the beneficiary or the clinic provider,
10 as long as the provider is within their service location or their service area, if they
11 are outside of the clinic they can still, you know, see individuals using the
12 appropriate telehealth modality and then be paid accordingly based upon their
13 applicable reimbursement rate under the Medi-Cal program. And equally,
14 beneficiaries would not necessarily have to be in the clinic setting itself, they
15 could be in their home and the providers can still be paid for these services.
16 We are also looking to expand both synchronous and
17 asynchronous telehealth modalities under our 1915(c) waivers, under our
18 Targeted Case Management Program and our Local Education Agency Medi-Cal
19 Billing Option Program. And then to also add synchronous telehealth and
20 telephone services to our Drug Medi-Cal Program. So again, looking to leverage
21 some of the best practices and some of the modalities that we felt were
22 appropriate during the public health emergency across other programmatic areas
23 that may not have historically used these modalities.
24 We would also require payment parity between in-person, face-to-
25 face visits and synchronous telehealth modalities when, again, they meet all the

1 requirements of the billing code, including for our clinics and -- including for our
2 clinics. Payment parity, again, would be required across the delivery systems for
3 fee-for-service and managed care. The only allowance would be in managed
4 care is if there were an already agreed upon reimbursement methodology
5 between the plan and the network provider. Next slide please.
6 Also, we would expand the use of clinically appropriate telephone-
7 only services and virtual communications and remote patient monitoring for
8 established patients only. And then these modalities would be subject to a
9 separate fee schedule and not billable by federally qualified health centers or
10 rural health centers.
11 We would also allow that for our Targeted Case Management
12 Program and our LEA BOP program because they do use a different
13 reimbursement structure. That reimbursement structure would be the basis for
14 reimbursement when services are provided through applicable telehealth
15 modalities. Next slide please.
16 So, come May revise. So, the things I just spoke about were part
17 of a policy that had come out in February. So, with May revise we did make
18 some updates to the policy that we had put out.
19 So one, in the policy, because in the original policy we had
20 identified that we would have a separate fee schedule for telephone-only
21 services that are provided telephonically or audio-only, that it would be at a lower
22 reimbursement rate. So in May revise, we updated the policy to indicate that if a
23 service is provided via a telephonic modality, it would then be paid at 65% of the
24 applicable Medi-Cal rate for services delivered via an in-person face-to-face
25 contact.

1 We also would look to have a rate similarly developed for our
2 federally qualified health centers and rural health centers that would be
3 comparable to the rate in our fee-for-service delivery system in lieu of their
4 current reimbursement structure. That policy would require us to work with the
5 federal CMS to get their approval as well as to also get engagement with and
6 acceptance of that reimbursement methodology by our clinic partners.
7 We would also then look to establish utilization management
8 protocols for the telephone-only modality. And this could include but not be
9 limited to looking at appropriate ratios of visits to that of in-person face-to-face
10 visits per day by provider, and daily limits and/or other standards that are
11 deemed appropriate by DHCS.
12 One of the things that we have been talking about with
13 stakeholders in engagement on the telehealth policy, just generally speaking, is
14 thinking through what might be that balance of the delivery of services. Because
15 there are some concerns with people going fully to telephone-only as well as
16 some concerns with not allowing that use, so looking at how we can balance the
17 use of those modalities for individuals. And then also recognizing that our
18 beneficiaries would at all times have the right to then be seen in person by
19 providers when they desire, because one of the guiding principles we have is the
20 choice of our beneficiary. So we do want to ensure that if services are being
21 provided via telephone-only that there is that opportunity and a requirement for
22 the providers to also offer them the ability to be seen face-to-face. Next slide
23 please.
24 In terms of our next steps, so you know, May revise comes out.
25 There is a process that has to be undertaken in terms of engagement, you know,

1 with our stakeholder community, with the Legislature and with the Administration.
2 We do have trailer bill language that we have put out. There would be an
3 effective date of July 1 in terms of some of the changes that we are looking to
4 make in the Medi-Cal program.
5 And again, for purposes of our telehealth policies, we would
6 maintain the current policies that we have in place during the public health
7 emergency and then these policies would become effective once the public
8 health emergency is eliminated. The only thing that would become effective, say
9 July 1, would be the use of remote patient monitoring because that was a
10 flexibility we did not implement during the public health emergency and that is
11 one particular component that we are looking to add and make that effective July
12 1 of 2021. And then we are also looking at there will be a payment schedule that
13 would be developed for remote patient monitoring.
14 But for purposes of telehealth because it is a modality, to the extent
15 that we are paying that modality the same as we are paying for face-to-face
16 services we don't have to update our state plan. But if we are looking at a
17 different payment structure, for instance with the telephone-only modality, we do
18 have to submit a state plan amendment to CMS to get their approval because
19 the rate structures are different. So that is something that we will be working on
20 between now and the time that the budget is approved to get us to that July 1
21 date.
22 We would also be allowing our Drug Medi-Cal providers to deliver
23 all their services and all allowable SUD services via synchronous and telephonic-
24 only modalities, because we did see a lot of utilization in that space and there
25 was a lot of acceptance of that modality, in particular, with those provider types.

1 Also, like I said earlier about the site definitions for the clinic
2 providers. So we are going to have to update in our state plan what a visit looks
3 like and how that visit is described in our state plan.
4 And then also that our managed care plans would have the ability
5 to use telehealth to meet certain network adequacy standards; and this would be
6 across all of the organized delivery systems that we have in the Medi-Cal
7 program.
8 And then we'd also revise Alternative Access Standards for the
9 managed care plans. That would have a sunset provision until 2026. Next slide,
10 please.
11 This just talks about our need to submit applicable state plan
12 amendments as well as updates to our 1915(c) waiver, so there would be waiver
13 amendments that we would submit to CMS for an effective date of July 1 of
14 2021.
15 And then also promulgating regulations for the specified programs
16 noted below. Next slide, please.
17 We are also going to be working on policy guidance through the
18 coming, between now and the end of the year, again, based upon the outcome
19 of the budget process.
20 And also making updates to applicable Medi-Cal provider manuals,
21 creating any type of provider and patient education materials, and then making
22 applicable contract amendments as needed.
23 And the other thing in terms of looking at the telephonic-only
24 modalities, we would also be looking to consult with subject matter experts and
25 stakeholders in terms of looking at those aforementioned utilization of protocols

1 for the telephonic-only modalities. Here in the slide there is a little typo, it says
2 for telehealth services, it is really geared towards the telephone-only modalities,
3 because we already have utilization management protocols for our existing
4 services. But as we are looking at the use of telephone versus in-person, it is
5 again looking at some of those ratios, either, you know, the number of visits, you
6 know, in-person visits, tied to telephone-only services and/or the frequency of
7 those services. So next slide, please. So the other -- so that is my report out on
8 telehealth.
9 So then the other ask of me was on COVID-19. So we were pretty
10 busy during the public health emergency here at DHCS and so we did a lot of
11 work in this space and we do have, and at the end of the presentation there is a
12 page of resources for COVID-19, but we did do a lot of work in this space. And
13 the one thing I really wanted to report out on today was the work that we are
14 doing as it relates to eligibility under the Medi-Cal program. So both through
15 executive orders as well as through federal guidance one of the big things we
16 had to do during this public health emergency is to maintain eligibility for Medi-
17 Cal enrollees during the public health emergency. By maintaining this enrollment
18 into the Medi-Cal program it also afforded us an additional enhancement in
19 terms of federal funding for our Medi-Cal program.
20 During the public health emergency this continuous enrollment of
21 Medi-Cal eligibility became effective March 16 of 2020 and it goes through the
22 duration of the public health emergency. The only allowable discontinuances in
23 the program during the public health emergency is if someone voluntarily
24 requests to be discontinued, if there is the death of an individual or if that
25 individual moves out of state. So those would be the only acceptable reasons to

1 have someone be discontinued during the public health emergency.

2 We did, because we were moving so fast, in the early days of the

3 public health emergency, because work had already been underway, there were

4 discontinuances that had occurred. But since that time, and since late, at the

5 end of last year in November, we have been working very closely with our county

6 partners to help make sure that if people had been inadvertently identified for

7 discontinuance for many different reasons, and they were actually discontinued

8 from our program, we then undertook steps to go back and have their coverage

9 reinstated. So because of those efforts we did undertake reinstatements of

10 approximately 131,000 individuals and their coverage was restored back to the

11 beginning date of the public health emergency.

12 And as of November of 2020, no one has now lost their coverage

13 during the public health emergency because now we have kind of gotten this

14 down to a science. And so we work very closely with our county partners each

15 month to take a look at cases. If they were inadvertently identified for

16 discontinuance they are not discontinued and they are maintained in coverage.

17 And so we have been doing this, like I said, since 2020 in November when no

18 one has now subsequently lost coverage. So we are not having to reinstate

19 folks. There is no break in coverage, people are staying in the Medi-Cal

20 program, staying with their assigned managed care plans.

21 And for those people that we did have to reinstate in coverage, we

22 did actually also go back and put them back into their last known managed care

23 plan that they were enrolled in with their time on the Medi-Cal program. Next

24 slide, please.

25 The other thing that we did that was a pretty big deal was through

1 guidance from CMS we did have an ability as a state Medicaid program to also
2 cover individuals who were uninsured; so we took up this option. Initially, it was
3 known as the COVID 19 PE group but now it has been renamed and it is the
4 COVID-19 uninsured group. This is for individuals who are uninsured and/or
5 who did not have access to COVID-19 testing, testing-related or treatment
6 services and for vaccine administration. Under this coverage group it was a
7 state option for us to take up and we did take up -- like I said we took up that
8 option. Their enrollment in the Medi-Cal program is a 12 month period or until
9 the public health emergency ends, whichever comes later, so they too also
10 remain enrolled in our program. The only services, again, that they are eligible
11 to receive would be COVID-19 testing, or testing-related services and treatment
12 services and vaccine administration.
13 For purposes of federal funding, we are only able to draw down
14 federal funding for their testing and their testing-related services. We have put in
15 a federal ask for their treatment services, but to date have not gotten approval
16 from CMS on that front. However, providers do have an ability to bill the HRSA
17 uninsured fund to receive payment for treatment services for individuals if they
18 are not enrolled in this program.
19 But because of our desire to ensure people are being treated and
20 getting the services that are medically necessary for them, under our COVID-19
21 uninsured group we did undertake the provision of treatment services for these
22 individuals and the treatment services are with state-only funding. So that is
23 covered today for individuals that are enrolled in this coverage group.
24 The way people can get enrolled in this coverage group is by using
25 our presumptive eligibility qualified providers. That includes hospital presumptive

1 eligibility, or the Child Health and Disability Prevention Gateway, or our PE
2 program for pregnant women. So if people show up at any one of those sites,
3 that is their pathway for getting enrolled in this uninsured group.
4 Because again, when we executed the implementation of this
5 program, we were doing it under the authority of presumptive eligibility so we
6 wanted to leverage those providers, and in particular our hospital PE and CHDP,
7 because it does give full scope coverage through presumptive eligibility for up to
8 60 days, depending upon when someone applies for coverage. But with
9 subsequent federal guidance we then learned that that coverage can be good for
10 12 months so we removed that PE limitation and their coverage is now good for
11 12 months. So, depending upon when they were enrolled in the program, they
12 may also have to undergo a renewal for their coverage to continue. Next slide,
13 please.
14 So with -- you know what, hold on, my apologies here, I cannot see
15 my screen fully for the slide there. So, with the public health emergency, CMS
16 back towards the end of December, they did issue policy guidance to us about
17 unwinding the public health emergency. And they have also -- with the
18 unwinding for us, a lot of that deals with the work that we are going to have to do
19 for purposes of resuming renewal determinations for our Medi-Cal population.
20 I do want people to know that today to kind of help with this
21 workload, because there is a group of people who had been identified for
22 discontinuance from the program. And again, they are being held in the
23 program. But in that policy guidance from CMS and some of the work that we
24 have been doing, we have an ability to do renewals. And if people are able to be
25 renewed and we can do it without having to get additional information from them,

1 they are automatically renewed in our program. That is what we call our happy
2 path or ex parte renewals in the Medi-Cal program. So we do have a swath of
3 people that we can do in that manner and then we have people where, you
4 know, under normal business processes we would then reach out to get
5 additional information so that that renewal can be completed.
6 What CMS has done, you know, like I said, we cannot discontinue
7 people. Even if we find them not to be eligible any longer they still remain in our
8 program. But at the end of December, CMS did issue guidance for the steps
9 that states need to take to start unwinding from the public health emergency and
10 what that length of time would look like. In accordance with our policy guidance,
11 they are giving states six months to kind of get caught up on all those backlog
12 cases that are sitting out there that still need to be renewed and/or appropriately
13 discontinued from the program.
14 For us, 6 months is not enough time. You know, we have
15 advocated for 12 months, some have said even longer, but at least 12 months.
16 Our budget is built on getting things back in order over a 12 month period but
17 right now the CMS guidance is for 6 months. We are expecting additional
18 guidance from CMS. Hopefully, they will come around and actually issue formal
19 policy guidance that does say it is 12 months versus the 6 months.
20 We have also been told that the Biden administration is looking to,
21 for the public health emergency to be in place through at least the end of this
22 year. The federal government has to renew the public health emergency for 90
23 day -- in 90 day increments and they have done that. So right now, with those
24 approvals, it goes through July of 2021. They did also indicate, the Biden
25 administration, that they would give states a 60 day advance notice of when the

1 public health emergency would end.

2 And just given the guidance and some of the messaging that has

3 come out, we have started doing our work in terms of working with our counties

4 and kind of socializing some of the steps that we believe that we are going to

5 need to take to start doing this unwinding as it relates to the Medi-Cal eligibility

6 determinations. So that work has started because it is going to be pretty

7 significant and we don't want to start doing that work towards the end of when we

8 think the public health emergency is going to end. So, the eligibility team here in

9 the department has started those initial discussions and kind of laying out a

10 framework for the path that we believe that we will need to take forward when we

11 start doing the redeterminations. So next slide, please.

12 I did want to share just briefly information on COVID-19 vaccine

13 administration. This is just a data point in terms of looking at statewide

14 vaccination numbers here in our state. This is not specific to Medi-Cal, this is a

15 statewide number, but I thought it would be kind of important to share this

16 information. And then to talk about what we are doing under Medi-Cal as it

17 relates to COVID-19 vaccines. So next slide, please.

18 So in terms of the Medi-Cal program, because the vaccines

19 themselves are covered by the federal government, we are just paying providers

20 for the admin rate for the COVID-19 vaccine.

