STATE OF CALIFORNIA

DEPARTMENT OF MANAGED HEALTH CARE

# FINANCIAL SOLVENCY STANDARDS BOARD (FSSB) MEETING

ONLINE/TELECONFERENCE MEETING

HOSTED BY THE

DEPARTMENT OF MANAGED HEALTH CARE

SACRAMENTO, CALIFORNIA

WEDNESDAY, AUGUST 19, 2020

10:00 A.M.

Reported by: Ramona Cota

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# APPEARANCES

## BOARD MEMBERS

John Grgurina, Jr., Chair

Larry deGhetaldi, MD

Jen Flory

Theodore Mazer, MD

Jeff Rideout, MD

Mary Watanabe

Amy Yao

## DMHC STAFF

Pritika Dutt, Deputy Director, Office of Financial Review

Lezlie Micheletti, Stakeholder Engagement and Outreach Coordinator

Sara Ortiz, Associate Governmental Program Analyst

Sarah Ream, Acting General Counsel

Michelle Yamanaka, Supervising Examiner, Office of Financial Review

## ALSO PRESENTING/COMMENTING

Anastasia Dodson, Associate Director of Policy
Department of Health Care Services

Kirk Davis, Deputy Director, Health Care Delivery Systems
Department of Health Care Services

Diana Douglas
Health Access California

Bill Barcellona
America's Physician Groups

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PROCEEDINGS

10:02 a.m.

CHAIR GRGURINA: A couple of housekeeping notes. For our Board Members, if you can keep yourself on mute until you would like to ask a question or a comment then unmute yourself. Also additionally for all of us, think the words of the day are patience, flexibility, and understanding. This is the first time we are doing this for the meeting, we are going obviously through rough times, not only with the virus, with the heat wave, the fires and potential power outages, so we are going to do the very best that we can. The Department set up all kinds of backups and we will continue to move forward through this meeting; and so we ask again for your patience, your flexibility and your understanding. Also just as a highlight, if for some reason some of you do lose power you can come back into the meeting on your phone through Zoom if you would like to do that.

We will take questions and comments after agenda items. For attendees who are on the phone if you would like to ask a question or make a comment please dial *9 and state your name and the organization you are representing for the record. For attendees who are participating online and you have microphone capabilities you could use the Raise Hand feature and you will be unmuted to ask your question or leave a comment. And if you would prefer we do have a type your question/comment in the Q&A feature that is available. All questions and comments will be taken in order of raised hands first followed by typed questions.

And then a comment for the Board Members. If you could we would like you to leave yourself on video to be able to see you but we certainly

understand the times that we are in and the life circumstances and if you need to turn it off for a reason, say a dog is barking, please feel free to go ahead and do so.

And with that we will go ahead and get started. Let's start with the agenda item, the transcripts and the meeting summary from February 5th, 2020. Do we have any questions or comments or edits from the Board Members?

Seeing none do we have a motion to move the transcript and meeting minutes forward?

MEMBER MAZER: So moved.

MEMBER DEGHETALDI: Second.

CHAIR GRGURINA: How about if, as we do it, if you could say your name as you make the motion and the second so we can go ahead and record that. I'm sorry, I apologize, I should have said that in front of that. Who was the first one who moved the motion forward?

MEMBER MAZER: Ted Mazer.

CHAIR GRGURINA: Appreciate that. Second?

MEMBER DEGHETALDI: Larry.

CHAIR GRGURINA: Larry is seconding, all right, great. Okay, all those in favor if you can say "aye."

(Ayes.)

CHAIR GRGURINA: All those opposed or abstaining?

(No audible response.)

CHAIR GRGURINA: Okay great, we move the transcript and meeting summary forward. Thank you, folks.

All right. Next we are going to go ahead and we are going to go

into the Director's remarks. But before we get started I wanted to just take a minute to say thank you for the years of service for Shelley Rouillard, for her years of fabulous service not only at the Department of Managed Health Care but at all the other departments in the state such as the old Managed Risk Medical Insurance Board. Really appreciate where Shelly took the department, her work with her staff, the work on all of the projects going forward such as the Provider Directory and the ones that we continue to work on. So we wish Shelley all the best in her retirement.

With that I am going to go ahead and also say a special thank you to Mary Watanabe who is the Acting Director of the Department of Managed Health Care. We are all very grateful for you stepping up, Mary, as I know you still continue to serve multiple roles. So with that I am going to go ahead and turn it over to Mary.

MEMBER WATANABE: Thank you, John. You know, we are certainly in unusual times. I was reading through the February transcript to try to get caught up on kind of just where the Board has been and been talking about and just it really struck me how much our world has changed just since February. We obviously were hoping to have a May board meeting and that just wasn't feasible with everything going on but I know Shelley was hoping to kind of close out her time at the Department and share some of her accomplishments that she has been very proud of but, you know, we obviously will continue that great work at the Department.

I will start by I guess addressing the elephant in the room and the question I am sure many of you have, which is what is going on with our executive leadership team and the permanent appointment of a director. I guess

what I will say is I don't have much more to share other than, you know, I have been appointed the Acting Director for now. There's obviously a lot of things going on so I can't really tell you where things sit at the Governor's Office in terms of appointing a permanent director.

But what I can tell you is that I am not planning to go anywhere. I am passionate and committed to the Department and the work that we do. I also have a fantastic leadership team, which you have had the pleasure of seeing many of them present here at the Board. They continue to step up and support me and continue the great work of the Department. We have not even had the opportunity to skip a beat with Shelley's retirement in the middle of July. We have been incredibly busy responding to COVID-19 and just with our regular work as well. So we will continue doing some great work here at the Department until such time that the Governor's Office appoints a permanent director.

I am just going to make a quick note. I know there's a few people trying to dial in on the phones. There may be some issues with the phones and we will work through that.

I wanted to talk for a minute just about kind of the impact to the Department and the organization with COVID-19. We have about 98 percent of our staff are currently teleworking. In March we made the decision very quickly to prioritize the health and safety and well-being of our employees and so within about a 24 to 48 hour period we transitioned all of our staff into teleworking. I want to acknowledge our Office of Technology and Innovation, our Office of Administrative Services, for the huge lift to get 450 people out of the building and really to protect our staff. So we are adapting to this new remote work environment as I can see many of you are as well. We are currently planning to

telework, continue teleworking, at least through the end of the year, likely longer.

We do have a handful of staff that continue to come into the office in some frequency to open mail and perform critical functions that need to be done in the office. I will say I think we have all been surprised by how well we have done teleworking; it may be the wave of the future for many of us. I think in many ways we have actually been more productive and so we have not seen a drop in any of our productivity levels. We are being forced to be innovative and creative in how we do some of our work like our financial exams and medical surveys because we are not traveling, as well. So I just wanted to give you a quick update on where we are as an organization.

I also just want to highlight, we had the state of emergency that was declared. I know many of us are dealing with wildfires in our area. We did just post to our website a fact sheet about our expectations of health plans and how we can help consumers who are impacted by the wildfires. So for any of you that are helping consumers navigate this very challenging time we do have some information we just put on our home page at healthhelp.ca.gov.

We shared with our Board Members a link to our 2019 annual report. This is a huge lift for the Department that every year we put out our annual report. We released the 2019 report in June, it's on our home page as well, for anybody else that would like to review it. I would encourage you to take a look at it. It seems like a distant memory right now but it really, it highlights the great work that we did last year. We have information in there on IMRs and complaints through our help center and independent medical reviews so there's some great information in there.

I also wanted to provide a quick update on our Health Net

encounter data project. I think you know this was a priority for Shelley during her tenure at the Department. At the February meeting she had mentioned that there had been workgroups around governance, state of standardization and training and technical assistance that had been meeting for the past year. This work was to culminate in a closing summit on March 30th in Sacramento and obviously that didn't happen. I am excited though that Health Net actually continued with that work. The workgroups did some great work. There was a virtual summit that was held on August 7 and I had an opportunity to attend that as well. I was very impressed by the continued engagement across the industry and the work that continues.

I reiterated, I think, that the urgency of tackling this huge industry issue around encounter data seems even more important now as we try to understand utilization and the long-term impact of COVID-19. I think we are all also very mindful that we have pushed much of our care into telehealth and so it is going to be very important that we understand the impact on consumers and health and quality as we have changed how health care is delivered and encounter data plays an important piece in that. And that is separate from some of the other areas where encounter data is critical to rate setting and premiums and all of those other financial pieces. So I am excited that that work is continuing.

The next step is Health Net will be releasing a request for proposal for a nonprofit entity to serve as kind of the governing body for this work. They will be charged with prioritizing, overseeing, coordinating and monitoring encounter data improvement across the state. There's also some work to get an RFP out to focus on technical assistance and training. And Health Net has also

made some investments with the encounter data funds to support quickly moving providers into kind of that expedited funding for telehealth as we really needed providers to move quickly into providing services via telehealth over the last six months.

I also want to provide a quick update on AB 731; we talked a little bit about this in the past. Last year the Governor signed AB 731, which expanded the rate review practice that the state already has in place for individual and small group and expanded that for the large group market. Starting this year plans will be submitting large group rate information to us. We worked very closely with the Department of Insurance to develop a template and we released those earlier this year. We will be reviewing the methodology assumptions and factors used by plans to determine premium rates in the large group market and we will have -- that first submission is due to us on September 2nd so we are excited about the expansion of our rate review program into the large group market.

Just a quick note, you probably have all read the news about Covered California's rates. That Covered California released their preliminary premium rate information for 2021 and they are citing an average statewide rate change of .6%, which is the lowest increase since the exchange was established in 2014. We are currently reviewing the 2021 rate filings in the individual market and we have -- I will be talking a little bit more later in the agenda about some of the financial indicators that we are looking at including rates, and so we will talk a little bit more about that later in the agenda.

The last item I wanted to talk about was our board member terms. You may recall that each board member serves a term of three years. And with

the exception of Dr. Mazer and Jen I think the rest of our board members' terms ended at the end of last year and you all graciously agreed to extend your terms for a year as we knew this was going to be a year of transition. We did not anticipate what this 2020 has brought in the form of everything else that we have been dealing with for the last six months but really wanted to acknowledge and thank all of you that have agreed to stay on. We have decided to go ahead and move forward with a solicitation to recruit new board members for those positions that the terms have expired, with the goal of kind of having that finalized by the November board meeting and have the new members start in the next year.