21 The admin rate for a COVID-19 vaccine is $40. This is based upon

22 the Medicare rate and we will maintain that rate for purposes of, for

23 administration purposes of the vaccine in the Medi-Cal program. And it is $40 for

24 each vaccine dose that is administered, so whether it is a single dose or a

25 double dose it is $40. And that's what we are able to reimburse the providers for

1 because again, the vaccine is provided free to all vaccinators that are able to
2 administer and receive the vaccine itself.
3 We have requested federal approval for our clinic providers to also
4 be reimbursed at the $40 for vaccine administration outside of their normal
5 payment structure. So far, tribal clinics, they have an all-inclusive rate that is set
6 by the federal government. CMS has given us federal approval that if the clinic
7 is not otherwise providing a billable service where they can get paid their all-
8 inclusive rate, if all the person is showing up for is for the vaccine, they can then
9 get that $40 payment, which would be separate and apart from, say, their all-
10 inclusive rate. But if they are being seen by a billable provider and they happen
11 to at that same time give the vaccine, then they will just pay their all-inclusive
12 rate, they don't get a separate reimbursement of that $40 because that would be
13 considered incidental to the service.
14 Similarly, we are also looking to have the same type of an approval
15 for our federally qualified health centers. While CMS has approved the rate for
16 the tribal clinics they have not yet approved that for our federally qualified health
17 centers. We are waiting for that approval because we had put those requests
18 before CMS back in December, I believe, so we are still waiting for those
19 approvals to come through. Next slide, please.
20 We have also put in a request to CMS for vaccine administration
21 for individuals with limited coverage. When they first came out with their policies
22 on vaccine administration it wasn't clear who would be eligible beyond, say, our
23 full scope Medi-Cal eligible individuals for the vaccine administration. So through
24 an 1115 waiver we did ask for coverage through, you know, for limited, covered
25 individuals, so that would be someone who would be in restricted scope Medi-

1 Cal. It was also for our individuals that are in that COVID-19 uninsured group,
2 individuals with TB-only covered services, individuals that were in pregnancy-
3 only coverage.
4 Subsequently, we did get notification through ARPA that some of
5 those limited covered groups are eligible to receive the vaccine administration.
6 So we are still waiting to get their final word on our restricted scope population
7 because that still is not clear if that population is covered for purposes of vaccine
8 administration and then reimbursement from the federal government to states for
9 administering vaccines to those individuals.
10 We are also providing call center scripts to all of our call centers
11 that we operate here in the Department as well as our Medi-Nurse Advice Line
12 and our managed care plans and county partners so that as we continue to roll
13 out COVID-19 vaccine we have current information and messaging for
14 individuals in terms of what the Medi-Cal program is doing in terms of coverage
15 options, as well as helping people to locate vaccine sites for purposes of vaccine
16 administration.
17 And then we do continue to roll out our policies on vaccine
18 administration and also we are working very closely with Department of Public
19 Health and Gov Ops in terms of the vaccine roll-out and getting vaccines into the
20 arms of individuals. Next slide, please.
21 The other big thing that we have done in our program as it relates
22 to COVID-19 is we got federal approval to do testing for children under Medi-Cal
23 and our CHIP program for fee-for-service in the fee-for-service delivery system
24 for testing in schools. And one thing I do want to clarify is that for our COVID-19
25 vaccine administration we did carve that out of our managed care plans. So

1 regardless if a person is in managed care or not, the vaccine itself is billed and
2 reimbursed through our fee-for-service delivery system.
3 The same thing here for this testing for kids in school, regardless of
4 the kids being in managed care or not. As kids are going back into school we will
5 have an ability to do testing and surveillance in those school settings. And they
6 can -- the schools can then be reimbursed for those tests that are administered
7 to those children and they would bill our fee-for-service delivery system for these
8 services when the testing is occurring in schools. We did get authority for this
9 effective February 1 of this year and then it will go through 60 days after the end
10 of the public health emergency, once we know the public health emergency has
11 actually been identified as ending.
12 And then we had also, like I said, we had also submitted approval
13 for the other populations for coverage and we did get approval for them to
14 reimburse the vaccine exclusively through our fee-for-service delivery system
15 and having it carved out of managed care. But again, the populations that we
16 had asked for coverage, we had requested that to be effective back to November
17 2nd of 2020. We still want that waiver asked to be approved because then we
18 can go back and claim for any vaccines that may have been provided in the early
19 days of the vaccine roll-out; so we are still waiting for that approval through the
20 federal government.
21 And then the last thing I will report on, I am sorry, I know it's a lot.
22 The last thing I will report out on next slide, please, is that we did pass here a
23 state law, there are two Golden State Grant Programs; so there is a stimulus
24 payment and a golden state grant payment. Those two payments, individuals
25 could either receive $600, a one time payment of either $600, or a one time

1 payment of $1200, and it is based upon the person's tax returns from 2020.

2 We did submit to CMS a disaster relief SPA to exempt those

3 payments to our Medi-Cal beneficiaries from counting for purposes of income or

4 resources, so that it will not have an impact on their Medi-Cal eligibility.

5 And then the last slide is just the resource page on our COVID-19;

6 and so all the things I talked about here, can be found there.

7 And with that I open it up to see if you all have any questions. And

8 again, thank you for the opportunity to share, you know, the good work that we

9 are doing here in the Department.

10 CHAIR GRGURINA: All right. Well, thank you, Michelle (sic), I

11 think that was 26 pages covered very well.

12 Let's turn to the Board Members who have questions. Larry, why

13 don't you go first?

14 MEMBER DEGHETALDI: That was once again fabulous and we

15 all have probably way -- I am going to limit myself to one question.

16 First of all, an offer. I have a physician leader who has been full-

17 time looking at telemedicine. And should you and did you ask for help and

18 advisory I am more than happy to offer up his expertise so you can reach out to

19 me full-time.

20 Our experience has been mixed with telemedicine for our broad

21 population. I would say telephone encounters are far less satisfactory for

22 patients and providers and in fact we are seeing waning interest in video visits. I

23 am concerned about the 65% because so many of our Medicare beneficiaries

24 lack access to broadband and a 65% imposition on those patients will force them

25 to travel unnecessarily; and there is a disparity, we could risk exacerbating

1 disparities. So as much as I dislike telephone visits, we tend to, if you don't have
2 access to broadband, I would recommend that we not impose a 65% hit.
3 MS. MOLLOW: Okay, thank you.
4 CHAIR GRGURINA: Ted. You're on mute, Ted.
5 MEMBER MAZER: Got it. Got it. Yes, I was going to start with -- I
6 have a couple of things. That was the longest one to hit so thank you, Larry. I
7 have to second what Larry just said. The people who primarily want to do
8 telephonic don't have access and to penalize the provider side for the fact that
9 we are trying to help those people get care just seems patently unfair. So I
10 would want to, I'd echo Larry's comments. If there is parity there is parity,
11 regardless of how that service is delivered, and we know that the parity has
12 managed to help keep physician offices, particularly primary care offices, afloat,
13 and patients having access when they otherwise couldn't, or wouldn't come in for
14 a visit.
15 Just a couple of other quick questions and comments. I didn't quite
16 follow with the fee-for-service payment for the vaccination. Who is the provider
17 to bill? Do they bill their managed care entity when they are contracted and the
18 managed care entity passes that through to Medi-Cal but pays them directly, or
19 does the provider now have to do two separate billings, one to the managed care
20 entity for the visit and another one to the state for the vaccination, and do the
21 providers even know that they have that opportunity?
22 Last one I'll do. I will cut off some of my questions because it was
23 a wonderful but very long presentation. There was a slide about network
24 adequacy, which has been a major issue for some of us dealing with the Medi-
25 Cal managed care programs, and it stated very quickly that it's going to delay the

1 network adequacy requirement compliance until 2026. I don't know off the top of
2 my head when that was supposed to occur but I am concerned anytime we push
3 those things further off. So, your comments, please.
4 MS. MOLLOW: Okay. So thank you. And again, thank you for the
5 comments across the board on the telephone parity issues. We have heard
6 those concerns across the board. We believe that in terms of the provision of
7 that service, and that modality, that when you are looking at the payment
8 structure that there is less, less in terms of costs for providing the benefit via the
9 telephone versus not. But I do understand people disagree with that; so we
10 understand that and we have heard that. And I do know that this is, you know,
11 now in the hands of the Legislature in terms of the next steps in terms of where
12 we are going to go with this.
13 In terms of the vaccine administration. So the vaccine and the
14 payment for that administration would be through our fee-for-service delivery
15 system. So you are correct, Ted, they would bill the managed care plan for the
16 office visit but they would bill the Department through our existing processes for
17 the vaccine administration. We did that purposefully because we did not want
18 there to be any issues with access to care if beneficiaries decided that they were
19 going to go to a provider who may not have been contracted with the health plan
20 to get that vaccine reimbursed. So we felt it was much easier in terms of pulling
21 it out of the managed care so that there's no access issues or anything of that
22 nature for our beneficiaries to then get the vaccines paid.
23 And I think on the network adequacy, I think that those rules and
24 state law, they were to expire, I want to say it was in 2023 so they were just
25 extended out three more years. I think that that was the date.

1 MEMBER MAZER: So just --
2 MS. MOLLOW: But in the trailer bill that we put out on this it will
3 show what that actual date is, I don't have it in front of me.
4 MEMBER MAZER: So two quick comments and then I'll shut up.
5 That's a long extension from 2023 to 2026 on something that we have been
6 fighting for for a long time so patients can get what they need within their
7 network.
8 And as far as the billing, you have got a lot of providers out there
9 who stopped doing fee-for-service Medi-Cal for various reasons, they only do
10 managed care Medi-Cal, and I am concerned about how they are being notified
11 that they need to do a separate billing where they might not even be set up for
12 that billing. I would encourage you to make sure that any time they have billed
13 the managed care plan that either the managed care plan needs to forward that
14 to the state, or that the managed care plan needs to make a direct contact for
15 each claim back to the provider's office and tell them how they can get
16 reimbursed.
17 MS. MOLLOW: So we have put out extensive policy guidance, we
18 have noticed the managed care plans on this in terms of what the requirements
19 are for billing the program. If you all are hearing of any concerns, issues in that
20 respect, or just not even having that knowledge, if you could let us know that so
21 we could follow up, I would be happy to do that.
22 MEMBER MAZER: I think it's just a growing problem now because
23 we are first starting to push this out to individual provider offices and that is going
24 to be a growing issue right now.
25 MS. MOLLOW: Okay. And I will also put that on the radar of my

1 managed care colleague.

2 CHAIR GRGURINA: All right. Jen?

3 MEMBER FLORY: Yes. First of all, just on the telehealth

4 provisions. Western Center obviously doesn't have a position on the provider

5 rates there but we do appreciate the Department really trying to balance some of

6 the issues, because we are hearing mixed from consumers as well. You know,

7 we understand that for some the access via telephone is the easiest, best way,

8 but we also want to make sure that the providers are actually there. So we

9 appreciated, in particular, the requirement that when telephonic appointments

10 are being used that the consumer has the option to actually see that provider

11 and that we are not using providers that are not even in the state or somewhere

12 else, so that was much appreciated.

13 And then on the COVID-19 response. I say this every time the

14 COVID-19 uninsured program comes up. I think California has something to be

15 incredibly proud of with this program. DHCS did a tremendous job of really

16 stretching what could be done with the federal options that were out there and

17 building some other state things in there. So what we were able to tell

18 beneficiaries or people out in the world was, you don't need to be afraid to get

19 health care because you are not insured. So, you know, just getting that simple

20 message out there is something that I don't even know existed in any other state

21 where they could say anybody can go get coverage for COVID-19, go to the

22 hospital when you need care.

23 And similarly on the vaccine roll-out. You know, I know it's bumpy

24 for the providers and how the reimbursement is going to work. But to have

25 something where beneficiaries can just go and get the vaccine and we sort it all

1 out on the back end, it is just much appreciated from the consumer advocate.
2 MS. MOLLOW: Thank you. Thanks, thanks for that, much
3 appreciated. The team did a phenomenal job bringing up the COVID uninsured
4 group. And then to your point, because we didn't know at the time when we
5 brought it up, we were just, to your point, interested in serving the residents of
6 the state of California. And this was a devastating situation that we were all in
7 while we -- and we didn't know about the HRSA uninsured provider fund that was
8 put out there subsequent to that guidance on that uninsured group. So what we
9 have heard is a lot of states, they were hesitant because they weren't sure of
10 what that would mean for them from a cost perspective, so a lot of states didn't
11 move forward with implementing that coverage group and they just said
12 providers could go to that uninsured fund for reimbursement. The uninsured
13 fund does cover the testing, testing-related and treatment services but it was just
14 those unknowns initially starting out. And then providers had to also learn about
15 a new billing infrastructure, they had to do an enrollment process. So, you know,
16 we saw the value in terms of executing this program here in the state, so thank
17 you for that.
18 CHAIR GRGURINA: So, René, I would double down on Jen's
19 comments of the thank you for the uninsured program and all the work that's
20 been done. I also want to thank you and continue to have you, and I know the
21 department will push with CMS, for 12 months on redetermination after the
22 public health emergency. When you look at the size of California and how many
23 folks we are covering, the expectations that we will get through redeterminations
24 for all those folks in 6 months is not realistic, and the last thing any of us want is
25 to watch people have their coverage removed because the redetermination

1 wasn't able to get done. So thank you and continue to push that and we hope
2 that they'll make some changes.
3 And I'll be nice René, I won't ask you exactly when you are going to
4 get the Rx decision because I know that that date hasn't been defined, we will
5 look forward to that.
6 MS. MOLLOW: Okay, thank you.
7 CHAIR GRGURINA: With that let's turn to members of the public.
8 René has four more minutes with us.
9 MEMBER RIDEOUT: John? John?
10 CHAIR GRGURINA: Yes. I'm sorry, Jeff, you had --
11 MEMBER RIDEOUT: I just had a real quick question.
12 CHAIR GRGURINA: Sure.
13 MEMBER RIDEOUT: I had a bunch but I'll just limit it to one.
14 René, other than what you covered in your presentation was any of the
15 governor's budget surplus applied to Medi-Cal provider reimbursement? I don't
16 think it was but that's --
17 MS. MOLLOW: No, it wasn't, it wasn't.
18 MEMBER RIDEOUT: Okay, thank you.
19 MS. MOLLOW: Mm-hmm.
20 CHAIR GRGURINA: Although, René, wasn't it true that Prop 56
21 that was looking to come to an end was --
22 MS. MOLLOW: It's a (overlapping).
23 CHAIR GRGURINA: -- removed the sunset so that continuous?
24 MS. MOLLOW: Yes.
25 CHAIR GRGURINA: So, Jeff, those are additional dollars that will

1 be used, but outside of that I think that's correct.

2 MS. MOLLOW: The only, the only other thing I'll add, Jeff, is that

3 both -- and thanks for that, John. Yes, the suspension language was removed

4 both on Prop 56 as well as on optional.

5 MEMBER RIDEOUT: And along the lines of what Larry said, we

6 also tracked a lot of utilization data as did Manifest Medex, and if you have any

7 need for seeing those trends we are happy to share them with you. And NCQA

8 did approve a lot of telehealth codes. They go to kind of performance

9 measurement that we are using in our program, so just an FYI.