I will say for any of our board members whose terms are expiring if you are interested in staying on you can reapply. I am happy to talk to any of you about what that might mean for your own personal situation and what that continued commitment might look like. So just know for those joining from the public, if you have an interest in joining the board watch for that, we will be releasing that, we will send that out to our listserv here probably in the coming month. So thank you again to our board members that have agreed to stay on to give us some continuity through this year.

And with that I am going to pause and take any questions from the Board.

CHAIR GRGURINA: Okay, well thank you, Mary. And before we take questions I will apologize. This is the difference of being in video versus being in person. In person we are supposed to do introductions and I usually forget that and Shelley kind of leans over and says, John, introductions. So what I'd like to do is I will call on the member, board member, and if you could just state your name and the organization that you represent. Why don't we start

with Amy; welcome, Amy.

MEMBER YAO: Hi, everybody, this is a new way. I'll introduce myself. My name is Amy Yao, I am from Blue Shield, and I am the chief actuary of Blue Shield.

CHAIR GRGURINA: Thank you, Amy.

Jen, how about you?

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

CHAIR GRGURINA: Thank you, Jen.

Jeff.

MEMBER RIDEOUT: I am Jeff Rideout, I am the CEO of the Integrated Health Care Association.

CHAIR GRGURINA: Thank you, Jeff.

All right, Ted.

MEMBER MAZER: Ted Mazer, I am an independent physician in San Diego, former president of the California Medical.

CHAIR GRGURINA: Thank you, Ted.

Larry.

MEMBER DEGHETALDI: Larry deGhetaldi, family physician, the Sutter Health PAMF CEO in Santa Cruz County.

CHAIR GRGURINA: All right, thank you, Larry. And I apologize, folks, Mary's reach wasn't able to get me quick enough. All right.

With that, do any Board Members have comments or questions on Mary's presentation and update from the Department?

MEMBER RIDEOUT: John? Go ahead, Larry, I think you --

MEMBER DEGHETALDI: Mary, I am very interested in the risk adjustment transfer data as it comes out in early July and its potential impact on pricing in the exchange. And at some point, I know not today, but I think that's a very important topic to keep track of.

MEMBER WATANABE: Yes. I will say, I will -- when we talk about our response to COVID-19 I am going to talk about medical loss ratio and individual and small group market rates. But there's -- I will tell you that the November board meeting is one you won't want to miss. We will have our typical presentations on the rates and the individual and small group market risk adjustment transfer medical loss ratio. It is, we will talk about this later but really this month is when we are really starting to get some of the early indicators of the impact to rates for next year. And just the financial impact of even COVID on the plan and RBO financials too. Thank you.

CHAIR GRGURINA: Jeff.

MEMBER RIDEOUT: Mary, in reference to the encounter data summit that you discussed, one of the comments you made in the general session was that as a consequence of COVID there was a movement of individual practice physicians toward capitated groups. Could you give a little bit more color on that because I found that a fascinating consequence of what we are going through but it has obviously huge implications for accurate affordability assessments and encounter data information as well.

MEMBER WATANABE: Sure, yes. I will talk a little bit later about the all plan letters that we have issued in response to COVID-19 and one of those was to ask the plans how they are supporting their provider network. I think we all share the concern that when we come out of this we need to make

sure that the plans still have an adequate network of providers. But also right now we need to make sure that consumers are not delaying or putting off care and really that support of providers is really critical.

So we issued an all plan letter to ask the plans how they were supporting their provider network and there were a wide range of things that they are doing from grants, low interest loans, providing PPE, and we have heard about some plans moving providers that have historically been on fee-for-service into capitation. And so as we see some of that happening and this is really to give them a sustainability source of income to keep them keep the doors open. Obviously the move to telehealth and really allowing providers to provide care that they were doing in person via telehealth with the payment parity there is really important.

But I think where the impact to encounter data is really important is we have heard even from those provider offices that have been on capitation that have been submitting encounter data, there's a lot of confusion about the importance of accuracy and timely submission of encounter data. And so now we may have providers that are moving into this world for the first time so I think that's where that training and technical assistance is going to be very critical. I don't know how expansive that move to capitation is but the fact that we have heard that it is happening, it highlights just that this is going to be important.

CHAIR GRGURINA: Ted.

MEMBER MAZER: Thanks. Mary, first of all, congratulations and condolences on your promotion (laughter).

MEMBER WATANABE: Thank you.

MEMBER MAZER: And I was going to bring this up a little bit later

but you've kind of touched on it now. And that's, there is this movement towards capitation which gives a cash flow, but we are also now seeing some capitated plans, Community Care in particular, notifying providers, primary care providers that they are going to flip them to a fee-for-service. And these are primary care providers who are dependent upon that cap check. So I think as we get more data, and unfortunately the data we are seeing today is about five months behind, and see what the implications of COVID have been, I think the Department needs to have a very keen eye on where the cash flow is going and whether RBOs, MSOs or plans are taking money off the table from providers just at the time that the providers really need that cash flow to stay afloat during the whole COVID crisis.

MEMBER WATANABE: That's very helpful, yes. I think the delay in the data is making this very challenging because what really, you know, we have as of last month is really for last year and the first quarter. But that is actually very helpful, we had not heard about that happening. So I think the more you all in the public can share with us about what you are hearing that's happening will be very important as well. Thank you.

CHAIR GRGURINA: Any other comments from Board Members? Jen.

MEMBER FLORY: Two things. One on the Covered California piece, we were happy to see the top line that, you know, it was the smallest increase that we had seen. But when you look how that splits up across the state, we are still seeing the north/south divide. And I think it was in Santa Clara in particular where there were actually significant rate increases. So we are glad that you are still doing your review and, you know, we will be following to see

what exactly is going on there.

And then the other thing with the encounter data, we have been following the telehealth conversation pretty carefully and we are curious to understand better how the encounter data can give us a better idea of what's actually happening with telehealth. You know, we see some real positives for consumers from it in certain areas, giving them increased access particular while people are scared to go to the doctor. But we also, you know, we have some concerns that you know, in some cases, it is not appropriate or some consumers might kind of start down a telehealth paths and never realize that there's an off-ramp. So we are curious to see how that can be used and if there can be further kind of studies of it done because we know that there's a lot of interest in making some of the telehealth provisions permanent.

MEMBER RIDEOUT: John?

CHAIR GRGURINA: Yes, Jeff.

MEMBER RIDEOUT: On that point from Jen, just so the Committee knows, we actually submitted a grant with Rand to AHRQ as a supplement to some work we have been doing with them for a few years to look at just those very issues. So if it gets funded that's great, if it doesn't get funded we still have essentially the research protocols to look at that and we plan to do it as just sort of our contribution to the thought leadership. We are also working around other issues of utilization related to pre-post COVID, especially around sort of what types of delivery systems seem to react and respond the best to it, you know, on a distribution. So hopefully we will have some of that available.

And the other thing, Jen, that you mentioned about the rates. Again, the top line for the exchange is great. We had seen, I think all of us in the

past, that the rate increases tended to track also where there were integrated groups available within the plan networks, so maybe as a request there could be a little bit of analysis of that. And I know Covered California has come a long way to moving toward more integrated care delivery options within the exchange so it'd be interesting to track whether that's another factor that is impacting rates differentially.

CHAIR GRGURINA: Thank you, Jeff.

MEMBER YAO: Oh hi, John. I'd just like to give a comment on the rates. I thought we were going to have a later session to discuss, but I this is so interesting so just to provide my perspective. I think the, I think the low rate increase is also reflecting, you know, we all understand the importance of affordability to the members, especially during the difficult times. But there are some key drivers of the low rate increase for 2021. I think one is the good work Covered California has done expanding the subsidies for the members and reinstating the individual mandate so we do expect there's more healthy members into the market.

Secondly is because of the economic situation. We do think there's going to be more people from the employer market, especially from small business, shifting into the individual market and that's going to also improve the population risk of that market.

The third one is the health insurance tax and it is going away in 2021 so that also helped with the competitive rate.

So, Larry, you asked about the risk adjustment, risk transfer. We did a -- at least at Blue Shield we try to really factor in the whole month into the rate as accurately as we can and now really try to make it as affordable as we

can. The last piece is on the COVID is still a big unknown. I think for most of the plans, if you look at their rate filings, didn't price for the potential implication for 2021. We know it is a big unknown but I think we are willing to take some risk on that and to see how it play out, even though there is not a consensus. Their loss status, even including Covered California, are talking about there potentially could be a rebound of utilization in 2021 but we are not factoring that into the 2021 rates.

MEMBER DEGHETALDI: To follow up on Amy's point on the risk adjustment transfers. And Blue Shield, Amy, it is clear from looking at the data, probably cares for more complex and sicker Californians than other plans when you look at the aggregate data. And I think more transparency on what the actual risk adjustments are in different regions, because I am concerned that the risk adjustment methodology, which is the Medicare HCC codes, you know, that we talked, about may not be adequate to properly make whole those plans that are caring for sicker patients.

And then to Jen's point on Northern California/ Southern California, I think we need to be a little more sophisticated and look at the wage differentials and sort of the cost elements that are part of the driver between -- and that may sound like an excuse for the Bay Area, but we have much higher health care costs due to wages.

CHAIR GRGURINA: Okay. And I will remind all of the Board Members that at the end of the meeting we have an opportunity to add topics we'd like for the future. We have already heard about risk assessment. Mary's already told us that they are going to be bringing us the small group and I believe large group rates as well so that's not a meeting anyone is going to want to miss.

Any other comments for Mary on her updates?

Okay, why don't we go ahead and let's move on to our folks from Department of Health Care Services. So we have Anastasia Dodson and Kirk Davis; I am not sure if Kerry Landry is with them as well. So, Anastasia, I am going to go ahead and turn it over to you, thank you very much.

MS. DODSON: Thank you. Good morning. Yes, we are pleased to be here. Kerry actually, she's on another call with our Medi-Cal managed care plans just at this same time but I am very pleased to introduce Kirk Davis. He just started here at the Department of Health Care Services in early August and he is our new Deputy Director for Health Care Delivery Systems. He has got many years of experience in post-acute care and so we are -- I am pleased to have him on the phone and I don't know if he wants to say a word or two? I don't know if the Zoom is working right for him. But at any rate, we are very pleased to have Kirk here.

And then -- I am still at DHCS and I will be working, so for the last six months or so I have been doing double duty working in my regular job in the Director's office and also as the Acting Deputy, so now I will be still at DHCS but just with one job in the Director's Office supporting our new Director, who is Will Lightbourne; he started in mid-June. I am sure many of you know him or know of him. He was the director of the California Department of Social Services for eight years and also the Santa Clara County Social Services Agency Director. His focus here at DHCS, his priorities are around reducing health disparities, addressing poverty, and of course, addressing the COVID pandemic. And in many ways his -- What many of you may have heard him say before is he thinks there's sort of three pandemics, COVID and health disparities and poverty, and

all three of those issues are greatly impacting our Medi-Cal beneficiaries and so our efforts at DHCS should be addressing all three of those areas. So we are very pleased to have to have Will here.

In the meantime, we have been very busy over the last few months. I apologize for not having detailed slides but I think we can go through several of these topics. You may have already seen the guidance and information that we have presented on these topics in other stakeholder meetings so I will just sort of hit the high points on each of these areas and certainly if there's questions I am glad to provide any information that I have. And some of the topics if there's more detailed questions I will need to get back to you based on consulting with colleagues.

But as far as our response to COVID, of course we have been working very closely with the Department of Managed Health Care, with Shelley and Mary and all the wonderful folks there, also the Department of Public Health CDPH, and of course our managed care plan partners, Medi-Cal providers, counties, advocates, provider associations, it has been a collaborative effort for many months.

We obviously recognize there's a significant impact on Medi-Cal beneficiaries, you know, those who have had COVID and family members with COVID plus the stay-at-home efforts and directives, the impact on children of distance learning and not going to their usual activities, the increase in unemployment and the delay in medical procedures and preventive services. The isolation of older and at-risk beneficiaries at home and those who rely on home community-based services as well as those who are in assisted living or skilled nursing facilities have been greatly impacted, so we greatly recognize the

human toll.

We have been working with our federal partners to get flexibilities as far as things like telehealth and expedited provider enrollment procedures. But we have also been working to make sure that our managed care plans are providing communications out to beneficiaries and particularly those at risk.

On the federal flexibilities, we had state flexibilities through an executive order but also the federal flexibilities have ranged from waiving face-to-face requirements in Medi-Cal for things like risk assessments and state fair hearings. We have provided direction to our managed care plans as far as telehealth, authorizing telehealth and directing them to authorize telehealth for their providers, as well as making sure that payments to providers for telehealth are equivalent as in-person types of visits. That includes FQHCs, as well.

We got federal approval for the establishment of a new presumptive eligibility group for the uninsured to cover COVID testing and treatment. We have had federal approval and state approval for increased payments to skilled nursing facilities to recognize their increased costs. And we have had flexibility on the fee-for-service side to waive prior authorization in order to ensure access to medical and pharmacy services, and we are trying to minimize administrative burdens for health plans and providers by conducting activities virtually or delaying them in terms of audits and site reviews.

And then I assume you are all aware that eligibility rules, there's no discontinuances right now for Medi-Cal beneficiaries due to the enhanced FMAP requirements from the federal government.

So those are some of the key areas that we have been working on.

In terms of COVID testing, we recently released guidance to

managed care plans. There has been quite a bit of discussion about what is authorized and what should be -- what our guidance should be to managed care plans on antibody testing as well as the testing for COVID, so we released guidance on that topic.

We also launched a Medi-nurse phone line for fee-for-service and uninsured individuals. So as you know, individuals who are enrolled in a Medi-Cal managed care plan have access to a 24/7 advice line; but those who are in Medi-Cal fee-for-service previously have not had access to something like that as well as folks who are uninsured. So we have that Medi-nurse phone line where callers can speak to a nurse about COVID symptoms and receive advice on staying home as well as advice on how to enroll in Medi-Cal or find a provider. We mailed notices to all Medi-Cal beneficiaries in May with information on testing and coverage.

We have partnered with managed care plans and encouraged them to do more outreach and communication on addressing delayed preventive care, especially childhood immunizations, and we are renewing our efforts there as well as on flu vaccinations in partnership with the Department of Public Health and DMHC.

And finally, we have had a strong focus on behavioral health needs and utilization. We have new online resources and hotlines for emotional support. We have had flexibilities with regard to provider enrollment and payment for mental health providers and we did receive a FEMA grant award to support Cal-Hope, which is a warm line for peer support, and an expanded media campaign. So I will pause there on the COVID topics before I go on to CalAIM and our 1115 waiver extension. Any questions or comments on the

COVID update?

CHAIR GRGURINA: Jen.

MR. DAVIS: This is Kirk. I am back on, I just -- I got kicked off.

MS. DODSON: Great, Kirk.

CHAIR GRGURINA: All right, Jen.

MEMBER FLORY: This is Jen from Western Center. I just wanted to thank the Department for a lot of fast work that was done on COVID. And just to make sure that it is clear to everybody on the Board, there should be nobody in California who is not getting testing or treatment for COVID because Medi-Cal has a program that covers people who are uninsured, it will cover people who are undocumented, and we have our regular Medi-Cal program. So just -- there was a lot of work to get that to happen, even a bit ahead of the feds. And so we really appreciate the work on that and we look forward to continue working with the Department on making sure that we actually get people enrolled and through the door.

CHAIR GRGURINA: Ted.

MS. DODSON: Absolutely.

MEMBER MAZER: The only comment is dealing with telehealth within the managed care, in particular the managed care Medi-Cal side, there was a lot of confusion initially on the provider side and on the plan side about how to code for telehealth, whether the modifier indicated that you're doing it onsite/offsite for your office. Some of the plans have still not adopted the full payment for telehealth as if you are in your office and I am wondering if you're tracking any of that at this point in time? I don't think there's a state mandate that they have to but most plans, commercial plans, Medicare, have adopted that

in order to support telehealth. Is there anything on the state level that is requiring or certainly strongly requesting full payment rather than facility-based payment?

MS. DODSON: Yes, and that is in our -- we actually just released a revised version for our all plan letter 20-004. I would have -- it is kind of -- it has gotten lengthy now but I am 90 percent sure that's in there. So yes, let's see, it is on page five and six. We'd be happy to provide any technical clarification on that. We do want to make sure -- because we know that it is essential that our providers remain solvent and supported in this time. And you know, now and as Mary was saying, going forward after the pandemic is over, we need to have maintained our robust networks.

CHAIR GRGURINA: Any other comments or questions for Anastasia before she moves on?

All right, thank you, Anastasia, if you want to go ahead and continue, please.

MS. DODSON: Okay. So the next topic is around our CalAIM initiative and our 1115 waiver extension. So as you probably know, last year in 2019 we launched an effort for the renewal of our 1115 waiver. The current 1115 waiver is called Medi-Cal 2020 and it was set -- it is set to expire on December 31st, 2020, this year. And so we started -- we announced and posted an extensive document that describes the various initiatives under CalAIM and CalAIM is the name for our next 1115 waiver. And what we had proposed last year was to actually in addition to a new 1115 waiver we would also transition our managed care program into a 1915(b) waiver, which is the type of waiver that several other states use for their Medicaid managed care programs.

So it was quite an ambitious initiative led by our state Medicaid Director Jaycee Cooper. We had a number of stakeholder groups and stakeholder meetings throughout the fall and the winter and we were getting ready to -- we got a lot of excellent stakeholder feedback and so we were incorporating that feedback into the version that we would be submitting to the federal government; and then of course COVID and the pandemic began in March.

So we in basically respect and response to the feedback that we got from stakeholders that there were obviously, responding to COVID is a higher priority and COVID was impacting both the delivery system as well as the administrative folks with the transition to telework, so we have delayed -- excuse me one second. We delayed the launch of CalAIM. And we have been working with our federal partners and our state partners to request an extension of our current 1115 waiver. We just had a couple of public hearings on that. And then we will be submitting an extension proposal to CMS in September 2020 to extend for one year our current 1115 waiver and then in the meantime we will continue to develop CalAIM.

And in light of, of course we have had a significant hit on our state budget so looking and partnering within the administration to see, you know, what parts of CalAIM can we go forward with in 2022? Are there things that may need to be delayed? We are in the midst of assessing that right now. But in the meantime we are extending our 1115 waiver by one year and then we will continue to work.

We know that, for example, our Whole Person Care pilots, they were successful and built important partnerships at the local level so we want to

continue that momentum, even leveraging those to respond to the COVID pandemic and finding ways for other aspects of CalAIM -- I'm sorry, other aspects of the current 1115 waiver as we look toward the transition to CalAIM to respond to COVID and to find ways to continue to engage all partners.

But given, you know, the time constraints that we all face now with all of the other priorities around COVID and you know, potentially fires, so, you know, again, we want to make sure that we are providing clarity to folks because we know that some of this is sort of technically complicated. And so we have got information on our website and making sure that, you know, we provide information at all of our regular other stakeholder meetings as well. But we don't want, we don't want to lose the momentum that we had as a department, as a state, on the success that we had in the Medi-Cal 2020 waiver and the excitement and the great thinking that we had from stakeholders on CalAIM.

So we really want to do both. We want to address the pandemic and we want to keep looking forward and ahead to delivery system reforms and incentivizing plans and providers. Again, back to our director's priorities and the administration's priorities to address health disparities and provide the right incentives for providers. So I will pause there on CalAIM and the 1115 waiver extension. Any comments on that?

CHAIR GRGURINA: No, go ahead and continue. Thank you, Anastasia.

MS. DODSON: Okay. For the Medi-Cal budget, as you all know, there was -- there has been a significant economic hit with the stay-at-home and the state budget so the administration proposed a number of reductions in the May revision. Many of those reductions were not included in the final budget but

there were some changes included in the final budget so I will just quickly hit on some of those.