10 MS. MOLLOW: Oh, thank you.

11 CHAIR GRGURINA: Okay, if we could turn to members of the

12 public. We probably have one or two questions or comments that we can take

13 before we have to release René.

14 THE MODERATOR: Yes, we have a question from Bill Barcellona.

15 Go ahead.

16 MR. BARCELLONA: I just wanted to thank the Department very

17 much for the work it did to maintain coverage for those 131,000 beneficiaries

18 over the course of the pandemic.

19 I just wanted to make a comment and an observation that the

20 charge of this Financial Solvency Standards Board is to review the financial

21 solvency of risk bearing providers. Just a request to the DHCS that in future

22 reports if you could provide updates on any relevant changes in Department

23 policy concerning delegation oversight or delegated entities, that that would be

24 very helpful. I think it would serve to advise this board on changes to Medi-Cal

25 that would potentially impact the solvency of risk bearing providers. Thanks

1 again.

2 MS. MOLLOW: Thank you so much, I will bring that back.

3 CHAIR GRGURINA: All right, thank you, Bill.

4 Are there any other comments, questions from members of the

5 public?

6 THE MODERATOR: Mr. Barcellona, do you have another

7 question?

8 MR. BARCELLONA: No, I just lowered my hand.

9 THE MODERATOR: Okay. That is all for now.

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

11 And so, René, we will let you go with another minute or two to

12 spare. Thank you very much. I think René, you are going to be the permanent

13 person coming before us with DHCS updates so thank you. Thank you for your

14 time and thank you for the great presentation.

15 MS. MOLLOW: Thank you all so much, it was my pleasure. You

16 all take care and I'll see you soon. Bye-bye.

17 CHAIR GRGURINA: All right, bye, René.

18 All right, next up is our permanent director Mary Watanabe and it is

19 her Director's remarks. So, Mary, take it away.

20 MEMBER WATANABE: Great, thank you, John. And I think we

21 have a good plan with DHCS where we will have René and Lindy present

22 depending on the topics that are of interest to the Board.

23 So I am going to start with just a few organizational updates. I think

24 as you all have gathered, the California Senate, State Senate, voted to confirm

25 me as the Director of the DMHC last Monday and earlier in the month I received

1 a unanimous vote of support from the Senate Rules Committee, so it is a relief to
2 have that behind me. It is a tremendous amount of work but it is an honor to
3 lead this organization, our amazing team. I also really appreciate the Board's
4 flexibility in moving our May meeting that conflicted with that confirmation
5 hearing, so glad to have this meeting still scheduled in May.
6 A couple of other organizational changes that I wanted to share
7 with you since our last meeting. We filled our last three vacant leadership
8 positions and as of June 1 we will have a full leadership team. So, no more
9 acting, I am really excited about that.
10 A couple of additions to our team: On March 17 the Governor
11 appointed Dan Southard as the Chief Deputy Director of the Department. Dan
12 started his state career at the DMHC Help Center in 2009 where he held a
13 number of management level positions before leaving in 2016 to lead our newly
14 created Office of Plan Monitoring at the time. He has been instrumental in
15 implementing several high profile priority projects including the implementation of
16 our behavioral health investigations and our timely access and network
17 adequacy projects.
18 In March of 2021 Rachel Long was selected as our new Help
19 Center Deputy Director. Rachel was the Independent Medical Review and
20 Complaint Branch Chief at our Help Center where she led the team responsible
21 for processing more than 10,000 consumer complaints each year; and before
22 coming to DMHC she spent almost 10 years at the Department of
23 Developmental Services.
24 And then the last one, I know some of you will be thrilled and some
25 of you are going to cringe. But the last vacancy on our leadership team will be

1 filled on June 1 when Nathan Nau will start at the DMHC as the Deputy Director
2 of the Office of Plan Monitoring in Dan's former position. I know many of you
3 know Nathan, he spent 14 years of his career at the Department of Health Care
4 Services. Most recently, Nathan served as the Chief of the Managed Care
5 Quality and Monitoring Division where he has been leading a team of 200
6 employees responsible for monitoring the Medi-Cal Managed Care Program. He
7 has extensive experience leading teams and conducting oversight of the
8 managed care delivery system, monitoring network adequacy and quality
9 improvement, as well as managing the intake of provider and encounter data. I
10 know that Nathan is looking to learn about the commercial market and we are
11 really excited to add his Medi-Cal expertise to our leadership team. Sorry, Jeff.
12 Nathan -- I know. Nathan has really been a big help to us on the encounter data.
13 I am thrilled to have his expertise as we take on some new work at the
14 Department. I know it's a loss for DHCS but we are excited to have him join the
15 team.
16 Let's see. Moving on to the Governor's May revise.
17 MEMBER RIDEOUT: Mary?
18 MEMBER WATANABE: Oh, go ahead, yes.
19 MEMBER RIDEOUT: At least I know where to find him, okay?
20 MEMBER WATANABE: Yes, you do. That's the sentiment of
21 everybody I think. Yes, he has been the go-to on a number of high profile
22 projects that we have worked with on so glad to have him join the Department.
23 But yes, you can, you can still access him at DMHC now.
24 Moving on to an update on the Governor's budget and the May
25 revise. I think, as you probably have all read, the Governor submitted his May

1 revise to the Legislature on May 14. The $267.8 billion spending plan includes a
2 projected budget surplus of $75.7 billion, which is a big improvement from where
3 we were a year ago when we were looking at a projected $54 billion budget
4 deficit.
5 The focus of the May revise is the $100 billion dollar pandemic
6 recovery package called the California Comeback Plan. The goal here is really
7 to hit fast-forward on the state's recovery by directly confronting some of our
8 stubborn challenges. This includes providing immediate relief for those hardest
9 hit by COVID, confronting the homeless and housing affordability crisis,
10 transforming public schools, building infrastructure and combating wildfires and
11 tackling climate change.
12 The California Health and Human Services Agency has released
13 six priority areas and I am not going to go into detail on these. The first one is
14 transforming behavioral health for children and youth. I'll talk a little bit more
15 about this and our involvement in a minute.
16 Also supporting vulnerable and homeless families with the goal of
17 ending family homelessness in the next five years.
18 The third is building an age-friendly state for older Californians and
19 really building on our master plan on aging and expanding Medi-Cal to older
20 adults and to our undocumented over the age of 60.
21 The fourth is advancing and innovating the Medi-Cal program and
22 really building on the work of CalAIM.
23 The fifth is envisioning a 21st century public health system and
24 really learning from the current pandemic and preparing for the next public health
25 emergency.

1 And then the last one is just providing care to the most
2 marginalized, including those in our state hospital system.
3 So I want to take just a minute to talk about the children and youth
4 behavioral health initiative because the Department has a significant role in the
5 initiative, even though we don't have a formal request for resources. The May
6 revise proposes $4 billion over five years, including $2.3 billion one-time funding
7 and $300 million General Fund, and matching funds starting in 2022-23, with the
8 goal of transforming California's behavioral health system for children and youth
9 into really a world class, innovative, upstream focused ecosystem where all
10 children and youth are routinely screened, supported and served for emerging
11 and existing behavioral health needs. As you all are probably familiar, half of all
12 lifetime cases of diagnosable mental illness begins by age 14 and three-fourths
13 of all lifetime cases of diagnosable mental illness begins by age 25.
14 The major components of this initiative are developing a behavioral
15 health service virtual platform that would provide all children aged zero to 25 with
16 access to virtual behavioral health services and interactive tools and supports,
17 supporting the development and sharing of evidence-based practices to improve
18 outcomes for children and youth, building up our mental health and substance
19 use disorder beds and facilities to provide in-person services when needs
20 intensify, enhancing Medi-Cal benefits, building the capacity to increase the
21 number of students receiving school-linked preventive and early intervention
22 behavioral health services, expanding the availability of school-based behavioral
23 health counselors and coaches, expanding the overall behavioral health work
24 force to meet the needs of children and youth, and creating a public education
25 campaign to reduce the stigma on behavioral health needs and encourage

1 children and youth and their families to seek needed care before a crisis.

2 The Department's role in this is really to ensure that children and

3 youth with commercial health insurance are able to access services at schools or

4 link through schools. In many cases today commercial enrollees are turned

5 away from some of these services or told to contact their doctor or health plan

6 after at least some initial services, and so we really want to make sure all

7 children have access to that screen and initial services, either through schools

8 are linked through schools.

9 And beginning in January 1 of 2024, commercial health plans will

10 be required to reimburse for behavioral health services provided at schools,

11 regardless of whether the plan has a contract with the school or health care

12 provider. If the school does not provide services on campus, this would include

13 services linked through the school such as those provided by community-based

14 organizations or clinics.

15 To streamline the reimbursement process and reduce the

16 administrative burden on schools we are proposing that health plans will

17 reimburse the schools for the services provided at the greater of the contracted

18 rate if they have a contract, or the rate set by the Department of Health Care

19 Services for Medi-Cal enrollees. The services will not be subject to any cost-

20 sharing or prior authorization.

21 And I will just acknowledge, this is a really big deal with a lot of

22 details that need to be worked out before implementation in 2024, including the

23 specific services the health plans would be required to reimburse. In the coming

24 years we will -- obviously, if this goes forward we will be working closely with the

25 health plans, our education partners, the Department of Health Care Services,

1 the Department of Insurance, on the implementation. Let's see. I will just note
2 too, we have trailer bill language that is related to this proposal, it was posted on
3 the Department of Finance's website over the weekend, so if you have questions
4 or want more information you can certainly take a look at the information that is
5 posted there.
6 The next thing I want to provide an update on, at the last meeting I
7 mentioned that the Governor's January budget included a proposal, a number of
8 proposals related to addressing health inequities, including a statutory change to
9 authorize the DMHC to establish and enforce a priority set of health equity and
10 quality measures, including setting annual health equity and quality benchmark
11 standards and enforcing health plan compliance. I couldn't share a whole lot of
12 information at that time but since then our budget change proposal and trailer bill
13 language has been released so I wanted to give you just a little bit of an overview
14 of what we are talking about here.
15 Currently, the DMHC's authority over health plan quality is limited to
16 the review of health plans' internal quality assurance programs through our Medi-
17 Cal survey process and so this would really give us additional authority to
18 oversee health plan quality equity and equity efforts. This would apply to full
19 service and behavioral health plans licensed by DMHC, including those that
20 contract with DHCS for Medi-Cal.
21 If this proposal is approved the DMHC's initial step would be to
22 contract with an external consultant to assist us with planning, organizing and
23 facilitating a Health Equity and Quality Committee that would convene at the first
24 part of next year. The purpose of the committee is to make recommendations to
25 the Department on the priority set of measures, which we really, our goal here is

1 not to create new measures but to look at what's already collected across the
2 purchasers and identify a core set of measures. We are looking at probably
3 somewhere around 10 to 12 measures and then identifying what the
4 benchmarks should be with the focus of a health equity lens. The committee will
5 include participants from DHCS, CalPERS, Covered California, OSHPD, CDI,
6 our consumer advocates, health plans, providers, and those with expertise in
7 quality measurement and health equity and disparities.
8 By September of next year the committee will make
9 recommendations to the Department and then based on those recommendations
10 The DMHC will establish a priority set of measures and benchmarks with
11 instructions to the plans by the end of next year for collection in measurement
12 year 2023. The plans will annually submit this data to us starting in 2024 and we
13 will annually produce a report with the findings and the results from that
14 submission starting in 2025.
15 The DMHC will have the authority to require corrective action plans
16 and take enforcement action when health equity and quality benchmarks are not
17 met and this includes monitoring corrective action plans and improvement efforts
18 and taking a progressive enforcement approach. You can read more about this
19 in the trailer bill language but for the first two years we really are focused on just
20 compliance with collecting and reporting the measures and the corrective action
21 plans and then we will move into more of a progressive enforcement action in the
22 subsequent years.
23 An additional requirement is that the plans and their subcontracted
24 health plans will be required to maintain NCQA accreditation by January 1 of
25 2026 and this is consistent with what is happening in the Medi-Cal program.

1 For the County Organized Health Systems, as you know, we don't
2 have any regulatory authority over them and so the Department of Health Care
3 Services will be conducting similar work for the County Organized Health
4 Systems through their contract.
5 And obviously, we will be working very closely with all of our state
6 partners on this.
7 Jeff, did you want to ask a question before I move on to my last
8 update?
9 MEMBER RIDEOUT: No, you can go ahead and finish.
10 MEMBER WATANABE: Okay.
11 MEMBER RIDEOUT: I'll ask the question at the end, thank you.
12 MEMBER WATANABE: All right. Yes, just one more quick update
13 on our COVID response. As you all can probably tell, things are slowing down a
14 little bit on our COVID response, which is a really good sign as our vaccinations
15 increase. We did issue two All Plan Letters since our last meeting. The first was
16 in response to updated guidance from the Department of Public Health. We
17 issued an All Plan Letter asking our health plans to identify those that were at the
18 highest risk for poor outcomes as a result of contracting COVID and so we
19 wanted to make sure in line with that guidance that we prioritized vaccines for
20 those at greatest risk.
21 The second All Plan Letter was requesting that health plans identify
22 and contact potentially homebound enrollees to see if they want to be vaccinated
23 and to arrange for that. We also gave information to our health plans for
24 enrollees that needed transportation. Our commercial enrollees are not required
25 in most cases to provide transportation so we wanted to make sure consumers

1 were directed either to the My Turn website or the California COVID Hotline for
2 assistance in getting vaccines.
3 All right, that's a lot of information so I'll pause and take questions
4 and turn it back to John.
5 CHAIR GRGURINA: All right. Jeff, why don't you go ahead first.
6 MEMBER RIDEOUT: First of all, IHA, of course, is happy to
7 provide any support we can for the equity and quality measures using our
8 existing measure sets and processes. I think for this group's benefit, there is an
9 adjuster to claims data that Rand has developed, it is called BISG, and that was
10 shared with the HPD Advisory Council back in November of 2019 and that allows
11 essentially an algorithmic match to identify race and ethnicity using existing
12 claims data and surname. So we are going to be applying that model to our data
13 set, regardless, but it is an opportunity to see how far that can take claims
14 information in the support of equity measurement. And it may take it a ways but
15 maybe not all the ways, but at least it's something we can experiment with over
16 the next couple of years.
17 MEMBER WATANABE: Yes, Jeff, and we really appreciate IHA's
18 support. This is new work for the Department so we will be relying on a lot of
19 outside expertise to inform our work.
20 CHAIR GRGURINA: Larry?
21 MEMBER DEGHETALDI: Yes. Mary, that was great. This is a
22 CalAIM comment and part of it is my generalized anxiety about the scope and
23 the beauty of what CalAIM is going to present us. And the one thing that I think
24 we are least prepared for is the duals' expansion. And I really would like -- I
25 could have brought this comment at the close of the meeting. You know,

1 California has 20% of the US's duals and when I look at the total cost of care
2 and how much we lose in caring for our 3.5 million patients, the duals are the
3 most challenging to have a sustainable way to care for them. They consume
4 twice what the typical Medi-Cal patient consumes, three times what the Medicare
5 patient consumes. So a deep dive, a focus, because the duals expansion will
6 significantly, assuming we all keep our doors open as we should to duals, it will
7 stress the solvency of any provider who is willing to care for duals. So that's just
8 a, that's an ask.
9 And one, I would also recommend, CHCF produced a wonderful
10 monograph last fall on dual beneficiaries in California. Happy to share it. It's a
11 wonderful graphic-rich, a study of this problem.
12 MEMBER WATANABE: I appreciate the comment. We will take
13 that back and that may be something that we ask DHCS to help us with the topic
14 for a future agenda.
15 CHAIR GRGURINA: Other comments, questions from Board
16 Members?
17 Okay. If not, Mary, why don't you go ahead and take us through
18 the agenda item of the role of the Financial Solvency Standards Board and
19 future priorities.
20 MEMBER WATANABE: Sure, happy to do that. Before I jump into
21 that topic I will just mention that we are getting some reports of intermittent audio
22 on the toll free line. So for anybody that is calling in, if you go to the agenda
23 that's posted on our website you can find a link to look up your local number and
24 you may have better sound quality with a local number. So again, if you are
25 having audio issues you may want to just try one of the local numbers instead of

1 the toll free number.