We did recognize the enhanced FMAP that the state receives for our Medicaid program so we certainly reflected that in the state budget. We provided increased funding for nursing facilities in recognition of the increased costs they have had due to the COVID pandemic. We included funding for the 340 B supplemental payment pool to provide certain payments to non-hospital clinics who participated in the federal 340 B pharmacy program. We included some reductions based to reflect managed care efficiencies. So recognizing the various acuity efficiency and cost containment adjustments that are appropriate given the reduction in utilization.

The budget includes a 1.5 percent rate reduction for starting July 1st, 2019 through December 31st, 2020. It also includes a risk corridor for that period. It does not implement a maximum fee schedule for inpatient services. There's also some budget adjustments as far as hearing aids and optional benefits. Those optional benefits are maintained such as CBAS and MSSP, but there is a suspension framework for audiology and speech therapy, a couple, a few other items. So that as of December 31st, 2021 the funding will be suspended unless the administration determines that there's sufficient general fund revenue in next year's budget process. We maintained funding for Prop. 56, but again subject to suspension depending on what happens in next year's budget. We did, we did include funding in the state budget for aged, blind and disabled expansion as well as the postpartum mental health expansion and several other behavioral health counselors in emergency departments, maintaining that general fund monies.

So, with that I think I will just pause. I know there's a couple other items that we want to cover here.

CHAIR GRGURINA: Comments or questions from board members? And I think overall, Anastasia, we understand where the budget situation is and the difficult decisions that had to be made and the absolute hope that there will be some funding coming from the federal government to preclude more cuts that potentially could be on the way. So we will continue to push and try and get the best that we can to be able to protect not only California but the other states as well. Why don't you go ahead and continue on to the next topic, Anastasia.

MS. DODSON: Okay. So for Medi-Cal enrollment, we are seeing increases but, again, they are not the dramatic increases that we had all anticipated but we are continuing to monitor what's going on locally. We are not taking negative actions on Medi-Cal cases, again, related to earlier policy decisions. I do want to mention that there were some inadvertent discontinuances during the beginning of the public health emergency and so we have been addressing that with the counties. There were about 200,000 letters that were sent out to Medi-Cal beneficiaries indicating that they were discontinued, but about half of those individuals have been restored and we are working with the counties to remediate the remaining cases. Certainly working very closely with the counties. And, you know, a lot of this is related to, you know, the really significant changes that happened in March and April as far as the state and county transition to telework as well as the shift in priorities and, you know, significant shifts in policy.

So, but just overall, again, we all expected a very significant

increase. So far we are seeing a much smaller increase than we had anticipated but, you know, we are continuing to work with our partners and look at the data very carefully. We suspect that there are some factors that are going on with families and individuals, whether it is the, you know, delay in seeking care. Unfortunately, we have heard from our medical directors that there is a delay in people seeking care because of concerns about COVID in medical offices. There is also a sense that there are sort of higher priorities, particularly for low-income families, around whether it is housing or food, child care, other issues that may be a higher priority than seeking medical care. And then public charge, the guidance from the federal government that came out very closely around the time that COVID began. We think all those are factors that are suppressing Medi-Cal enrollment.

Any questions or comments on that?

CHAIR GRGURINA: Amy?

MEMBER YAO: Yes, I have one question. You talked about the wrong termination letter. Is that issue across all the counties or is it just focused in certain counties?

MS. DODSON: I am sorry, I don't have that information on which counties but we can get back to you on that.

CHAIR GRGURINA: Anastasia, my understanding it is, it is limited to certain counties, it is not across the entire state of California.

MEMBER YAO: Okay, thank you.

MS. DODSON: Thank you.

CHAIR GRGURINA: Other comments or questions from the Board Members?

MEMBER DEGHETALDI: Yes. We have observed the delay in Medi-Cal enrollment increase and maybe you know more, John, but it may simply be due to various financial incentives that are now expiring that a lot of Californians have had. When would we see the steady state now? Would it be January? When do you think we can say, this is where the Medi-Cal enrollment will end up post-COVID?

CHAIR GRGURINA: I think still unknown, Larry, still a guess as to what happens. Our situation in San Francisco is similar to what Anastasia described, which is the numbers of what we refer to as 'on holds.' Folks who haven't turned in or gotten all their information out are still being kept on the program. We are not seeing a lot of new enrollments coming in. However, what we do know in our county and many other counties is significant increase in CalFresh.

MEMBER DEGHETALDI: Yes.

CHAIR GRGURINA: So there are questions, as Anastasia said, about how much of this has to do with what are the priorities in the families, how many folks are still maintaining employer-sponsored coverage versus going in to Covered California? I think it is still an unknown as to what is going to happen as we continue to roll through this. And then as we also see, what continues to happen with the economy and those employees that continue to be, and employers who have been able to hold it together.

Jen, you have a comment?

MEMBER FLORY: Yes. I mean, in addition to the factors that Anastasia outlined, the one other factor we think that is really playing here is that this is the first big recession we have had post-ACA, and so the perception

people have about public health programs isn't necessarily that they are for them. You know, if you lost your job, you know, prior to 2014 what you were offered was COBRA and most people can't afford that when, you know, they have just had a big cut in income. So while we had a lot of outreach and a lot of heavy enrollment in 2014 when we implemented the ACA, that was, you know, that was with enrollment events, you know, big kind of huge events to get people to understand that, you know, Medi-Cal is actually for them now. So this is a different population that hasn't necessarily got that messaging.

So we have been working with the Department and with partners trying to figure out how we can better get the message out that there is a program for you. It is just income dependent, you don't have to have a qualified child, you don't have to have a disability or some of these other things that people tend to think that that's what Medi-Cal was.

CHAIR GRGURINA: Good points, Jen. Okay, any other comments or questions?

All right, Anastasia, you want to cover your last topic?

MS. DODSON: Sure. The last topic is Medi-Cal Rx, a project update. I presume that you are all familiar with the policy change there, which is to transition Medi-Cal pharmacy services from managed care to fee-for-service in order to standardize the Medi-Cal pharmacy benefits statewide, improve access and apply statewide utilization management protocols and strengthen the state's ability to negotiate for supplemental drug rebates.

So we are at DHCS in partnership with Magellan. We are, of course, carefully monitoring COVID, the public health emergency, and we are looking at you know, and responding with measures intended to address any

potential delays or constraints. Our planned implementation date is still January 1st, 2021 and we continue to work toward that date. But again, we are doing contingency planning for anything that might be held in-person such as training and testing activities and at this point we don't anticipate any substantive impacts. On the actual timeline status we are in green status, which means we are tracking on schedule for all major deliverables.

Managed care data, both claims and prior authorization, is flowing from the plans' pharmacy benefit managers to Magellan; Magellan is our contractor for this effort. So far, stage one testing has wrapped up and stage two testing is underway and going well. DHCS and DMHC have been collaborating on a all plan letter for Medi-Cal Rx from a regulatory and compliance perspective and then DHCS is developing a separate APL which has programmatic and operational and policy direction. Both of those APLs are going to include feedback from health plans, stakeholders, associations.

On August 15th the provider portal will be launched, which actually was a couple days ago, sorry. Providers can register to get access to that portal. And also this month providers will be able to start signing up for training and the training starts in September and runs through December. At the end of August the health plans will receive the final 30 day notice templates and that will have had stakeholder feedback from our Medi-Cal Rx advisory workgroup. And then DHCS and Magellan will be sending several rounds of notices to all beneficiaries at the end of September so that they -- those notices will reach beneficiaries around October 1st, November 1st and December 1st and health plans will also be doing an outreach campaign noticing their members.

So that's it for the Medi-Cal Rx item. I don't know if you have any

questions or comments on that.

CHAIR GRGURINA: Questions, comments from the Board Members?

MEMBER DEGHETALDI: I have a general comment on this great presentation if this is a good time?

CHAIR GRGURINA: Sure.

MEMBER DEGHETALDI: I understand the realities of the Medi-Cal budget cuts coming, I understand that many of our COHS and local initiatives are starting to consume their reserves and that this will have an impact on rates. And I am particularly concerned about physician access or access for Medi-Cal beneficiaries to physicians because of downward pressure on rates. I don't know if we have any early data on that. CMS is going to implement a very significant increase in payments to primary care physicians next year, it could widen the gap in payments between Medi-Cal and Medicare. I don't have an answer, but I think we need to watch this very carefully.

CHAIR GRGURINA: Thank you, Larry. And then, Anastasia, just one final comment on the Medi-Cal Rx. As you walked through all the stages and what's going on I appreciate the comment where you said that you are doing contingency planning. This is a big, big move and very important to the, you know, 13, 14, 15 million folks on Medi-Cal who receive their prescription drugs. That is one of the most common ways that members are receiving their health care so appreciate the contingency planning and we will continue to work with you. All right, Anastasia, thank you very much for the update.

MS. DODSON: Thank you.

CHAIR GRGURINA: Kirk, welcome. Glad to have you with us.

Why don't we go ahead.

If you could just hold on and I will ask if there are any comments from members of the public?

MS. MICHELETTI: There are no questions submitted.

CHAIR GRGURINA: Okay. All right, Anastasia and Kirk, thank you very much, we appreciate your time today.

MR. DAVIS: Thank you.

MS. DODSON: Thank you.

CHAIR GRGURINA: All right. Next up on the agenda is the DMHC's response to COVID-19 and so, Mary, you are back on.

MEMBER WATANABE: Great. Yes, I've got, I think, the next two. So Anastasia talked a lot about the response that DHCS has done in response to COVID-19 and I will walk through some of our responses as well. We have worked very, very closely with both the administration and our sister agencies, in particular the Department of Health Care Services and the Department of Public Health, just to make sure that we are aligned in the guidance that we give to both our plans but just in kind of the state's response to protecting consumers.

We did launch a COVID-19 resource webpage and I wanted to make sure everybody knows that that's available. So if you visit our website at healthhelp.ca.gov, towards the right you will see the state's COVID-19 link, a link to their website there with CDPH. But you can find all of our all plan letters and the guidance that we have put out in response to COVID-19 on that resource page. So if you weren't aware of that I'd encourage you to check it out.

So again, all plan letters are the way that we provide specific guidance and information to the plans we regulate. We have issued, I think we

are up to about 29 or 30 this year already with about 16 related to COVID-19. So I don't know what our normal count is but I can tell you that that's a lot more than we typically issue in a year. So I will walk through just a couple of these to highlight them for you.

Really starting in early March we released our first APL in response to COVID-19 that directed the plans to reduce cost-sharing to zero for all medically necessary screening and testing. This included waiving cost-sharing for emergency room, urgent care or provider offices when the purpose was to screen for COVID. Sarah is going to talk later about our emergency regulation and I will just acknowledge that kind of the state's approach and our guidance related to testing has evolved since we first issued that APL in March and Sarah will cover that more when we get to the regulation presentation.

We also issued an all plan letter around telehealth and Anastasia mentioned this and I talked about it earlier, really just making sure that as we had provider offices closed that providers were able to provide the same level of care via telehealth with the same reimbursement. We did follow that up with an FAQ and some consistent guidance; we worked with DHCS on this around the coding and the reimbursement. So you can find all that information on our website. But that is an important issue, we wanted to make sure that providers are able to continue to provide that care.

We also issued an all plan letter working with Covered California to create a special enrollment period for people who had lost their health coverage. So that was first issued towards the end of March and we have done two subsequent APLs to extend that. So the current special enrollment period was just extended through the end of this month so that's kind of the state of things at

this point.

We also issued an all plan letter to the health plans asking them to tell us how they were reaching their vulnerable populations. And so you probably will remember particularly towards March and into April there was a lot of concern about those that are in a high-risk category based on them having a chronic condition, are seniors. We wanted to make sure that the plans were proactively reaching out to those individuals and we just didn't know what was happening. We were pleased to see that most of the plans had already mobilized to get their case managers and pharmacists reaching out to these vulnerable populations to make sure that they had food, that they were getting their medication, that they know knew what to do if they were in crisis and understanding kind of what the symptoms were of COVID-19 too. So that was kind of our first attempt to understand what the plans were doing.

Let's see. We also partnered with the Office of the Surgeon General to issue an all plan letter offering reminders and resources for plans to work with their vulnerable populations, acknowledging the toll that COVID has taken on families, particularly those that may be in domestic violence situations, just the toll on mental health, so we provided resources to the plans to address those issues.

Let's see, moving on to the next slide here. We also partnered with the Department of Aging to provide resources specific to working with seniors to make sure that our seniors were taken care of. I think isolation, as Anastasia mentioned, has been a big concern and making sure that our seniors had food and they weren't isolated. So we partnered with the Department of Aging to provide some resources related to making sure our seniors were staying home

but had what they needed as well.

We also issued an all plan letter that delayed the Timely Access Provider Appointment Availability Survey. As you can imagine, the early months of March and April was not the best time to be calling providers to say, when is your next available appointment, because their office was probably closed. So we issued an all plan letter to delay the start of that survey to start no earlier than August. We believe the plans should be able to administer the survey now, we are hearing that more offices are open. We also want to understand the availability of telehealth to enrollees and make sure that they are still able to get appointments as they need to.

Let's see. We also issued an all plan letter which directed plans with commercial lines of business to submit an informational filing about what they were doing to support their providers; and I mentioned this earlier too. We obviously all share the concern about the impact on provider offices and our ability to have an adequate network now and in the future and this was a way for us to collect information from the commercial plans about the steps that they are taking.

And then again, we have issued a frequently asked questions related to our emergency regulation that Sara will talk more about later.

I just really wanted to acknowledge Sarah Ream and our Office of Legal Services. This has been a really big lift to push these all plan letters out under very short time frames. The legal analysis that goes into this has been a lot of work and it is been some late nights and busy weekends for us.

So that's a quick summary of the all plan letters that we have pushed out.

I will move on to financial indicators. We have been getting a lot of questions over the last few months of just the impact of COVID-19 on plans and providers. There are lots of questions about utilization, are the plans sitting on huge profits, paying out bonuses. We have got providers struggling to keep the doors open, questions about capitation, fee-for-service. So I wanted to just take a moment to share kind of publicly the things that we are thinking about and will be looking at. And as I mentioned earlier, this is a little bit of a preview because much of this information is just starting to come in now. We are doing some analysis now and we will have, obviously, much more information to share at the November meeting but wanted to just kind of preview some of the things that we are thinking about.

So starting with medical loss ratio. Federal laws require health plans that sell products directly to enrollers or employer groups to spend 80% of their premium revenue on medical expenses and this went into effect in 2011.

Health plans in the large group market, the requirement is 85%.

If the health plan fails to meet this requirement they have to pay a rebate to the enrollees or to the employer group. And I am going to pause and just reiterate that point because we have had a lot of questions about whether or not MLR rebates could be paid to providers or to the state or to pay for PPE and what have you. The answer is no. The federal requirement says either the consumer or the employer group paid that premium and so the rebate goes back to them. The health plans can choose to provide rebates to the enrollees in the form of a premium credit, a lump sum check, if they used a credit card, it can go back to the means by which they paid their premium.

And since 2011 the DMHC regulated health plans have paid $352

million in rebates. And I know there was some discussion earlier about the latest MLR information that we have for 2019, which is just coming in.

So going to the next slide. MLR is calculated using data for a three year period. And this is another one that we have been getting a lot of questions about. We have had questions about whether or not MLR could be reported monthly or quarterly or annually. The federal requirement is it uses data for a three year period, which means when we get the 2020 data that will be submitted next year it will include some information about the impact of COVID-19 for this year but it will also include information for 2018 and 2019. So it is intended to kind of smooth the fluctuations but is not necessarily a good indicator of events that happen in just one year.

For the 2019 MLR reporting, the reports are typically due on July 31st but CMS extended that due date to August 17th. So we just got in those filings earlier this week so if you have questions we probably won't be able to answer a whole lot other than we have them and we are reviewing them. And CMS also provided flexibility to permit health plans to prepay a portion or an estimated amount of the MLR rebate to enrollees or medical groups. So there have been some changes for this reporting year in recognition of the unprecedented circumstances we are in. And again, we will see the impact of COVID-19 partially reflected when we get those filings next year.

Okay, moving on to health plan and RBO financial filings. So all health plans and RBOs are running to submit their annual audited and quarterly financial statements to the DMHC. They report on their assets, liabilities, reserves, revenues, medical expenses, administrative costs, profits, losses, enrollment and other detailed financial information. Again we have been getting

lots of questions about that earlier and we have only had the first quarter financial statements, which obviously was before we had the impact of COVID-19. So those second quarter financial statements were due to us on August 15th so again we are just starting to kind of dig into those; those will be reflected in the information that we present at the November board meeting. We will be reviewing those financial statements, comparing them to previous quarters, looking for any abnormalities in the reserves, medical expenses, profits and losses. We spend a good amount of time going back and forth with both the plans and the RBOs to really understand what's in those and we will be digging into those. We wanted to have this discussion here as well, just because as we review those we appreciate your input on things we should be looking for. And again, we will have more information to share with you.

All right. So health plan rate filings. I think we talked a little bit about this but just wanted to reiterate that we review individual and small group rate filings as well as Covered California. We received 12 individual rate filings and 14 small group rate filings with an effective date of January 1st of 2021.

The individual rate filings range from a decrease of 4.6% to an increase of 8.8%. One of the things that we will be looking very closely at is that geographic variation that you mentioned. And we also asked the plans to provide an estimated impact of COVID-19 on their rates, so we did ask them to call out what the specific impact of COVID is, so we will be taking a very close look at that.

The proposed rate change in the small group market ranges from a decrease of 4% to an increase of 4.3%.

And just a reminder that we have, most of this information I just

talked about is shared publicly on our website, you can find the MLR filings, you can find the financial statements for our health plans as well as the rate filings that are on our website. For the rate filings we have a public comment period as well so the public can review and submit comments on those rates. So this is -- you don't necessarily have to wait until November. We will summarize it and give you a lot more digestible information in November but if you are anxious to see what is in those filings they are available on our website. You can reach out to Pritika if you need help finding those. But the rate filings are on our home page, you can find them under our dashboard.

And just a reminder, through our premium rate review program we have saved consumers $296 million to date so that is something that we are that we are very proud of.

So I think that ends my presentation on just kind of our response to COVID-19, the things that we will be looking at. Again, still a little bit early; but we will have more information in November so you don't want to miss that meeting. With that, I will pause and take questions and comments from the Board.

CHAIR GRGURINA: Jeff.

MEMBER RIDEOUT: Yes, Mary, a couple of questions. I know you don't regulate large group rate filings but is the information you receive on those adequate to look at some of those same trends in the large group market?

MEMBER WATANABE: I will let Pritika jump in here. The large group rate filings are going to be new and so we will start to get some large group rate information. Pritika, are you there? Do you want to maybe add some comments on large group rate and what we will be looking at?

MS. DUTT: We will be looking at the plans' methodology on how they built the rates in the large group market. And starting next year, July 1st, 2021, employer groups with more than 2,000 employees, they can come and request an individual rate review for their own book of business and then we will conduct that and determine if the rate increases for that particular employer group are reasonable or not. So right now for this year we will be looking at the methodology and determining if it is reasonable or not.

CHAIR GRGURINA: Ted, you had your hand up?

MEMBER MAZER: Yes, thanks. Just you have a variance there on both the small and the individual market rates that you've been submitted. Where does the median fall out? That's a pretty big range, an 8% increase/4% decrease. Are we seeing most of it on the upside, downside, where is it lying?

MEMBER WATANABE: Pritika, I don't know if you have a sense yet. I mean, I think on the individual it may be very close to what Covered California is looking at, but do you have a sense yet?

MS. DUTT: We are still looking at it. One of the things is for some of the plans with the higher increases the enrollment is pretty low. So when you look at the weighted average for most enrollees, you know, with the plans with the larger book of business, with a large amount of enrollees, their increases are lower.

MEMBER RIDEOUT: And I think we have asked if we could to see a weighted average based on enrollment on a lot of this stuff.

MS. DUTT: We will include that information in November when we present our individual and small group information and risk adjustment transfer data.

MEMBER RIDEOUT: Thank you.

CHAIR GRGURINA: Any other comments, questions from the board members? Jeff?