2 All right. So with that, let me move on to a topic that we have

3 actually put off for half a year. We had intended to have a discussion about this

4 towards the end of last year, but with our potential refresh of some of our Board

5 Members, which never materialized, we did want to make sure we had our Board

6 Members stabilized and set into place for the next at least year or two. So we

7 wanted to talk quickly just about revisiting the role of the FSSB.

8 And as a reminder, the Board was established by SB 260 in 1999

9 in response to concerns about financial solvency of our risk bearing

10 organizations, many of which were going bankrupt in the late '90s.

11 The purpose of the Board is to advise the Director on matters of

12 financial solvency affecting the delivery of health care services; develop and

13 recommend to the Director financial solvency requirements and standards

14 relating to plan operations, plan affiliate operations and transactions, plan

15 provider contractual relationships, and provider affiliate operations and

16 transactions; and to periodically monitor and report on the implementations and

17 results of the financial solvency requirements and standards.

18 SB 260 also directed the Board to provide a study or report to the

19 DMHC Director on several specific criterias related to risk-sharing arrangements

20 and RBOs. This was due back in 2001 and all of all of this has been done. It

21 also required the DMHC to adopt regulations related to solvency standards, and

22 you may remember that we updated those, I think it's been about a year or two,

23 and they took effect recently.

24 The primary focus of the Board really is to, in those first early

25 years, was to develop the regulations and standards. And then beginning in

1 2005 the meeting agendas really started to expand and to include other topics.
2 And obviously, with the implementation of the Affordable Care Act there were a
3 lot more things for the Board to discuss. We have used these forums to provide
4 regular updates on other Department areas and at the Board's request we have
5 really put the Department of Health Care Services, a regular attendee, to update
6 on topics that impact the financial stability of the RBOs and the health plans.
7 One of the last times the Board revisited kind of the purpose and
8 priorities was back in 2012 so it has been almost 10 years. And at that time, as I
9 mentioned, the focus was really on the Affordable Care Act, the setting up of the
10 health benefit exchange Covered California, rate review, Accountable Care
11 Organizations, medical loss ratio, and then obviously, the federal risk adjustment
12 reinsurance and risk corridors.
13 We wanted to provide this. There's two slides here with kind of the
14 cadence of the documents and items that we bring to the Board. We really feel
15 like we are at a good time to pause and do a temperature check to see if this is
16 still, is this still relevant and are these still meeting the needs of the Board and
17 the Department? We really look to you to advise us and give us input on a lot of
18 things that impact the financials of both the plans and the RBOs.
19 So you will notice here that we have things that we bring to the
20 Board every single meeting. I think the Director's update, the DHCS update and
21 our health plan and RBO quarterly financial reports, these are our standing
22 agenda items.
23 And then you will see here too, we have things that we present to
24 you every other meeting, so our Medi-Cal Managed Care Report we present to
25 you twice a year.

1 And then on an annual basis we have things like we will talk about
2 the Governor's budget or our Department budget. Let's go to the next slide here.
3 We also have a number of things that we will present, including
4 rates, on an annual basis. I will just note on this slide of things that we present
5 annually, some of these we have not necessarily done on an annual basis, it just
6 depends on the time we have and what is going on. There's a couple of things
7 here that I think are worth considering.
8 For example, our Dental Medical Loss Ratio is a report that we
9 present every year. However, until the Legislature takes action to set a Medical
10 Loss Ratio or something else, we don't really have anything else we can do other
11 than to continue to present the information; and I know every year it seems to
12 raise the same issues and some frustration. So one thing we really would look to
13 the Board to provide input on is, is this something we should just provide as
14 information only but maybe not have a whole discussion or presentation?
15 We also, I know there has been a lot of interest in having Jeff
16 present the Cost and Quality Atlas information, which we were hoping to have a
17 presentation at our next meeting. We have had in the past a presentation on
18 national trends in individual and small group rates. And so there's a lot of
19 different things here that we present annually. But again, the goal here is really
20 to get your input on, are there things you would like more frequently, less
21 frequently or potentially for information only or let's just not do that anymore.
22 Let's see.
23 The other thing that I wanted to mention, as part of your packet,
24 your virtual packet and on our website, we have included a letter from America's
25 Physician Groups, APG, which was provided to the Board back in November with

1 some suggestions for future areas of focus for the Board. And Bill, Bill
2 Barcellona, I appreciate your patience as we got our Board settled to bring this
3 back to the Board. That letter highlights some of the history of the RBOs'
4 performance and the value of the Board's oversight. It also includes some
5 suggestions for the future direction of the Board, including looking at the root
6 cause of RBO financial instability, a scoring system potentially that the
7 Department could use to look at the financial solvency of RBOs based on the
8 number of quarters the RBO is compliant. This is really tied to that corrective
9 action plan chart that we have discussed previously. Also reporting quarterly on
10 closures or consolidations and looking at IHA's quality scores to see if there is
11 any correlation. You have a copy of the letter, I won't go into too much more
12 detail and Bill may want to provide some comments. I will just say there is also a
13 suggestion to have OSHPD come and do updates on their healthcare payments
14 database and the Office of Healthcare Affordability. And that's something I think
15 there is a lot of correlation and overlap with the work that OSHPD potentially will
16 be doing so we want to make sure we are working closely with them.
17 So with that I think I will pause and turn it back to John to get the
18 Board's input.
19 CHAIR GRGURINA: Comments, questions, input for Mary from the
20 Board Members?
21 MEMBER RIDEOUT: I've got a few.
22 CHAIR GRGURINA: Jeff.
23 MEMBER RIDEOUT: I want to make sure this is not scope creep
24 on our charter but I guess a couple things I'd say. If we are going to look at
25 plans and risk bearing providers I think the best unit of analysis is the plan

1 provider level contract, as opposed to the RBO. And I think that's important
2 because plans and providers do negotiate and do perform differently based on
3 their individual contracts. They can be rolled up to RBOs but I think we have
4 always measured with IHA at that level of contract; so that would be one
5 suggestion and this is following Bill Barcellona's comments.
6 We would be pleased to have our programs quality scores be used
7 as part of any sort of assessment or scorecard. We have in the past presented
8 to DMHC staff sort of the full monty, so to speak, on our measurement, which
9 includes quality and total cost of care and utilization. There hasn't been a
10 correlation between RBO financial solvency issues and quality and I am not sure
11 I would have expected one. But to the extent that an expanded view of
12 performance at the medical group or IPA level is appropriate for the scope we'd
13 be happy to have that standardized measurement used because it is already
14 publicly available and relatively easy to incorporate.
15 And then lastly, I mentioned this in the equity measures. Again, to
16 the extent that we can adjust our existing performance measures for equity using
17 some of these national risk adjusters, we'd be happy to do that if that's of use to
18 the Department.
19 CHAIR GRGURINA: Okay, how about Jen, then Ted then Larry.
20 MEMBER FLORY: Yes, two comments. One on the dental
21 medical loss ratio. I know we have the same concerns every time it's presented.
22 We would at least like the information presented. That is the only way we are
23 going to get the Legislature to take action is if we have access to that
24 information. Additionally, and I apologize that I didn't review the notes of the last
25 time this came up. I know, every time it comes up we have some considerations

1 for other information that might be helpful to have looking side by side, I am not
2 sure if we are talking about their profit and loss or other things that might help
3 evaluate alongside the medical loss ratio to kind of figure out what's going on
4 there since there is such a wide spread.
5 And then on the risk bearing organizations, I mean, with regards to
6 the ones that are now eligible for exemptions, if there is information that could be
7 presented about what DMHC is learning about those organizations and kind of
8 what's happening in the industry, I think that would be helpful to understand.
9 CHAIR GRGURINA: Thank you, Jen.
10 Ted.
11 MEMBER MAZER: Yes, just a tag-on for Bill Barcellona's
12 suggestions, most of which I think are excellent. The scoring system that he
13 suggests I think may hide the rapid decline of solvency and ability of certain
14 RBOs to function. He is looking for just what's the total duration of an RBO in
15 the score versus how many times they have been on a CAP. I think both
16 measures of the long-term and the short-term will continue to be important,
17 because if somebody is suddenly into trouble we won't know that if we are just
18 looking at a 12 year history.
19 A couple of things that I think would help us also is we never look
20 at whether there is a relationship between complaints to the Department and
21 solvency issues as they develop. I know firsthand that you've got a Department
22 that deals with complaints by providers, thank you, but there is a question of
23 whether that may be the red flag leading to solvency issues; and we don't look at
24 that at all, I would suggest that we do that.
25 And I do appreciate that we are getting more health plan-specific

1 information, at least for the Board Members to look at. That, to me, is way more
2 helpful than some of the generalized data that we got when I first joined on this
3 Board. I know we can't necessarily divulge that out in the public but I think that
4 needs to be continued information that we get as we try to understand where the
5 RBOs are getting into trouble.
6 My final comment for now, we will get to this when we get to the
7 Medi-Cal groups later. There is a tremendous problem with cost shifting and
8 with everybody doing this, okay. Particularly we saw that when we had the loss
9 of co-payments coming from a patient in the commercial side. The plan wasn't
10 increasing the CAP, the managed care group in-between wasn't paying the
11 provider, the patient wasn't paying because they knew they didn't have to, and
12 the doc lost out at a time when they were really struggling in many cases to try to
13 keep their offices open.
14 Same thing with the DOFRs and are the DOFRs really accurate.
15 Maybe the only way that we can get the information before this Board is to see,
16 again, when complaints come to the Department about those issues are we
17 seeing individual plans or individual groups at the root cause of that? Thanks.
18 CHAIR GRGURINA: Thank you, Ted.
19 Larry.
20 MEMBER DEGHETALDI: Yes, so I am going to piggyback on both
21 Jeff and Ted because they are so wise. First, Jeff's concern about scope creep
22 is valid, but. The patient experiences access, quality outcomes, service levels.
23 The providers should be measured and we should pay attention not just to the
24 narrow financial side of the value equation, but as best as we can on the total,
25 the totality of how IHA looks at how we deliver care to Californians.

1 And to Ted's point under risk adjustment. We are seeing the
2 neediest patients in California have the lowest rates of pay per unit of service.
3 Those that need care the most we are paid the least; and each year the delta
4 between commercial payments and government payments grows and it is
5 reaching a point where access will suffer. And one of the most important ways to
6 make visible the disparities and equity issues would be to appropriately adjust to
7 look at what Medicare Advantage does in risk adjustment, what Covered
8 California does in risk adjustment, because an equitable and sustainable
9 payment system must appropriately adjust for social determinants, clinical risk,
10 and all the things we know that our neediest patients bring to us.
11 So understanding risk adjustment as we move to regional rates in
12 Medi-Cal as we go forward so that there is adequate payments, because we are
13 going to, we are reaching a point where, you know, it doesn't matter what you do.
14 If you have no access to needed providers you are not providing, we are not
15 doing our work, and I am very worried about this.
16 CHAIR GRGURINA: All right, thank you, Larry.
17 I will add, I'll double down on Jen's comment which is, I know we
18 are frustrated with the dental MLRs and it seems like it's a redo of the
19 conversation each year. But as Jen said, it's something that we need to continue
20 to take a look at to see, is there some opportunities to find some solutions and
21 eventually that we will get there.
22 Secondly, I thank Bill for submitting his letter and raising this and I
23 think it would be good for, Mary, a presentation to go back from the beginning of
24 the, what was recommended by the Board on the provider solvency and the
25 changes that DMHC made in the regulations. Just to refresh that memory to

1 take a step back and say, where are we. I recall reading those documents from
2 quite some time ago and I don't recall all of it so I think it will be good to have a
3 refresh on that and for us to take a look at that.
4 And then the third and final comment for me comes along the lines
5 of what Larry just mentioned which is, the Department of Health Care Services is
6 looking to do regional rates in Medi-Cal. That is a big change and potentially
7 with some potential really unintended consequences of dollars moving around
8 between plans. And given the concerns of where plans' reserves are, I think that
9 is something we really need to have the Department of Healthcare Services here
10 taking a close look before that would actually be implemented because that is a
11 huge systemic change, depending on where they determine the regions are and
12 how many plans are going inside there.
13 And then I would also just finally say that, I think that we should
14 bring this back again to be able to allow Amy and Paul who are not with us today
15 to get a chance and for us to have another conversation to see where we are. I
16 know these meetings we take up almost all the time, I don't know how we are
17 going to get done on time today, we will just see what we do. There is a lot for
18 us to cover but I think we do need to be able to prioritize and say, what is the
19 important things that we need to be bringing forward. I appreciate you leading us
20 through this conversation today and I do appreciate Bill submitting the letter and
21 putting this on the agenda. So with that, are there any other comments,
22 questions from the Board Members?
23 If not, let's turn to members of the public.
24 THE MODERATOR: Yes, we have an attendee with the screen
25 name L-E. Go ahead. Go ahead.

1 Okay, we will go to the next person, Bill Barcellona, go ahead.
2 MR. BARCELLONA: Thank you, John and Mary and the rest of the
3 Panel, for considering our proposal today and we really appreciate that. Just
4 want to reiterate a couple of things. The CAP metrics study that analyzed 50
5 RBO closures was performed in 2002 and so it's 19 years old. It could be very
6 helpful to summarize some of the things that we have -- that we and the
7 department have done in terms of over the last year to look at the direction of
8 risk bearing organizations and how they fared.
9 I still want to stress to this, this body that it is important to look at
10 the root causes of why RBOs fall into corrective action plans. As we have
11 iterated in the past, there seems to be a 10%, a constant presence of 10% of the
12 RBOs in California remain on corrective action plans. And I think that this should
13 be studied to determine what we can do to raise the level of performance overall
14 to get some of these groups out of the basement and into a higher performing
15 mode, if you will.
16 And then also I just will say, my one last comment is that we really
17 need to focus on contracting and on DOFR integrity. We really should look at
18 having a panel over the next year to talk about the relationships between plans
19 and risk bearing providers. The potential here for a negative impact through the
20 ambiguity of DOFR language is very real. It has manifested itself very directly
21 during the pandemic with COVID-19 services and I really urge you to consider
22 that we study this more and discuss it in a public forum.
23 So thanks again for considering our proposal and we appreciate
24 this discussion.
25 CHAIR GRGURINA: All right. Thank you, Bill.