MEMBER RIDEOUT: Mary, I think it is pretty clear we can infer MLR is not going to be useful even as a weak indicator because of the way the restriction is calculated. Do you see the quarterly submissions from health plans and RBOs as having some validity in terms of their response and impact of COVID or is that going to be to be determined?

MEMBER WATANABE: I think that's our hope. I think the concern we have is that the second quarter financials may not, may not be enough. There may not have been enough time for us to really use that to understand the impact. I think the individual and small group rates give us some indication of the impact of what the plans are assuming and projecting in terms of utilization, what might happen next year. Again, I think we wanted to be very transparent but I don't think MLR is the answer; just because it is a three year average there is such a delay. But I think the financial statements are probably going to be one of the better indicators. Pritika, I don't know if you have anything to add there?

MS. DUTT: No, Mary, you're on point. So yes, the financial statements are, you know, more actual information coming in faster and representative of, you know, the quarterly information. Again, I think we were in lock down mode until May so second quarter might show some indicators there but then I think third and fourth quarter might show more information on what is really happening with COVID-19 claims and just the plans' reserves and income, their net income and losses. So we will see more detailed information at the end of future quarters.

MEMBER WATANABE: And we will continue to get small group rate filings too so, you know, there's a number of indicators that will be keeping an eye on.

CHAIR GRGURINA: Amy, you want to go ahead.

MEMBER YAO: Yes. I had a comment. I tend to agree with what Mary said. I think even the Q2 financial filings, you probably want to be very careful how you draw conclusions from it. Because this year, you know, with the dip of the utilization, we have heard a couple of times (indiscernible). I mean, they all have record earnings but we do expect some utilization is going to come back in the later half of the year. And just touching on current data, we have already seen utilization is somewhere between like 90% to like over 100% because of the type of service is at the pre-COVID level. So I do think the rate filings are probably the better indicator of what we think the whole year is going to look like?

CHAIR GRGURINA: Larry, I believe, did you have your hand up?

MEMBER DEGHETALDI: Yes. Just to Pritika's point on a small plan may be the 8% outlier. That may be appropriate. Again back to Jen's interest in looking at geographic variation. A small plan might be in the Central Valley with very high risk patients and might be caring for disproportionately sicker patients and that may be appropriate. So that's why a side-by-side on what the risk is, the population a plan serving by region, rather than vilify the plan that is at 8%, they may be doing the right thing.

CHAIR GRGURINA: Jeff.

MEMBER RIDEOUT: Just a shout out to Sarah Ream who, back it seems forever ago in mid-April, participated in a IHA sponsored webinar on

telehealth along with CMS. And I reference that just because there was a lot of very detailed information on codes that were applied and consistency across commercial and MA plans. I don't know if that's holding but we included a lot of live links to individual plan policies on payment, which presumably they are updating. So we can certainly provide that if people want kind of a quick inventory of how to get to individual plans' policies on telehealth payment. But again, Sarah was very helpful on that, that webinar.

CHAIR GRGURINA: Any other comments, questions from the Board Members? I will just add that obviously we are all going to want to be present in November because there's so much information we'd like to have now that will be presented at that time. And also I appreciate the comments, Mary and Pritika, from recognizing in prior board meetings where when you talk about the rate range to go look and see what that weighted average is, which basically means what people are actually paying, which is an important marker. Because as folks - Jen had said earlier and then also Larry and others - it is one thing to see that wide range. The question is what's happening for a lot of people in addition to trying to see where are those increases? And as Larry and Jen mentioned earlier, are they appropriate? Why are they happening in those areas? So we very much look forward to the November meeting.

And then just a highlight, I believe, Mary and Pritika. The second quarter is submitted, I believe, mid-August, which means it is probably not available on your website until sometime in September is my guess.

MEMBER WATANABE: I think they are up. Pritika, are the Q2 filings up?

MS. DUTT: Yes, the Q2 filings are up, they are available, they

were due August 15. As soon as we get those, those get posted on our website so they are available on the website.

CHAIR GRGURINA: All right, great. Thank you very much. So for folks who can't wait until November you can go ahead and go in - as I have done before - in the DMHC website and you -- you do need to go plan by plan. This is part of the value of this meeting, as Mary, Pritika and the team will come back and give us some highlights and give us an opportunity to dig deeper. So we will look forward to that in November.

With that do we have any comments or questions from members of the public?

MS. MICHELETTI: No questions submitted.

MEMBER WATANABE: No raised hands and no Q&A.

CHAIR GRGURINA: Okay. All right. Thank you very much. And also Mary and Sarah, it is one thing to be able to do your normal workload, it is another thing during times like this, and as you had mentioned earlier, Mary, about the vast majority of staff now being at home and the difference in that. But the amount of workload that went in to the regulations, congratulations to the staff for a lot of important work that's been able to get done, so thank you.

Okay with that why don't we go ahead and let's move on to the 2020-2021 budget update and, Mary, you are back on.

MEMBER WATANABE: Right. I am going to pause and give just two housekeeping notes. We have had some issues with the phone number that was on the agenda. We have sent out a notice to our listserv, but if you happen to be joining us on Zoom and you know someone that's been trying to get the phone number, just submit a question through the Q&A, but also know that we

sent that out to our listserv.

We also had a couple of questions coming in about whether or not we are recording this. This is a little bit unusual because normally you can tell we are recording, we have the transcriptionist and there's mics everywhere in the room. So we do have a transcriptionist that will be putting out the transcript like we normally do. We also are recording the Zoom meeting and plan to post that this week. So just know if you missed part of this, you'll be able to watch it later.

Alright, so moving on to our budget update. I am not going to kind of rehash the state of the state's budget and the dire circumstances that I think we all understand that the state is in but just wanted to update you quickly on the Department's funding.

So last fiscal year our budget was right around $91 million and we had 482 authorized positions.

So our budget has actually increased to $96 million this year, largely as a result of BCPs that I will talk about in just a minute. And we are now over 500 authorized positions with a total of 505.

So you can see on the next slide kind of our growth over time in both our budget as well as our authorized positions. So we are continuing to grow. Most of that is a result of legislation that is keeping us very busy as we expand both our consumer protections and our oversight of things like rates, so exciting to see our growth continue.

Moving on quickly, I just wanted to highlight a couple of our budget change proposals that have been approved and that have provided additional funding and positions to the Department.

The first is AB 744, which is very relevant to a lot of what we talked

about today, which expands the use of telehealth by establishing payment parity between telehealth and in person visits. It requires DMHC to review health care service plan documents for compliance with reimbursement requirements. We will be reviewing plan records regarding payments to make sure they were paid in parity and reviewing claim samples when conducting our financial examinations. We also will have a consultant that will assist us in reviewing the cost-sharing portion of health service contracts, telehealth contracts, for both our full service plans as well as our specialized plans. So in this current fiscal year we received $331,000 in funding plus that includes $60,000 in consultant services. In fiscal year 2122 and ongoing the funding amount is $379,000, including $120,000 in consultant services.

So the next one is AB 290. And this requires DMHC to establish an independent dispute resolution process through which providers and health plans can seek rates above the Medicare rate. This is really related to providers that have a financial incentive and are making those third-party premium payments. This legislation actually has been paused, I think we talked about this at the last board meeting, but on December 30th of last year a federal judge granted a preliminary injunction to block AB 290 from taking effect. We actually thought this might be heard again in the courts this summer or early fall but with the delays in the courts related to COVID-19 this may get pushed to next year.

But we did receive some limited term funding in case this moves forward and so for this fiscal year it is right around $1.1 million, close to $1.2 million in funding to set up that IDRP process as well as to review plan documents. And then starting in fiscal year 2122 we received $775,000 limited term funding. So again, that funding is contingent upon this actually moving

forward.

The other one, again, I mentioned this earlier, AB 731, which will allow the Department to review large group rates. There also is a requirement beginning next year, July 1st of 2021, where individual contract holders that meet specific criteria can ask the DMHC to review their health plan rate increases before that rate moves forward. So there's quite a bit of work for us to do both as we develop the templates, we will be reviewing rates, but also those individual contract holder requests. So the BCP gives us five positions. In this current fiscal year it is about $1.7 million including $617,000 in consultant services and then for next fiscal year and ongoing it is about $2.6 million along with additional consulting funding of about $960,000. So excited to do that work.

We also had an informational security resources BCP for two positions and $384,000 in this fiscal year, $368,000 in the following two fiscal years, and $328,000 ongoing. This is really to improve our oversight of our security breaches and security attacks. As many of you know, those working in healthcare as well as those working in government, those security threats have increased and so this will allow us to optimize some of the tools we have to make sure that our data is protected.

The final BCP is related to our behavioral health focused investigations and we may have talked a little bit about this before. The Department has done a tremendous amount of work on behavioral health access and mental health parity compliance. And one of the things that we still hear from our stakeholders, we get complaints at our Help Center and we have heard from the Legislature, is that despite all of these efforts there are still access challenges for consumers who are trying to access behavioral health services.

These behavioral health focused investigations are really intended for us to take a very different approach to how we look at behavioral health access. We will be doing focused investigations of 25 full service commercial health plans. That's about five plans per year over the next five years. And it is really looking at mental health parity, but also really the consumer experience. We want to understand all the different ways the consumer touches the health care delivery system. We will be looking at utilization management, the plans' oversight of their delegates, the clinical guidelines that are applied, and just trying to understand where the barriers are for consumers as they access telehealth services. So that is going to be a lot of work for the Department over the next five years.

In fiscal year 2021, we have received about $2.7 million and 14.5 positions. In fiscal year 2122 it is about $4.7 million and 18.5 positions, and 2022 and 2023 and annually it will be about $4.7 million and 18.5 positions. So it is work we are already starting the planning phases on. We will be bringing in a clinical consultant to help us with that and look forward to sharing more information with the Board as we get started with that work next year.

And that does it for me on the budget. I'd be happy to take questions.

CHAIR GRGURINA: Questions or comments from the Board Members? Jeff. You're on mute, Jeff.

MEMBER RIDEOUT: Mary, can you give us a little bit of a color on onboarding new employees in general during this because I know that's really challenging.

MEMBER WATANABE: Yes.