1 MEMBER RIDEOUT: John? John?
2 CHAIR GRGURINA: I'm sorry, does someone have a comment?
3 Jeff?
4 MEMBER RIDEOUT: Jeff. Just on the DOFR issue. I wanted to
5 just -- kind of a historical reminder. IHA did have a standard DOFR that we
6 discontinued about five or six years ago and the reason really was we can define
7 it but in the end, it comes down to whether people want to share their contracted
8 rates for individual services and whether or not they want to standardize that. So
9 I am not taking anything away from Bill's goal, it's a very tricky area of proprietary
10 information to standardize.
11 CHAIR GRGURINA: All right, thank you, Jeff.
12 And for those who are asking what in the heck is a DOFR, it is
13 Division of Financial Responsibility. Those of us in the health care world,
14 everything is an acronym.
15 Okay, do we have more comments from members of the public?
16 THE MODERATOR: Yes. Sean Atha, go ahead.
17 MR. ATHA: Hi, this is Sean Atha, from River City Medical Group. I
18 actually thank you for letting me speak. And actually, Mary, congratulations,
19 actually, on the permanent position.
20 I just wanted to second parts of what Bill had brought up. River
21 City Medical Group, as many people know, has primarily focused for the past 25
22 years on serving the state's Medi-Cal population. We have close to like 300,000
23 Medi-Cal lives. And one of the things that we would just like to raise as an
24 ongoing concern and issue is the potential area of sort of DOFR creep. Right
25 now we look at a number of cases that come up where health plans, quite

1 frankly, due to the ambiguity of the DOFR and who is responsible for what, are
2 sort of having expectations of actually us managing and accepting the cost for
3 even non- Medi-Cal related cover services, the areas of continued, you know,
4 injectable areas that depending upon new technologies and as new medications
5 are being put out, can be quite expensive, and having those be put into the area
6 of risk. And so looking at areas and potentially supporting the movement to a
7 codified DOFR to bring greater clarity and transparency to DOFRs I think would
8 be a great help moving forward. Thanks for this moment to speak.
9 CHAIR GRGURINA: Thank you, Sean.
10 Any other comments from members of the public?
11 THE MODERATOR: Yes, we have Janet. Go ahead.
12 MS. VADAKKUMCHERRY: Can you hear me okay, now?
13 CHAIR GRGURINA: Yes, we can.
14 MS. VADAKKUMCHERRY: Oh, great. This is Janet
15 Vadakkumcherry from Health Center Partners of Southern California, located
16 mostly in San Diego, representing three counties with RFQHCs. Thank you very
17 much. This has really been a great presentation, all of the, all of the information
18 that you have provided also with DHCS.
19 I am kind of interested. Larry, I believe it was Larry mentioned that
20 he had some kind of a graphic with regard to the duals and I am kind of
21 interested in seeing that. And I don't know that that would necessarily be shared
22 as a follow-up item so I am just asking how I might get it or is there a web link or
23 something?
24 CHAIR GRGURINA: Larry, do you want to respond?
25 MEMBER DEGHETALDI: Yes. I sent a link to Mary but it's quite

1 easy. California Health Care Foundation, CHCF, dual beneficiaries, and you will
2 find a 50 page from September. If you like graphs, you'll be in heaven. But it
3 tells a scary story.
4 MS. VADAKKUMCHERRY: Okay, thank you, appreciate the
5 reference.
6 CHAIR GRGURINA: All right, thank you very much, Janet.
7 Any other members of the public with comments or questions?
8 THE MODERATOR: That is all for now.
9 CHAIR GRGURINA: All right, thank you.
10 All right. Well, thank you, Mary. We will move on with Sarah for
11 the federal update.
12 MS. REAM: Yes, good morning. I am Sarah Ream; I am the Chief
13 Counsel for the DMHC. I have two federal updates for you today.
14 So the first issue concerns subsidies for Cal-COBRA and COBRA
15 continuation coverage. In March, the federal government enacted the American
16 Rescue Plan Act of 2021, which is sort of a word salad so it is often shortened to
17 ARPA. Among other things, ARPA provides premium assistance to eligible
18 individuals who are receiving COBRA or Cal-COBRA, which is the state's mini-
19 COBRA continuation coverage law. The subsidy is equal to 100% of the amount
20 of the enrollee's premium and is available to eligible individuals for up to six
21 months, running between April 1 and September 30 of this year.
22 To be eligible for a subsidy an individual must have lost their
23 employer-sponsored coverage due to the qualifying event of a loss of a job or a
24 reduction in hours. If the qualifying event was a job loss, that loss must have
25 been involuntary, the person cannot have simply quit their job. In contrast, if the

1 qualifying event was a reduction in hours, that reduction could have been either
2 involuntary or voluntary, it doesn't matter for purposes of qualifying for the
3 subsidy. It is important to note here that other types of usual qualifying events
4 for eligibility for COBRA or Cal-COBRA coverage such as a divorce or losing
5 status as a dependent do not qualify a person for the subsidies under ARPA.
6 So in addition to having lost employment or experienced a
7 reduction in hours, to be eligible for a subsidy the individual must still be either
8 receiving COBRA or Cal-COBRA coverage or still within the time frame for which
9 the person would have been eligible to receive COBRA, even if they didn't elect it
10 in the first place. So if someone was eligible for federal COBRA, federal
11 COBRA, but didn't elect it initially, they can now -- because oftentimes the
12 premiums can be fairly higher than what the person could necessarily buy in the
13 individual market. So if that person didn't elect federal COBRA when they
14 initially could have, they can now elect COBRA and gain the benefit of the
15 subsidies, assuming that fewer than 18 months have elapsed since the person
16 experienced the loss of coverage. I say 18 months because that is the typical
17 amount of time a person can continue their employer-sponsored coverage
18 following a job loss or a reduction in hours.
19 However, for someone who is only eligible for COBRA coverage,
20 Cal-COBRA, excuse me, and not COBRA because their employer has fewer
21 than 20 employees. If that person currently isn't receiving Cal-COBRA coverage,
22 ARPA does not allow them to elect COBRA now, so unfortunately these folks will
23 not be able to take advantage of the subsidies.
24 As you can probably tell from my word salad, this is a very
25 complicated area of law. The federal government has issued two sets of

1 guidance to clarify many of the issues and questions that have come up since
2 ARPA was enacted in March. In April, the Federal Department of Labor issued
3 FAQs but those left many questions unanswered. Then last week the IRS
4 issued 41 pages of guidance that actually answered quite a few questions that
5 consumers, states, employers and plans had been confused about.
6 Very shortly, the DMHC will put on our public website an enrollee-
7 focused FAQ to help alert enrollees that they may be eligible for subsidies and
8 how to get more information. In the meantime we encourage anyone with
9 questions about the subsidies to contact their employer, their health plan or the
10 DMHC's Help Center and we can provide them with more information.
11 My second federal update concerns health plan coverage for
12 COVID-19 testing. So as you will recall, in June of last year the federal
13 government issued sub-regulatory guidance saying that under the CARES Act,
14 health plans had to cover COVID-19 testing only when an enrollee had
15 symptoms of COVID-19 or had been exposed to someone who may have had
16 COVID-19. This left questions open about when-14 health plans had to cover
17 testing for asymptomatic people, who we know still were spreading the virus.
18 Largely in response to that federal guidance, the DMHC adopted an emergency
19 regulation requiring plans to cover COVID-19 testing for all enrollees, including
20 those who were asymptomatic and hadn't recently been exposed to COVID-19.
21 The DMHC's regulation took effect July 17 of 2020 and recently expired on May
22 15.
23 While the DMHC's regulation was in effect, however, the federal
24 government issued new guidance regarding when plans must cover COVID-19
25 testing. That new guidance, which was issued in February of this year, largely

1 reversed the old guidance and now requires plans to cover COVID-19 diagnostic
2 testing for all enrollees, including those who are asymptomatic and haven't been
3 exposed to COVID-19. So as a result, the DMHC's emergency regulation was
4 largely no longer necessary to ensure that enrollees, including asymptomatic
5 enrollees, had ready access to COVID-19 tests. Because of this, the DMHC
6 decided to not move to make the emergency regulations permanent. However,
7 we are continuing to monitor the plans coverage of COVID-19 testing to ensure
8 that they comply with the new federal guidance.
9 On a final note, you will likely recall that last fall the California
10 Association of Health Plans sued to challenge that provision in the emergency
11 regulation that required plans to negotiate with their delegated providers if the
12 plans wanted the providers to take financial responsibility for COVID-19 testing.
13 The plans couldn't simply point to their preexisting DOFRs or Division of
14 Financial Responsibility documents and say that providers were at financial risk
15 for COVID-19 testing because the providers had agreed pre-COVID to be at
16 financial risk for diagnostic testing generally.
17 In April, the judge in the CAHP lawsuit determined that because the
18 DMHC had not provided a five day public notice before it adopted the emergency
19 regulation, the DMHC had not adopted the financial risk portion of the regulation
20 in compliance with the California Administrative Procedure Act. Accordingly, the
21 judge held that that provision of the regulation, again the Division of Financial
22 Responsibility portion, was void. The judge's ruling, however, did not impact the
23 remaining provisions of the regulation, which remained in good standing. So we
24 have received a number of questions from stakeholders about whether the
25 outcome of the CAHP lawsuit or the expiration of our emergency regulation

1 means COVID-19 testing is no longer covered; and the answer is a resounding
2 yes, it is still covered. Under federal law, as identified by the Federal guidance
3 issued in February, plans must still cover COVID-19 testing both for symptomatic
4 and asymptomatic enrollees.
5 And with that, I will welcome your comments and questions. Thank
6 you.
7 CHAIR GRGURINA: All right, thank you, Sarah.
8 Comments, questions from Board Members?
9 You covered it well, Sarah.
10 MS. REAM: All right.
11 CHAIR GRGURINA: Let's go ahead and see if there's any
12 comments or questions from members of the public.
13 THE MODERATOR: Not at this time.
14 CHAIR GRGURINA: All right, thank you very much.
15 Okay, thank you, Sarah.
16 Let's go ahead and move on to large group aggregate rates and
17 the prescription drug costs with Pritika.
18 MS. DUTT: Good morning. I am Pritika Dutt, Deputy Director for
19 the Office of Financial Review. This presentation is broken into two sections.
20 First I will go over the large group rates and prescription drug information
21 submitted by health plans for measurement year 2020 and then next I will
22 provide a brief overview of the Prescription Drug Cost Transparency Report for
23 measurement year 2019; and both of these reports are available on our public
24 website.
25 In 2015, California enacted SB 546 for the purpose of increasing

1 transparency of large group rates. So, SB 546 requires health plans that offer
2 commercial large group products to submit aggregate rate information and the
3 weighted average rate increase for all large group benefit designs during the 12
4 month period ending January 1 of the following year to the DMHC on October 1,
5 2016 and annually thereafter. So, the DMHC prepares a report and then we do
6 a public meeting every even-numbered year. Next slide.
7 This chart shows the side-by-side comparison of the rate increases
8 for CalPERS, Covered California individual market products and the large group
9 statewide health plans since 2016. While the Covered California increases have
10 fluctuated widely, the average rate increases for large group statewide plans,
11 with the exception being 2018 measurement year, have remained in or around
12 the 4% range for each measurement year in the five year period. Next slide.
13 We received the 2020 filings from 23 health plans, which included
14 eight statewide plans, so the statewide plans are in multiple regions, 10 regional
15 plans, so those plans only offer products in one region, and 5 county plans that
16 have in-home support services plans or IHSS for their IHSS workers.
17 Over 8.1 million enrollees in nearly 14,000 groups were impacted
18 by a rate change in 2020.
19 We did not include the IHSS data in the rest of the large group rate
20 analysis. The five IHSS plans had 70,000 enrollees December 31, 2020. The
21 rate development process for IHSS plans differs from traditional large group
22 health plans, which utilizes community-rated, experience-rated or blended-rate
23 development methodologies. For IHSS products what I have learned is the
24 county and the IHSS plans determine the rates, which are based on anticipated
25 costs for providing services to the IHSS employees.

1 This chart shows the average premium per member per month for
2 regional and statewide plans from 2016 to 2020. From 2016 to 2020 the
3 average premium per member per month increased by 14% for regional plans
4 and 18% for statewide plans. So if you look at the year 2020 and 2016, the rates
5 have increased by 18% for statewide plans and 14% for regional plans. On an
6 annualized basis over this period the average rate increase for the regional plans
7 was 3.3% and the average rate increase for statewide plans was 4.2%.
8 This chart here shows the weighted average rate increase trend
9 from 2016 to 2020. The rate increases on average have fluctuated from 2016 to
10 2020 but have remained below 6% each year.
11 So, plans were required to provide their overall average increase
12 and adjusted average rate increase for all large group products. The adjusted
13 average increase adjusts for changes in such things as benefits, cost sharing,
14 provider network, geographic rating area and average age. The average
15 unadjusted rate increase was 4.3% for all plans, the average adjusted rate
16 increase was 5% for all plans, and the average monthly premium across all plans
17 was $516. Kaiser has approximately 65% of the large group enrollment so we
18 have separated the information for Kaiser to show Kaiser on its own and then all
19 the plans without Kaiser. And since Kaiser had a lower premium increase of
20 3.7%, the overall average increase goes up to 5.3% for the remaining plans.
21 This table here shows the average premium increase in monthly
22 premium by product type. In 2020, PPO plans had the highest premium with an
23 average premium of $600 per member per month. Overall, HMO plans
24 experienced the lowest average rate increases with a 4.1% increase and had the
25 lowest average premium at $509 per member per month. High deductible health

1 plans had the lowest average premium, but the out of pocket costs for high
2 deductible health plans are higher compared to traditional HMO plans.
3 This slide shows large group market enrollment by product type
4 and actuarial value. The majority of the plans, or 6.8 million enrollees, are in
5 HMO plans with higher actuarial values, which are the richest benefits overall. In
6 contrast, high deductible health plans tend to give members a lower premium,
7 but they have a higher out-of-pocket cost. Actuarial value is how much the
8 health plan pays versus how much an enrollee pays, so the higher AV, which
9 means the plan covers most of the costs for those care. Next slide.
10 Large group health plans use one of the following three rating
11 methodologies to set premium rates. Community rated, experience rated, or
12 blended. Community rating uses a standard base rate for a pool of large group
13 employers and additional factors specific to that employer group, such as
14 geographic region or industry, to determine rates. Experience rating uses
15 actuarial claims experience of an employer group to determine rates for that
16 particular employer group. Finally, blended rates are calculated using a
17 combination or blend of rates determined via community rating and experience
18 rating. This slide shows the percentage of renewing groups, number of
19 enrollees, average rate increases, and average premium per member per month
20 by rating methodology. Although the percentage of experience rated groups is
21 lower, there's more enrollees in experience rated groups compared to the other
22 two rating methodologies.
23 The next two slides summarize prescription drug costs for the large
24 group health plans. Prescription drug costs, net of rebates, was 13.3% of large
25 group premium. This equates to about $68 per member per month out of an

1 average premium of $508 per member per month.

2 Year over year the average premium increased 3% for renewing

3 and new groups entering the market where incremental amount attributed to

4 pharmacy costs was 1.7%.

5 Manufacturer drug rebates totaled approximately $703 million in

6 2020 for the large group plans, up from $650 million in 2019.

7 All 23 health plans, including the IHSS plans, utilized a pharmacy

8 benefit manager. PBMs may be used by health plans to handle claims

9 processing, utilization management and enrollee grievances.

10 Now, I will move on to the Prescription Drug Transparency Report

11 for Measurement Year 2019. So, I will briefly go over the requirements of the

12 reporting and then provide a high level summary.

13 In 2017, California enacted SB 17 with the purpose of increasing

14 transparency of prescription drug costs. SB 17 requires health plans that file rate

15 information with the DMHC to report specific rate data on their prescription drugs

16 beginning October 1, 2018 and annually thereafter. So this was the third year

17 that we received information and we published a report on our public website.

18 The commercial health plans must report to the DMHC information

19 on their 25 most frequently prescribed drugs, 25 most costly drugs by total

20 annual spending, and 25 drugs with the highest year-over-year increase in total

21 annual spending for the individual, small group and large group commercial

22 business.

23 So this slide discusses the reporting parameters and limitations of

24 the report. The Prescription Drug Transparency Report for Measurement Year

25 2019 includes information for 25 commercial health plans covering approximately

1 12.5 million enrollees, Californians.

2 Health plan reporting is limited to prescription drug costs

3 associated with the pharmacy benefit.

4 Health plans do not include prescription drugs for inpatient drugs or

5 costs borne by delegated medical groups such as infusion drugs administered in

6 a physician's office.

7 Prescription drugs costs for self-funded arrangements, Medi-Cal

8 managed care plans, Medicare Advantage and self-insured plans and insurers

9 not regulated by DMHC are not reported in this report.

10 Some of the key findings of the Prescription Drug Transparency

11 Report for Measurement Year 2019 include:

12 So, health plans paid more than $9.6 million for prescription drugs

13 in 2019, which increased by $600 million from 2018 and $1 billion from 2017.

14 The prescription drugs overall accounted for 12.8% of total

15 healthcare premiums.

16 And then health plans' prescription drug costs increased by 6.3% in

17 2019, whereas expenses, medical expenses increased by 5.2%. Overall, total

18 health plan premiums increased 5.3% from 2018 to 2019, so you can see the

19 prescription drug cost increase percentage was higher compared to medical

20 expenses and the premium increase. Next slide.

21 Manufacturer drug rebates totaled approximately $1.1 billion or

22 about 12.5% of the $9.6 billion spent on prescription drugs.

23 While specialty drugs accounted for only 1.5% of all prescription

24 drugs dispensed, they accounted for 56.1% of total annual spending on

25 prescription drugs.

1 Generic drugs accounted for 88.5% of all prescribed drugs, but
2 only 20.9% of the total annual spending on prescription drugs.
3 So that wraps up my presentation. I will take any questions.
4 CHAIR GRGURINA: Questions or comments from the Board
5 Members? Larry, why don't you go ahead.
6 MEMBER DEGHETALDI: Yes. Pritika, IHA and others have
7 identified a significant delta between commercial premium costs in Northern
8 California and Southern California. Have we looked at that? Are there trends?
9 What are the trends? And maybe it's a question for Jeff. Because I am
10 concerned as we move probably to have an Office of Healthcare Affordability, I
11 think we need to make visible those facts and any reasons behind it.
12 MEMBER RIDEOUT: Larry, I can make a comment. We observe
13 it, what drives it is still to be determined. And just so people understand, it is
14 both clinically and wage-adjusted information and uses a standard definition of
15 total cost of care that was approved by NQF. So, causality is still to be
16 determined and there's, obviously, a number of presumptive reasons that people
17 have talked about.
18 MS. DUTT: Larry, AB 731 added a requirement for individual and
19 small group and large group plans to report on geo-region information. So we
20 started collecting that information starting September of last year so we can look
21 at that and include some information in future presentations.
22 CHAIR GRGURINA: All right, thank you.
23 Any other comments, questions from the Board Members?
24 Just one comment I'll have, Pritika, just the stunning difference. It
25 is not surprising, we know this in our own book, but 1.5% of the prescriptions

1 costing over 56% on the specialty side. And actually I think this is a positive is,
2 almost 89% of all prescriptions are generic, which is great, but then only
3 accounting for 20% of the total cost. So, it is what it is, but how that hits you
4 when you see those numbers, so thank you for doing that.
5 So can we see, do we have comments? I think I see a couple of
6 hands raised from members of the public for comments, questions for Pritika's
7 presentation.
8 THE MODERATOR: Yes, Yasmin, go ahead.
9 MS. PELED: Good afternoon, this is Yasmin Peled with Health
10 Access California. I just want to thank Pritika and her team for their ongoing
11 work on both the SB 546 report and the SB 17 report. We really appreciate
12 these and they are very useful so thank you.
13 CHAIR GRGURINA: Thank you, Yasmin.
14 Next?
15 THE MODERATOR: Yes. We have Bill Barcellona.
16 MR. BARCELLONA: Thank you, John; and, Pritika, thanks for your
17 presentation. I just wanted to note in your slide that broke down the cost trend
18 increases between HMO, PPO, EPO and high deductible, that these cost trend
19 differences between the different types of coverage models are reflective of the
20 same information that is presented in the IHA Regional Cost and Quality Atlas
21 within the 19 rating regions of California. I think the report was very relevant and
22 also very helpful to the way we are going to approach this with the Office of
23 Health Care Affordability. Thanks.
24 THE MODERATOR: It looks like that is all at this time.
25 CHAIR GRGURINA: All right, thank you.

1 Okay, well, Pritika, you are up again to be able to talk about the
2 financial summary of the Medi-Cal managed care plans.
3 MS. DUTT: Thank you, John. So, I will provide you a quick update
4 on the financial summary of Medi-Cal managed care report for quarter ended
5 December 31, 2020. A copy of the report is available on our public website
6 under the Financial Solvency Standards Board section. This report is prepared
7 by the DMHC on a quarterly basis and highlights enrollment and financial
8 information for Local Initiatives, County Organized Health Systems and Non-
9 Governmental Medi-Cal plans. Non-Governmental Medicare Plans are plans
10 that report greater than 50% Medi-Cal enrollment but are neither an LI or a
11 COHS. The report is divided into three distinct areas, first focusing on LIs, then
12 COHS, and then we look at our NGM plans.
13 There are 9 Local Initiative plans that serve 5.4 million Medi-Cal
14 beneficiaries in 13 counties. Total enrollment increased by 9.2% since
15 December 2019, with all LIs reporting an increase in enrollment. L.A. Care
16 Health Plan, the largest LI plan with 2.3 million enrollees, had an 8.6% increase
17 in enrollment over the last year. Overall the LI plans' enrollment increased by
18 almost 500,000 enrollees from December 2019 to December 2020.
19 There was a slight decrease in total medical expenses for LIs at the
20 quarter ending December 2020 despite an increase in enrollment of 9.2%. The
21 decrease in medical expenses is due to a decrease in utilization of services as a
22 result of the COVID-19 pandemic. However, the decreased medical expenses
23 did not result in profits for the LIs.
24 The Medi-Cal plans had a retro rate reduction effective July 1,
25 2019, all the way through December 31, 2020. Another program that DHCS had

1 in place during the same period was a COVID risk corridor program where if the
2 plans have excessive gains during that period the plans would have to reimburse
3 a certain percentage of those gains back to DHCS. Or if the plans had
4 excessive losses, then DHCS would reimburse the Medi-Cal plans a certain
5 percentage of that loss. Additionally, the plans were subject to the MCO taxes
6 starting January 1, 2020.
7 For the fourth quarter the LI plans reported a total net loss of $41
8 million. L.A. Care reported net losses for three consecutive quarters. The plan
9 experienced increase in their hospital and fee-for-service claims payment and
10 they accelerated the claims payment process in order to send payments to
11 providers faster during the pandemic.
12 All LIs met the DMHC's reserve requirement or tangible net equity
13 requirement. TNE to required TNE for the LI plans ranged from 554% to 795%.
14 There are 6 COHS plans that serve 22 counties. We receive
15 financial reports from 5 COHS; Gold Coast does not report to the DMHC.
16 The 5 COHS that report to the DMHC serve over 2.1 million Medi-
17 Cal beneficiaries. All COHS plans experienced enrollment growth for the last
18 three quarters of 2020, adding almost 200,000 enrollees.
19 For the fourth quarter the COHS reported a total net loss of $1.2
20 million. Two COHS plans, CenCal and Partnership reported net losses of $11.5
21 million each. CenCal has reported five consecutive quarterly net losses and has
22 attributed its net losses to the MCO tax. CenCal's TNE to required TNE at
23 December 31, 2020 was at 572%. Partnership reported net profits for quarter
24 end December 31, 2019 and March 31, 2020; however, reported over $63 million
25 in net losses from April 1 through December 31, 2020. For Partnership its losses

1 were as a result of DHCS's rate reduction. Central California Alliance reported a
2 net profit of $7.7 million after several quarters of net losses.
3 TNE to required TNE for the COHS plans ranged from 555% to
4 1,008% of required TNE.
5 There are 7 NGM or Non-Governmental Medi-Cal plans that serve
6 over 3.3 million Medi-Cal beneficiaries in 31 counties. NGM plans' enrollment
7 increased 3% or about 210,000 enrollees from December 2019 to December
8 2020.
9 For the fourth quarter, NGM plans reported a total net loss of $87
10 million. Similar to the LIs and COHS, the NGMs were impacted by the rate
11 reductions, risk corridors and the MCO tax. Molina had to book a reserve to pay
12 DHCS back under the risk corridor program at December 31 2020, which
13 resulted in the plan reporting a loss of almost $66 million at December 31, 2020.
14 As a result, Molina reported noncompliance with the TNE
15 requirement at December 31, 2020. However, Molina cured the TNE deficiency
16 in January of 2021 through a cash infusion from its parent company. TNE to
17 required TNE for the NGM plans ranged from 98% to 1,031%.
18 So some of the take-aways from the report for the fourth quarter:
19 Enrollment in Medi-Cal plans decreased from December 2017 all
20 the way through March 31, 2020; however, all Medi-Cal plans reported an
21 increase in enrollment for the last three quarters of 2020.
22 The Medi-Cal managed plans reported a slight decrease in medical
23 expenses in the second quarter of 2020 compared to the first quarter of 2020
24 because of the decrease in utilization of services during the pandemic. In the
25 second quarter of 2020 all Medi-Cal managed care plans reported slight

1 increases in their medical expenses due to an increase in member utilization of
2 services and enrollment. So compared to the first half of the year medical
3 expenses did start increasing in the second quarter, the last two quarters.
4 Most Medi-Cal plans reported net losses for the period ending
5 December 31, 2020 compared to December 31, 2019. The net losses caused
6 decline in tangible net equity reserves for a majority of the Medi-Cal plans.
7 The DMHC will continue to monitor enrollment trends and financial
8 solvency of all LIs, COHS and NGM plans reporting to the DMHC.
9 That ends my presentation. Any questions?
10 CHAIR GRGURINA: Board Members? I see Ted first then Larry.
11 MEMBER MAZER: Thanks, Pritika, for the presentation. I don't
12 know how you sift through this data because everything seems so disparate.
13 You have got the COHS that actually seem to have performed better in 2020
14 than 2019 but still lost money and it sounds like a few, a couple, had major
15 losses and some did better than that, some showing profits. I am trying to figure
16 out aside from the MCO tax and the rate reductions, and I don't remember how
17 big those rate reductions were, if they are all losing money why is a rate
18 reduction, or inversely, how much is that rate reduction causing difficulties in
19 managing, managing the dollars flowing back to patient care? What really
20 puzzles me is you've got a chart there that showed, there is something in there
21 that shows that the PMPM exceeded the medical expenses, enrollment grew
22 through the rest of the year after the first quarter, and yet they are all showing
23 these rather magnificent losses across the board with the exception of a couple
24 of the COHS.
25 So two questions. Number one, how much cash flow is flowing out

1 of the state and flowing into profit, particularly for the NGMs, that should be going
2 back into care here, particularly when there is reported loss? And aside from the
3 MCO tax and that rate reduction, is there any pattern? What are we seeing
4 that's contributing to the huge losses with increased enrollments and PMPM that
5 apparently covers their medical costs?
6 MS. DUTT: So, Ted, I want to take the PMPM question first and
7 maybe John and Larry can speak for those LIs and COHS plans they represent.
8 So, the PMPM. When you look at those, the PMPM medical
9 expenses and PMPM premium revenue, the difference is they still have to pay,
10 those plans still have to pay the administrative costs from that difference. So,
11 this is just the net of your premium revenue versus your medical expenses, they
12 still have the administration cost to pay for. John, do want to speak to the cash
13 flow?
14 CHAIR GRGURINA: Let me also just add, Ted, because you did
15 ask, you said, what was the rate reduction? The rate reduction was 1.5 percent
16 and that was decided in late June of 2020 and went retroactive to July of 2019,
17 so 1.5 percent across the board was huge. And for the vast majority of plans,
18 such as our plans and the other local plans, we did not recoup any of that from
19 the providers, that came straight out of, if you will, our reserves, which caused
20 losses. When that occurred we were pretty close to break-even for the fiscal
21 year and we ended up with over a $6 million loss, and then we continued losses
22 for another six months because those rates were reduced. So that was very
23 significant. The managed care organizations tax was significant.
24 And then each plan has something different going on in their area,
25 or perhaps their area or the rates that they are receiving are not covering the