MEMBER RIDEOUT: And then AB 731. Is that purely consultative work to those that request it or is there any regulatory oversight that comes with that?

MEMBER WATANABE: Yes, so maybe I will take the onboarding of new employees and I will let Pritika take the 731. So I fully agree, onboarding new employees has been a big challenge; we actually are trying to think creatively about how we do that. We are doing it, we are navigating it, it is tough to build those relationships and have that oversight. We have -- our training office is working on some consultant services to help advise us. Really I think what we have found is it is getting creative with your Skype and Zoom and your staff meetings to really try to build that culture and that cohesive team. But obviously bringing on, I think we are looking at bringing on about 28 new employees this year, and that's in addition to our existing vacancies and the turnover we have. So I will say we have been doing it and it seems to be working. We are doing monthly all-staff meetings just to try to keep the information flowing and that engagement. But I don't know, if you have any suggestions I welcome them because it is a challenge in this new remote environment.

MEMBER RIDEOUT: Well, we are obviously much smaller but yes, it takes just a ton, in my experience, of like one-on-ones and get-to-know-yous and virtual escape rooms and, you know, whatever it takes to kind of help people feel that they are part of something, even though they may never meet the people in person that they are working with, at least until now.

MEMBER WATANABE: Yes, no, I agree. I will tell you that we were surprised that one of the -- we got incredibly positive feedback about our

monthly all-staff meetings just because it is a chance for all of our staff to continue to engage with the leadership team and to see people that you don't normally see; so it is definitely something we are trying to navigate. I am thankful we have some really creative people on our team that have come up with fun games and surveys and polls, but that one-on-one engagement I agree is, I think, critical.

Pritika, do you want to answer the 731 question?

MS. DUTT: Yes. So Jeff, is your question around for outsourcing all the work to consultants for 731?

MEMBER RIDEOUT: No, it was are you, is DMHC acting purely in a consultative manner or is there any regulatory oversight that comes with that?

MS. DUTT: So we are going to review those rates -- not rates, the methodology that each plan implements, like how they build their rates. We will be reviewing that to ensure that how they set their rates in the large group market is reasonable. So, and then, you know, basically working with the plans to make a determination on if those, their methodology they implement is reasonable.

MEMBER RIDEOUT: And if it is not? I guess I am asking if it is not reasonable what's the authority?

MS. DUTT: So, I mean, we have -- the plans will have notification requirements. So again, like we will try to work with them, if we have concerns we will go back and forth. But if we do find those unreasonable then there is notification requirements that fall on the plan. We will have to post that information on our website as an unreasonable methodology finding, the plans will have to notify the employer groups, et cetera.

MEMBER WATANABE: Jeff, it is the same authority we have on the individual and small group side.

CHAIR GRGURINA: Other questions, comments?

Okay. If not, any comments or questions from the public?

MS. MICHELETTI: I have no questions submitted.

CHAIR GRGURINA: All right, thank you. Okay. Thank you.

The next item is the regulations update. Sarah, additional work that you have been doing; you are up.

MS. REAM: It makes the time go by very, very, very fast. I've got to say the last five months have flown by, it felt just like a matter of weeks. I am not actually complaining, that extra work keeps us, keeps us busy and our minds off of everything else that's going on.

So yes, so I wanted to give you an overview of the big lifts that my team has done this summer, and that is promulgating an emergency regulation regarding COVID-19 testing.

Our mission statement, obviously, to protect consumers' rights and ensure a stable health care delivery system. Next slide, please.

So let me just hop right into it. Why did we do an emergency reg? We certainly have a plenty of other things on our on our plates. We have a whole host, as I talked about at the last FSSB meeting earlier this year. We had intended to do quite a bit of reg work this year and we are still hoping to do so but we have obviously been a little sidelined by COVID-19 and we unexpectedly did this emergency reg.

The reason for it was first we wanted to help ensure that people who need COVID-19 testing can get testing and covered by their health plans.

And we also wanted to provide clarity and certainty to enrollees, providers and plans as to when testing is covered, whether the enrollee may go in-network or out of network, what the cost-sharing ramifications are. So we thought, you know what, we need to do a regulation on this, this is this is obviously a significant issue. Next slide, please.

So, let me -- I think some background would be helpful here to tell you how we got to the point where we decided, yes, we do need a regulation to provide some clarity. So back in what feels like a million years ago now, in March the federal government enacted two statutes, the Families First Coronavirus Response Act and then the CARES Act, the Coronavirus Aid, Relief and Economic Security Act. Both of these statutes said in very clear terms that health plans, health care, essentially anyone providing health coverage to anybody, including self-insured ERISA plans, must cover COVID-19 testing with no utilization management, no medical management, no in-network requirements and at zero cost-share.

Shortly thereafter though, I said June 24th here, there was guidance issued before that as well, but the June 24th guidance is really the one that is significant here. HHS, the Federal HHS, Department of Labor and Department of Treasury, issued joint guidance regarding the CARES Act and the FFCRA. Next slide, please.

So essentially before I get into what our reg does, that guidance modified or attempted to modify the plain language of the statute of the CARES Act and it put in restrictions and put in modifiers on when health plans had to cover or when carriers or provider/payers had to cover COVID-19 testing. It said that for symptomatic people, they could be tested. It was covered for

symptomatic people in all circumstances, in-network, out of network. But for asymptomatic people really there was going to be utilization management. Utilization management was going to be allowed for people who were asymptomatic and did not have exposure to COVID-19.

So we looked at that and we thought, well, now this is this is getting confusing. And it is not just, it wasn't just California that was confused, other states were confused as well and issued questions to the feds asking, what does this mean, this is not the same as what the plain language of the statute is, how do we interpret this? And to a large extent the feds said, well, we will take it back. And so there, there were a lot of holes. We also had concerns that this was really scaling back who could get covered testing so we wanted to address this issue.

So our emergency regulation does a number of things. It clarifies coverage and access requirements for COVID-19 testing. It clarifies when cost-sharing is allowed. It clarifies who is at financial risk for testing. Is it the providers or the health delegated providers if the DOFR delegates labs and diagnostic testing? And then the reimbursement rates to providers for testing. So I am going to go through each of these. Next slide, please.

So regarding coverage and access requirements. So there are three categories of enrollees that are impacted by the reg and then also the interplay of the reg with the federal statutes.

So first I'll call them Category 1 enrollees. And these are enrollees who have symptoms of COVID or known or suspected exposure to COVID. So these folks under federal law, they may go to any authorized testing provider to receive a test. They do not have to go in-network. The health plan must cover

the testing without UM and at zero cost-share. Under the CARES Act if the enrollee goes out of network the health plan must pay either the negotiated rate if it has one with the provider or it must pay the provider's quote/unquote cash price that the provider has posted on their website. So Category 1 enrollees are really, their testing is provided under the CARES Act under federal law.

Category 2 and Category 3 are the folks that our reg was really intended to capture to make sure that they were given access to coverage for COVID-19 testing.

Category 2 are people with no symptoms or exposure, but are enrollees who are considered to be "essential workers" as defined in the regulation.

Category 3 are folks who also have no symptoms or exposure but they are not essential workers as defined in the regulation.

So moving on to Category 1. So again, Category 1, symptomatic, you have symptoms or you have known or suspected exposure. The federal statutes require the health plans to cover these folks with no UM or prior authorization requirements and no in-network requirements. So these people can go anywhere and get a test. Next slide, please.

Category 2, the asymptomatic essential workers. Testing, the regulation deems for these individuals that testing is medically necessary in all cases. The reason this is important is if it is deemed to be medically necessary then there is no UM or prior auth allowed by the plan. I say that "by the plan" because we have been having discussions with stakeholders and internally about what happens when an enrollee goes to a provider. So the health plan makes an appointment for the enrollee or provides access to an appointment for

testing to the enrollee.

The enrollee goes to the provider and the provider says, well, based on guidance from CDPH, based on guidance from the CDC, based on what you are telling me, enrollee, I really don't think that a test is appropriate for you, rather I think you should quarantine yourself or take some other steps. What happens there? And we certainly don't want to regulate the practice of medicine, obviously, in that regard. So if a provider were to say, no, I don't think, asymptomatic enrollee, I don't think you need a test, then that decision stands, we are not going to second guess that. But if the enrollee goes to the appointment the plan has to cover the appointment; and if the provider says yes, I do think you need a test, then the enrollee gets it as a covered service.

And just backing up to the last bullet point on the slide. The enrollee, an essential asymptomatic worker, they must try to get an appointment in-network. They need to contact their provider or contact their plan. But if the plan cannot get them an appointment that will take place within 48 hours of that initial contact then the enrollee can go out of network and have that covered. Next slide please.

So now we have the last the last category. I call this the Sarah Ream category currently. I have no symptoms and under the reg I am not deemed to be an essential worker. So if I decide that I need a test or I want a test, it is deemed to be an urgent service when medically necessary just as it is for an asymptomatic enrollee -- an asymptomatic essential enrollee. But in this case, because I am not an essential worker and because I have no symptoms, the plan is allowed to impose prior auth requirements, and they must get me an appointment within 96 hours of my request. So it is a little bit different.

Obviously, getting an asymptomatic non-essential worker a test is not necessarily as -- it is urgent but it is not as urgent as ensuring that an essential worker has that, has that coverage. Next slide, please.

You know, I apologize, I did not define who the essential workers are and as we are going through the slides I can't recall where in the slides I defined or discussed who is an essential worker so let me hit that really quickly before we go any further. I realize I was remiss in that.

So the reg does define broad categories of who are essential workers, by industry. So it includes healthcare, education, retail, manufacturing, public safety, corrections, food service and those sorts of things. For some of the categories it is anyone working in that field. So for example corrections, anyone working in corrections is considered to be an essential worker. For others such as food service or retail, they are considered to be an essential worker if they work in that industry or that sector and they have interactions with the public or with co-workers in such a way that it doesn't allow for social distancing. That obviously raises the likelihood or the risk of exposure.

The reason we did some caveating on the sectors is because there are certainly people who work in, for example, retailing, who you know, while it is essential for the economy they may be able to work from home, they are not interacting with the public. So we wanted to put some boundaries around it so that we were really targeting the folks who are the most likely to come into contact with the people either who have the virus or they are likely to expose others. So we wanted to make sure that we tailored it sufficiently broadly but also narrowly to allow support to make sense.