1 cost of some special populations or new programs that were created that the
2 rates weren't matching up with, so each add a different thing. I'll stop here and
3 let Larry, if he wants to discuss and add because of his own experience being on
4 the Board at Central California Alliance for Health.
5 MEMBER DEGHETALDI: Ted, our counties are different, our
6 populations are different. And if you compare two COHS that are adjacent,
7 Health Plan of San Mateo where COVID had very little impact relative to the rest
8 of the state because of the demographics of San Mateo County; compare that
9 with the Central California Alliance for Health, which has three counties with lots
10 of ag workers, where the inpatient COVID expenses were -- the physician PMPM
11 expenses were much below budget but the inpatient costs, largely due to COVID
12 and other delays in care for at-risk populations, coupled with the decreased
13 PMPM revenue, are responsible for CCAH's troubles. So it is demographics, it is
14 risks.
15 And I would even go further, you could look at the two plan county
16 models like a Santa Clara County. As John said earlier, as you go to regional
17 rates, I am very concerned that a plan that is avoiding sicker populations might
18 do better than one that isn't. And so this is why you have to be, we have to be
19 increasingly nuanced with risk with social determinants that add to the cost to
20 care for patients. Where access is poor costs will go up. So I am just comparing
21 the world that I see around Santa Cruz. But Monterey is not Merced County, is
22 not San Mateo County. San Francisco did very well with COVID and that might
23 have helped John, but I don't know that.
24 CHAIR GRGURINA: Let me add, one more piece, Ted, was
25 additionally when the rates are set, what is called the rate development template,

1 there is 2% set aside for margin profit risk, which is you need to build that up for
2 the years when things are tough. They also reduce that from 2% to 1.5. So that
3 was a .5 point loss that was on top of the 1.5% loss so it just, it was a tough time,
4 it was a really tough time.
5 MEMBER MAZER: I --
6 CHAIR GRGURINA: Other comments, questions? I've got -- Ted,
7 you have a comment?
8 MEMBER MAZER: Just to follow-up. I appreciate the answers and
9 I understand that there's administrative costs, but I do think that this is yet
10 another evidence back to DHCS that lowering of rates puts everybody at risk and
11 the downstream patient is the one who is at the most risk. So whether we are
12 talking about the current budget or we are talking about internal regulation, every
13 time you take money off the table, even when you don't expect something like
14 COVID to hit, you are putting solvency at risk.
15 CHAIR GRGURINA: Jeff.
16 MEMBER RIDEOUT: This kind of follows on with Larry's comment.
17 Are these, the way we are looking at these plans just historical or are they based
18 in any sort of financial rules that are different for a COHS versus a NGM versus
19 somebody else? Because I think the dominant characteristic of solvency and
20 financial success is going to be related to geography and the populations being
21 served. I don't know why necessarily, and maybe there is a great reason, we are
22 looking at just COHS as a separate group and trying to draw any conclusions
23 from that, versus something maybe a little bit more specific to the population in a
24 particular geography. It feels like an artifact maybe.
25 CHAIR GRGURINA: I would say that, let me, let me guess for our

1 friends at the Department and for the Department of Health Care Services, given
2 that the models were different, and they were really different years ago, they are
3 coming closer and closer, but COHS covered a lot of things that the two plans
4 didn't. So for example, duals, long-term care. So I think that was one of the
5 reasons for taking a look at that. But things, you know, long term-care and duals
6 are supposed to be coming to the two plan models that don't have it in CCI,
7 coming in January of 2023, so things are starting to come closer together. And I
8 think that maybe what the comment that you are making, Jeff, is we need to be
9 able to take a look at everyone and make sure they are all doing well regardless
10 of whether or not it's a COHS, a two plan model, GMC model or a not-for-profit
11 or a for-profit plan participating in Medicaid.
12 MEMBER RIDEOUT: Yes, as long as sort of the definitions of why
13 one model is being applied in a region doesn't in and of itself create a difference.
14 And I know DHCS in their recontracting is looking to change which geographies
15 qualify for COHS or not so I think it would be good to get in front of that if we
16 could.
17 CHAIR GRGURINA: Other comments from Board Members?
18 I will just close with adding on to Larry's comment, this conversation
19 we are currently having is why the regional rates are so important. So you have
20 got a lot of plans who are struggling right now and if you are going to change the
21 way you do things what are the unintended consequences and who may be the
22 winners and losers? Because what DHCS has said is it's a zero sum game.
23 They are not looking to add money, they are not looking to take money away.
24 Well, if you go to a regional rate and you throw six counties in there and they all
25 have six different rates, there is going to be some changes, so we need to be

1 very careful about doing and implementing this in the next couple of years. And
2 we on the Financial Solvency Standards Board along with DMHC have got to be
3 taking a closer look at the plans and making sure that they are solid because
4 when you look at the local plans, they are covering more than 70% of the Medi-
5 Cal managed care population.
6 Ted?
7 MEMBER MAZER: Yes, I had asked another question there that I
8 didn't hear any response to and that's looking at the NGMs, how much cash has
9 been flowing out while they are reporting these losses? How much cash has
10 been flowing out to their parent company and shareholders that is not being
11 reinvested in health care?
12 MEMBER DEGHETALDI: Can I restate? I was going to ask, what
13 is the MLR when you compare the two different plans?
14 MS. DUTT: We can take a look at the MLRs. For the dividend
15 information, we included that, it's on pages 24 and 25. So there were a couple of
16 plans that paid dividends to their parent companies for the entire 2020. One of
17 them was Molina, the other one was Health Net.
18 CHAIR GRGURINA: And then, Pritika, could I just add one thing
19 because I believe you had it in there and you said it orally but there was a slide
20 that said there was a plan that, not a local plan but a plan that was at 98% TNE,
21 which sends up huge red flags. But what you did is you did orally say that that
22 was because of some liability they set aside, they got a cash infusion, and I
23 would assume they are above 200% TNE and not on the watch list where they
24 need to come visit Mary and you in Sacramento and explain what they are doing.
25 Did I get that correct?

1 MS. DUTT: So that was Molina. They called us in January and
2 they -- the parent company made the capital infusion and they corrected the TNE
3 deficiency immediately.
4 CHAIR GRGURINA: All right, thank you. It is important to note
5 that because if there was a plan at 98% TNE that is a huge signal of problems. I
6 can recall years ago when things were tough, this was quite a while ago, where
7 we were told that if you get below 200% get yourself and drive out to
8 Sacramento and sit down and explain yourself and put your budget together
9 about how you are going to get out of this trouble. So, I just wanted to make
10 clear for folks that while the slide said that, you orally talked about, Pritika, that it
11 was taken care of.
12 MS. DUTT: So, one of the other points, John, I wanted to make on
13 Jeff's question, why we started doing this report and why it's broken out like that.
14 So we started looking at our Medi-Cal plans very closely because, as you
15 remember, historically we had some plans that were struggling financially.
16 Currently the TNE positions look really great but that wasn't the case a few years
17 back when we started doing this report. So due to the different managed care
18 models it made sense to break down the LIs and COHS into two different
19 sections. And later we realized there's other non-LI, non-COHS type plans that
20 have Medi-Cal, a lot of Medi-Cal lives, so at that point we added NGM plans in
21 the report.
22 MEMBER RIDEOUT: Pritika, my only comment was, if those
23 distinctions are meaningfully related to financial risk and distinguish one type of
24 plan from another they are worth keeping, if they are historic and there's other
25 ways to group Medi-Cal plans, maybe on geography or enrollee risk, that might

1 be worth thinking about.

2 CHAIR GRGURINA: And I would just add one more that obviously

3 we are focusing on where are concerns. I think it is also important to highlight

4 the positive which is, as Pritika had mentioned, years ago it was Alameda

5 Alliance that got into financial difficulty. And as you saw in Pritika's slide, the

6 lowest of the TNE for the Local Initiatives plans, the two model, was well over

7 500%. So Alameda has really turned themselves around, which is a very, very

8 big positive.

9 With that, why don't we go ahead and go and see if there are

10 questions, comments from members of the public for Pritika.

11 THE MODERATOR: Not at this time.

12 CHAIR GRGURINA: All right, thank you.

13 Well, thank you, Pritika, and we will go ahead and move on to

14 Michelle and the provider solvency quarterly update.

15 MS. YAMANAKA: Thank you, John. This Michelle Yamanaka,

16 Supervising Examiner with the Office of Financial Review. Today I will provide

17 you with updates for risk bearing organizations or RBO financial reporting. There

18 will be two parts to my presentation. I will begin with the financial reporting of

19 RBOs during the pandemic and then I will continue with the quarterly update for

20 the quarter ended December 31, 2020. Next slide please.

21 We reviewed the financial trends to see how the pandemic

22 impacted the RBOs financial conditions. We compiled information, the quarterly

23 survey reports for the quarter ended December 31, 2019 before the pandemic, to

24 the latest quarter of December 31, 2020. We focused our review on the grading

25 criteria and the medical expense ratio. Next slide, please.

1 So let's start with the cash-to-claims ratio. This ratio shows if there
2 is sufficient assets to cover the total claims liability. The assets used in this
3 calculation are cash, short-term investments and health plan capitation
4 receivables collectable on 30 days. The revised cash-to-claims requirement
5 went into effect October 2, 2020, so for purposes of comparative purposes for
6 quarter ended September 30, 2020 and prior we used the new cash-to-claims
7 ratio.
8 A ratio of .75 or higher represents compliance and the ratios were
9 compiled into ranges. A ratio of 2 means the RBO had twice the amount of the
10 assets to pay their medical liabilities. The data shows that the cash-to-claims
11 ratio increased for several RBOs. This is reflected through 112 RBOs, or 60% of
12 the RBOs reported a cash-to-claim ratio of greater than 2 at December 31, 2019.
13 And this increased to 158 RBOs, or 80% of the RBOs, at quarter ended June 30,
14 2020. And there was a slight decrease to 153 RBOs or 75% of RBOs at quarter
15 ended December 31, 2020.
16 Moving on to working capital, we took the relative working capital
17 ratio, which shows that the amount of current assets to cover the RBOs' current
18 liabilities. All current assets were used in this calculation with the exception of
19 current unsecured affiliate receivables. A ratio of 1 or higher represents
20 compliance. RBOs also reported higher levels of relative working capital. This is
21 reflected through 50, or 27% of RBOs, had a relative working capital of greater
22 than 2 at December 31, 2019. This increased to 90 RBOs or 45% of RBOs at
23 quarter ended June 30 and remained at 90. The percentage decreased to 44%
24 of the RBOs at quarter ended December 31, 2020.
25 Moving on to TNE. We calculated the TNE to the required TNE.

1 The revised TNE requirement also went into effect on October 2, 2020. Again,
2 for comparative purposes we converted quarter ended September 30, 2020 and
3 prior to the new reporting requirement. This slide shows that RBOs also
4 reported higher levels of TNE, above 500% of required TNE. This increased
5 from 99 RBOs at quarter ended December 31, 2020 to 137 RBOs at quarter
6 ended June 30. There was a slight decrease to 133 RBOs, or 56% of the RBOs,
7 at quarter ended December 31, 2020.
8 Looking at claims timeliness, we just wanted to provide this slide to
9 show that there has been an increase in the number of CAPs for claims
10 timeliness. The noncompliance is not due to any financial concerns, rather it is
11 due to changes in an MSO, new claims processing systems, staffing issues and
12 converting from to working at home, so there has been an increase in the
13 number of CAPs. Okay, next slide please.
14 And we also looked at the medical expense ratio. This calculation
15 shows the percentage of health care revenues that were used to cover the
16 medical expenses. The health care revenues were limited to the HMO revenues
17 and the fee-for-service revenues that were reported in the financial survey
18 reports. The data shows that the average medical expense ratio decreased from
19 87% at quarter ended December 31, 2019 to 68% at quarter ended June 30, and
20 as of December 31, 2020 it is starting to increase.
21 There were several RBOs that relied on assistance in the forms of
22 a subordinated loan, capital infusions or the use of a sponsoring organization to
23 maintain compliance with the grading criteria. The number of RBOs that relied
24 on assistance has increased from 23 RBOs at December 31, 2019 to 30 RBOs
25 at quarter ended December 31, 2020. This increase may be a part of the new

1 revised regulations in order for the RBOs to meet the new requirements. And it's
2 just important to note that without the assistance we could have had additional
3 corrective action plans.
4 Okay, so our review, just to go over the past few slides, a majority
5 of the RBOs had sufficient cash to pay their total claims liability.
6 In 2020, 90% of the RBOs had sufficient cash or current assets to
7 pay their current liabilities.
8 A majority of the RBOs had higher levels of excess TNE.
9 The medical expense ratio shows a decrease in medical expenses
10 during the early quarters of the pandemic.
11 And there are several RBOs that relied on assistance to maintain
12 compliance with the grading criteria.
13 So I want to stop there real quick before I start my presentation on
14 the quarter ended December 31, 2020, are there any questions right now?
15 CHAIR GRGURINA: Questions or comments from the Board
16 Members? One quick one, Michelle, when did the rules change to move to the
17 TNE?
18 MS. YAMANAKA: So, for the -- it was -- there was a, there was a
19 phase-in period of a year but then they went into effect October 2, 2020.
20 CHAIR GRGURINA: Okay, thanks, Michelle.
21 MS. YAMANAKA: Sure.
22 CHAIR GRGURINA: Okay, Michelle, why don't you go ahead.
23 MS. YAMANAKA: Okay. And next slide, please.
24 So for quarter ended December 31, 2020 we have 203 RBOs
25 reporting to the Department. We received 24 annual surveys for the fiscal year-

1 ends March, June and September of 2020 and we receive monthly financial
2 statements from 5 RBOs as a requirement of their corrective action plan. We
3 have five new RBOs reporting to the Department. And during quarter ended, the
4 fourth quarter of 2020, 1 RBO became inactive and we have 23 RBOs on
5 corrective action plans.
6 The next two slides are going to discuss a little bit about the
7 inactive RBOs so next slide please.
8 So we keep a running tally of the number of RBOs that we
9 inactivate. So as of December 31, 2020 there have been 114 since we started
10 receiving financial information in 2005. The inactive reasons are broken down
11 into three categories. Financial Concerns, which is at the time the RBO became
12 inactive the RBO was on a corrective action plan and there were concerns. No
13 Financial Concerns, these RBOs are meeting all grading criteria requirements.
14 And in our Other category it is really a catchall of organization; giving you a
15 couple of examples, duplicate RBO numbers, an organization become -- not
16 meeting the RBO, definition of an RBO, et cetera. So, for quarter ended
17 December 31 we had one RBO that became inactive and as you can see it is in
18 our No Financial Concern category, there is an increase of one. Okay, moving
19 on to the next slide.
20 For those inactive RBOs we also look at the enrollment assigned to
21 them. So as of quarter ended December 31, 2020 there have been 114 RBOs
22 that have been inactivated at approximately 69%, or 79 of the RBOs had less
23 than 10,000 lives assigned to them. For that one RBO that became inactive,
24 they were in the 70,000 to 100,000 category. Okay, next slide, please.
25 When the RBOs submit their financial survey reports we also

1 receive enrollment information from them. As of quarter ended December 31
2 there were approximately 8.7 million lives assigned to the 203 RBOs. This is a
3 1% increase from the previous period, and as you can see, a majority of the
4 change of that 1% increase was in the Medi-Cal and Medicare area. Next slide
5 please.
6 This slide represents the status of the survey reports that we
7 received. So, 180 RBOs reported compliance with the rating criteria
8 requirements and in that 180 there are 12 RBOs on our monitor closely; and we
9 have 23 RBOs that are reporting non-compliant with one or more of the grading
10 criteria requirements. We have 24 CAPs, however, the slide shows that there
11 are 23 RBOs on CAPs because there is one RBO that has two CAPs. And post-
12 FSSB, after a review of the quarter ended September 30th, 2020 we were able
13 to complete 13 CAPs. All of those RBOs met their final CAP and are meeting all
14 other grading criteria. Next slide please.
15 So, information regarding the corrective action plans. As of
16 December 31, 2020 we have 24 active CAPs; 10 are continuing from the
17 previous period and 14 are new. Of those 10, 9 are meeting their final approved
18 CAP and one is not and we are working with that RBO to ensure that they are on
19 track to obtain compliance very, very soon. And we have -- of those 24 CAPs,
20 23 are approved and 1 is in review.
21 For additional information regarding the corrective action plan there
22 is a report on the website titled Risk Bearing Organizations on a Corrective
23 Action Plan and this provides additional information regarding the RBOs on
24 CAPs. It lists, it includes, it is sorted by the MSO if they have an MSO and it
25 includes the contracted health plans and RBOs, enrollment ranges, the quarter

1 the RBO the CAP was initiated, the compliance status if they are meeting their
2 approved CAP, and the grading criteria deficiency. One of the things that we did
3 add that was requested from the previous FSSB meeting was an indicator so you
4 could see the cap duration, which has a little -- there's several columns, I think
5 five columns that have the quarter, the quarter ends and it has an X on when the
6 RBO was non-compliant, so that's a nice visual so you can just kind of see where
7 these RBOs are at. Next slide please.
8 To discuss the Medi-Cal enrollment, there were approximately 4.8
9 million Medi-Cal lives assigned to 88 RBOs. This represents approximately 56%
10 of total lives assigned to 203 RBOs. Of those 88 RBOs, 69 have no financial
11 concerns, 5 are on our monitor closely list and 14 were on corrective action
12 plans. Next slide please.
13 And looking at the top 20 RBOs that had greater than 50% Medi-
14 Cal enrollment assigned to them. This is approximately 3.8 million lives
15 assigned. Twelve RBOs had no financial concerns, 2 RBOs were on our monitor
16 closely list and 6 RBOs were on corrective action plans.
17 And with that, that concludes my presentation and open for
18 questions.
19 CHAIR GRGURINA: Questions from the Board Members or
20 comments? Ted, why don't you go first and then Jeff.
21 MEMBER MAZER: A comment. Number one, thank you for
22 listening the last time and giving us that historical on the review summary, I do
23 think it's really helpful. And I think I know the answer to my question. There was
24 a pretty dramatic increase to the number of RBOs that are on CAP in the last
25 quarter. Is this directly, as best you can tell, is this directly related to COVID

1 issues or is there something else going on that is causing this kind of an increase
2 on CAPs?
3 MS. YAMANAKA: You know, what we are seeing is that a majority
4 of the CAPs that have come in in the past couple of quarters are due to claims
5 timeliness. And it is not due to a financial reason at all, in fact, it has to do with
6 more an MSO issue where there was the MSO had a system conversion and so
7 it caused some delays in claims processing. So that's what we are mainly
8 seeing, yes.
9 CHAIR GRGURINA: Jeff.
10 MEMBER RIDEOUT: Hey, Michelle, another wonky question from
11 me. But in the definition of RBO are there service area restrictions or any
12 indicators for degree of clinical integration? And I don't know, but we are trying
13 to continue to correlate how you reference a risk bearing organization and how
14 we track it at IHA.
15 MS. YAMANAKA: Sure. So the definition of RBO is in the Knox-
16 Keene Act under Section 1375.4(g) and it pretty much outlines. I will just give
17 you a high level of what it is but it is really the structure. Is it a medical
18 corporation, a group of physicians that owns the organization? Do they contract
19 with a health care service plan or arrange for services for the health plan
20 members? Do they receive a capitation or a fixed periodic payment? And do
21 they process and pay claims, do they take that claims processing risk? So if an
22 entity meets all four of those requirements then they would need to start filing
23 with the Department.
24 MEMBER RIDEOUT: But you don't put any additional restrictions
25 on that, like, maybe one organization needs to file two RBO applications as

1 opposed to a single one, for instance, or a sense of whether they have
2 infrastructure for clinical management or care management? Is that not
3 something you would apply?
4 MS. YAMANAKA: No, that is not something we would apply.
5 MEMBER RIDEOUT: Thank you.
6 CHAIR GRGURINA: All right, comments or questions from
7 members of the public?
8 THE MODERATOR: Not at this time.
9 CHAIR GRGURINA: All right, thank you, Michelle.
10 MS. YAMANAKA: Thank you very much.
11 CHAIR GRGURINA: Pritika, you are back for the health plan
12 quarterly update; and I would just highlight, it is 1244. We are definitely ending
13 before one o'clock so, Pritika, if you can give us the shortened version we would
14 appreciate it.
15 MS. DUTT: John, I do hear you. I am between you and your lunch
16 so I will try to make this quick. So the purpose of this presentation is to provide
17 you an update of the financial status of health plans at quarter ended December
18 31, 2020. We have been tracking the health plan financials and enrollment
19 trends very closely and working with the plans if we see any unusual trends that
20 would raise concerns.
21 We also included a handout that shows the enrollment at
22 December 31, 2020 and TNE for five consecutive quarters starting from
23 December 31, 2019 through December 31, 2020 for all licensed health plans. It
24 is broken into three categories, full service, restricted full service and specialized.
25 As of April 27, we had 138 licensed health plans. We licensed 4

1 additional full service plans, which included 3 Medicare Advantage and 1
2 restricted Medicare Advantage.
3 We are currently reviewing 10 applications for licensure, 7 full
4 service and 3 specialized. Of the 7 seven full service, 5 are seeking licensure to
5 offer restricted Medicare Advantage products and 2 for restricted Medi-Cal. For
6 the 3 specialized, 1 is looking to get licensed for dental and 2 for EAP.
7 At December 31, 2020 there were 27.75 million enrollees in full
8 service plans licensed with the DMHC. Total commercial enrollment includes
9 HMO, PPO, EPO and medicare supplement. Total government enrollment
10 includes Medi-Cal and Medicare enrollment. Total full service enrollment
11 increased by 1.2 million lives since December 31 of 2019. Medi-Cal plans added
12 over 1 million lives, while commercial enrollment increased by 160,000 lives.
13 Next slide.
14 This slide shows the makeup of the HMO enrollment by market
15 type. All markets saw a slight decrease in HMO enrollment except the small
16 group market. Overall, HMO enrollment decreased by 90,000 lives when
17 compared to the previous quarter. Large group HMO enrollment dropped below
18 the 8 million mark so that was the interesting observation we made, that it was
19 holding steady at over 8 million lives, so the large group market now is below the
20 8 million mark at December 31, 2020. Next slide.
21 This slide shows the makeup of PPO/EPO enrollment. As you can
22 see on the table, the large group, small group and individual PPO enrollment
23 remained consistent for the most part, so just changing just by 10,000 here and
24 there.
25 This table shows government enrollment, which is Medi-Cal and

1 Medicare. Overall, the government enrollment increased December 31, 2020, a
2 trend we saw for the last three quarters of 2020. The majority of the increase in
3 the government enrollment was due to Medi-Cal enrollment, which increased by
4 290,000 lives from the third quarter to fourth quarter.
5 We are currently monitoring 29 health plans closely, one less than
6 last quarter, due to various reasons, including but not limited to declining
7 financial health, issues with claims processing, issues identified during our
8 financial audits, newly licensed health plans, concerns with parent entity, low
9 enrollment, and there's other reasons why we may have someone on the watch
10 list. There were 4.5 million enrollees enrolled in the closely monitored full service
11 plans. Of the 25 closely monitored full service plans, 13 are restricted licensees
12 and had less than 1 million enrollees. Next slide.
13 Three full service health plans did not meet the Department's
14 minimum financial reserve or tangible net equity requirement.
15 Molina Health Plan of California, they reported a TNE deficiency at
16 December 31. As I mentioned during the Medi-Cal presentation, the plan's
17 parent quickly made a capital contribution and that TNE deficiency was remedied
18 in January.
19 Golden State reported a TNE deficiency at December 31, 2020.
20 The plan has not cured the TNE deficiency as of as of today. We are getting
21 weekly updates from the Plan. Per Golden State, it is working on getting
22 additional funding to cure its TNE deficiency. On April 27, 2021, the DMHC's
23 Office of Enforcement issued a Cease and Desist Order that prohibits Golden
24 State from accepting new members effective May 1, 2021. CMS has placed a
25 similar sanction on Golden State based on DMHC's C&D order.

1 So one point I wanted to make, both Golden State and Vitality are
2 Medicare Advantage plans and that is why we have to work with CMS on those,
3 any enforcement action we take there.
4 And then on Vitality, they remain TNE deficient and we continue to
5 work with CMS. As I had mentioned at previous meetings, the Department's
6 Office of Enforcement had issued a Cease and Desist Order on June 30, 2020
7 that prohibits Vitality from accepting new members effective July 1, 2020. And
8 then due to the severity of Vitality's TNE deficiency and financial viability
9 concerns the DMHC issued an Accusation on July 31 to revoke Vitality's license.
10 And then in December of 2020 Vitality notified the DMHC that it had filed a
11 Chapter 11 bankruptcy; so our Office of Enforcement has been in
12 communication with Vitality's bankruptcy attorney. At March 31, 2021 Vitality's
13 enrollment has further dropped to 821 enrollees. And we have been in
14 communication with Vitality's bankruptcy representatives who are looking for
15 buyers that would be interested in purchasing Vitality.
16 So for both Golden State and Vitality they cannot add any
17 additional enrollees because of the Department's C&D Order.
18 This chart shows the TNE of health plans by line of business. A
19 majority of the health plans with over 500% of required TNE are specialized
20 health plans. Again, reminding here that the higher TNE for the full service, the
21 required TNE for the full service plans is higher because their medical expenses
22 or risk they take is higher so they are subject to a higher reserve requirement.
23 For most plans the TNE is driven by medical expenses and the higher medical
24 expense the higher the required TNE. Next slide.
25 This chart shows the TNE of specialized service plans by

1 enrollment category. Thirty-seven plans, or over half of the total licensed
2 specialized plans had TNE over 500%.
3 This chart shows the TNE of full service plans by enrollment
4 category. Sixty-one health plans, or over half of the total licensed full service
5 health plans, report a TNE of over 250% of required TNE.
6 And then this chart shows the breakdown of the 21 full service
7 plans in the 130% to 250% range. If a plan's TNE falls below 130% of the
8 required TNE the plan is placed on monthly reporting. We also monitor the plans
9 closely if we observe a declining trend in their financial performance. We see a
10 declining trend in their TNE, net income, enrollment, other financial matrix, or if
11 we hear about claims concerns we start working on those plans sooner rather
12 than waiting for the 130% mark.
13 This chart shows the TNE by line of business for plans that are
14 being closely monitored. So there are two plans that are being monitored
15 closely. They are on, they have more than 500% of required TNE. Again, as I
16 mentioned, they could be a newly licensed plan or we had claims concern that
17 we discovered during our financial exam. Next slide.
18 This chart shows the TNE comparison for full service plans from
19 quarter end December 31, 2019 to December 31, 2020. At quarter ended
20 September 30, 2020 there were 43 plans with TNE to required TNE of over
21 500%, compared to 38 at December 31, 2020. As I mentioned earlier, we had 3
22 plans that were TNE deficient at quarter end December 31, 2020. There are
23 some plans that have non-Knox-Keene, non-health plan business so they
24 combine all their business. So if a plan is doing the health plan side of business
25 and then they have other non-Knox-Keene or administrative service-only type of

1 lives they are all reported in their financial information. For example, Kaiser's
2 financial results includes financial information for Kaiser hospitals as well as
3 Kaiser's out-of-state health plans.
4 So that brings me to the end of the presentation. Any questions?
5 CHAIR GRGURINA: Questions, comments from the Board
6 Members?
7 Okay. If none, any comments or questions from members of the
8 public?
9 THE MODERATOR: Not at this time.
10 CHAIR GRGURINA: Great, thank you.
11 And thank you, Pritika. Thank you for your lovely comment at the
12 beginning that you would go quickly so I could get my lunch. That wasn't exactly
13 what I meant, I was more concerned about folks' schedule; but that's okay, I'll
14 look forward to that.
15 So a couple of quick things before we go. First of all, are there any
16 public comments on matters that were not on the agenda?
17 Okay. If not, Board Members, anything that you would like added
18 to future agendas outside of the conversation we had before that Larry was
19 discussing and others of you? Mary has her hand up.
20 MEMBER WATANABE: Yes, if I could just really quickly maybe
21 flag what we will have on the agenda for the next meeting, which is Jeff,
22 hopefully, you are willing to present the Atlas results again. Our August meeting
23 is a little bit of a lighter meeting so if you have suggestions, let me know. Our
24 November meeting is when we will have the Medi-Cal report, we will have rate
25 information, we will have MLR, so the November meeting will be the really meaty

1 one.

2 I will just ask too that if the Board has specific things you would like

3 DHCS to talk about, let us know, because we do kind of prompt them in advance

4 and I know there is a lot going on with re-procurement and rates. Pritika and I

5 were chatting a little bit that I think in the future when we present the Medi-Cal

6 report we will see if we can put that after the DHCS update and have them stick

7 around to help answer questions, because some of your questions would

8 probably, it would be very helpful to have DHCS here to help answer. And just

9 thank you all for your patience with a very heavy, information-heavy agenda

10 today. Thank you, John.

11 CHAIR GRGURINA: All right, thank you, Mary. So just as we get

12 ready to close, a reminder that our next meeting, which Mary promises will be

13 lighter, will be August 11. It will continue to be on video. And then as Mary

14 promises us, we will have a very heavy November agenda, which I believe will

15 most likely be on video as well.

16 And so lastly, a special thank you to Sarah Cain, Sara Ortiz and

17 Jordan Stout for all the work behind the scenes to make this work, because if

18 this was left to me I don't think we would have been live for five minutes.

19 So thank you, everyone, for a very heavy agenda, all the

20 comments, questions. Actually enjoy and have a good time as we roll into the

21 summer and continue to stay safe. Thank you, everyone.

22 MEMBER WATANABE: Thank you.

23 (The meeting was adjourned at 12:56 p.m.)

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1 CERTIFICATE OF REPORTER

2

3 I, RAMONA COTA, an Electronic Reporter and Transcriber, do

4 hereby certify:

5 That I am a disinterested person herein; that the foregoing

6 Department of Managed Health Care, Financial Solvency Standards Board

7 meeting was electronically reported by me and I thereafter transcribed it.

8 I further certify that I am not of counsel or attorney for any of the

9 parties in this matter, or in any way interested in the outcome of this matter.

10 IN WITNESS WHEREOF, I have hereunto set my hand this 17th

11 day of June, 2021.

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15 ______________________________

16 RAMONA COTA, CERT*478

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