With regard to cost-sharing. So as I said before, if you have

symptoms or known exposure or suspected exposure to COVID-19, under federal law no cost-sharing is allowed. So those folks have their tests with zero cost-sharing.

With respect to Category 2 people who are asymptomatic essential workers and Category 3 people, the people like myself, no symptoms, no exposure, non-essential worker, the cost-sharing is allowed per the existing Knox-Keene Act provisions, so those folks would pay their ordinary cost-share amount when they go to seek a test. Next slide, please.

So moving a bit from the coverage to financial risk for the test. We have had discussions with stakeholders as to between the plans and delegated providers who, who is best to bear that risk at this time, and we settled on the plans. So in the reg itself it says the plans may not pass on the financial risk for COVID testing unless they and the providers have specifically negotiated and agreed that the providers will assume that risk. The way we did that was in the reg itself it defines assuming financial responsibility for COVID-19 testing as a material change to the contract. And current law under the Provider Bill of Rights provides that before a health plan can change the material term of the contract the health plan must provide the opportunity for the provider to review that change and negotiate if the provider chooses to do so. So that is in, that is our reg. Next slide, please.

Submission and payment of claims for COVID. The reg also provides that the plan may not delay payment over, you know, an argument that the plan has delegated financial risks to the provider and the plan may also not demand proof, essentially, that the enrollee is an essential worker apart from an enrollee's statement saying yes, I am an essential worker. We did not want to

get into a situation where plans and providers were going back and forth with well, where does the person work and what do they do? Do they actually deal with the public? So we wanted to just cut that, cut that off and make sure that payment is efficient. Next slide, please.

Reimbursement rates. I had mentioned before that for enrollees who are symptomatic or exposed, federal law requires the plan to pay either the negotiated rate if there is one or the provider's cash price. And then for asymptomatic essential workers and asymptomatic everyone else payment is per the usual terms of the Knox-Keene act. So it is the negotiated rate, if there is one, or it is the reasonable and customary amount if either the enrollee has gone out of network appropriately after first trying to seek services from the plan or if there is no negotiated rate. Next slide, please.

Effective date. So the regulation took effect July 17th. It will remain in effect -- because it is an emergency reg it is not, it is not a permanent regulation. It has a limited shelf life unless the Department moves to make it a permanent reg, which I am really hoping we do not have to do. I hope COVID-19 is behind us by next summer. May 14th is when this regulation will drift off into the sunset unless we have to put it into permanent status. Next slide, please.

And that is all. I am happy to take questions and go from there.

CHAIR GRGURINA: Any comments or questions from the board members? Jen.

MEMBER FLORY: Yes. First of all, thanks for the transparency with which you've been trying to deal with it. We understand how difficult it is when the federal guidance is not exactly what people were expecting considering what the federal statutes were. The consumer advocates still have a lot of

concerns about these, particularly when it comes to people who aren't covered because they are not symptomatic or they are not essential workers. The reason that they are generally looking for testing is to avoid spreading COVID, you know, because they want to interact with a vulnerable family member or they need to travel or you know. And then there's some confusion around certain cases when they have been advised by a health care professional to get COVID testing because of another health care need that they have that is not strictly around whether they are symptomatic at all.

So we are still, you know, looking into this from the consumer advocacy side, you know. We would have preferred that the messaging had been, or that the regulations had gone along with a messaging that consumers understood, which was COVID testing was supposed to be free. So I just wanted to put that out there. But I do appreciate that you guys have been, you know, trying to walk us through on several occasions now, exactly what you are looking at and why the regulations are what they are but there are still, we think, significant gaps to consumers.

CHAIR GRGURINA: Thank you, Jen. Jeff.

MEMBER RIDEOUT: Yes. Sarah, thank you for wading into the swamp as you've done. Are you willing to go deeper and think about sort of test time returns as well? I know that's a moving target but I think most tests become moot due to just how long it takes to get results back, especially for anything other than essential worker categories. And even that, you know, I got tested, I get tested regularly, and I was told even as a physician it could take up to seven days. And I said, that's fine --

MS. REAM: Yes.

MEMBER RIDEOUT: Patience. But I don't get that. I don't think any of us get it, but it is kind of silly to require it and then not have a result.

MS. REAM: No, I -- yes, we have been having discussions and hearing that as well. I think that may be a bigger issue than our regs, testing.

MEMBER WATANABE: I will just jump in here and say I appreciate a little bit of the complex testing environment that we are in. I think we were trying to solve the piece of kind of the plans' role in helping to pay for testing, particularly in light of the new federal guidance. But you know, I think we all recognize it, from a consumer perspective the messaging is really challenging. Sarah has done a phenomenal job and she gets better every time I hear her do this, of just explaining all of these pieces. But I think, you know, you think particularly for a consumer or someone that's maybe non-English speaking, low literacy, this is really complicated stuff.

So I will just acknowledge that we are continuing to have conversations with our health plans, with our provider associations, with consumer advocates, within the administration, our sister departments as well, to see if there's clarification that we can provide. And, you know, adding these nuances of both the local, state and federal guidance, testing capacity and the return times, there's a lot of nuances to this. So just, I think we are laying out what we have done so far but this continues to evolve as everything else with the virus.

CHAIR GRGURINA: Ted.

MEMBER MAZER: Yes. The very same concerns on the consumer side and the physician side. To require essential workers to wait to get in-network testing, which is a delay already on top of the delays on getting

results back, to subject them to potential cost-sharing, I don't understand the justification for that. For the non-essential worker it is probably just as bad, it is a confusing message. It is discouraging them from getting testing, it is delaying testing, which is exactly the opposite of where we want to be and knowing what our community's risks are and how to reduce those risks. I just don't think these regs, while they may be an interpretation of our state regs versus the federal regs, I don't think they are consumer protective and I don't think they are pro-COVID control.

MS. REAM: Dr. Mazer, I hear what you're saying. I think ideally COVID-19 testing -- I am going to speak for myself here as a citizen. COVID-19 testing would be, you know, available to everyone at no cost-share and that is what we had thought the federal law did, until the feds came back and walked it way back with their guidance.

Under our state law, under the Knox-Keene Act the DMHC simply does not have authority to direct via a regulation people to be allowed to go out of network without first trying to go in-network. So that is why we shoe-horned, we used the timely access standards which require plans to provide appointments within 48 hours or 96 hours depending on the circumstance to enrollees. So we deem these services to be urgent and we said, health plans, you need to get these folks in within a matter of days. Under the Knox-Keene Act we have authority to issue a regulation like that but we did not have authority to say, enrollees may go out of network for testing, we just don't have that authority in the Knox-Keene Act.

We also don't have broad authority under the Knox-Keene Act to waive cost-sharing; so that is why the cost-sharing piece is still there, it tracks

with the statute. And we can't -- with a regulation we may not go outside of the parameters of the statute. I hear your frustrations. It is a function of where the statutes, where the guardrails are on that statue.

MEMBER MAZER: So two quick follow ups. Number one, what does this mean where counties are providing services? You can drive right up to my office, a block away there's a county testing site that may not be contracted with all of these individual payers. What does it mean if somebody chooses to go there? Is the county going to bill the patient or the plan is going to build the patient the co-pay? And second question or challenge is, if you feel the Knox-Keene regs don't give you the authority to do this is this not something to take the next step up to the Governor and say, we need an emergency regulation coming from him saying we are waiving all cost-sharing to the patient so that we don't discourage people from going and getting tested?

MS. REAM: So with respect to the counties, that's an excellent question. If somebody has -- if someone is symptomatic or has exposure, under the federal law they could go to the county, they can go to a drugstore, a pharmacy, they can go to any FDA-approved site that is administering tests within, you know, the bounds of law and have that test done, and federal law would require no cost-share. The county would then bill, if the enrollee has health coverage, bill the carrier, bill the plan for that. So that is clearly under federal law, symptomatic folks could do that. The asymptomatic would need to contact their plan or provider first.

I see that we have a question. Someone had asked along the same lines as yours, similar, saying, if a Category 3 person, so asymptomatic non-essential worker has Kaiser, if they decide to go to CVS out of network

would they be charged a co-pay? They would potentially not have that test covered because they didn't access, they didn't go to the plan first to access that test, to attempt at least to access that test in-network. So I think I answered your question. Sorry, I got a little distracted by looking off to the side and these other questions started coming through. So yes, for someone who is symptomatic they need to go through their, they can go anywhere; asymptomatic they need to come, they need to go through their plan.

CHAIR GRGURINA: Okay, Amy and then Jen.

MEMBER YAO: Okay. Yes. So thank you for sharing the background and the rationale behind this emergency regulation. I understand what we are trying to do for the consumers but I just want to offer some perspective from the plan perspective. This is complex, this is definitely adding a lot of administrative burdens to the plans. And also like the access requirements, sometimes I feel like it is out of the plan's control because in California we have testing capacity issues and so sometimes it is really that limitation causing some of the delays. And, you know, I can give you an example, on the payment delay, you know, the requirement, sometimes it is not the plans, it's the labs, they are delayed in their submission. You know, the question that everybody's asking, who is eligible for what? So it is really complex.

But my question is, after May 14, so if there is a need to continue -- are we willing to consider a different model? Would it be better to have a consistent plan methodology from the state instead of having each individual health plan trying to interpret what that means, try to come up with their own guidance, the members will not have uniform experience across the different health plans. So maybe you can do a tax assessment so you can get some

money out of the plans (laughter). But, you know, administered at a state level. I am just asking.

MS. REAM: We will acknowledge it is definitely a confusing, you know, the need to walk through the regulation to understand it and so we understand that the messaging can be, can be tough. We are working on an all-plan letter to provide some more clarity and guidance to the plans and hopefully it also provides some clarity and guidance to the providers with respect to when testing is covered and when cost-sharing is allowed and those sorts of things. So I am hopeful that that guidance will help provide some streamlining and answer questions and provide some uniformity across the plans.

MEMBER YAO: I just want to say I do appreciate you are trying to balance everybody's needs and the complexity. I know there is not a perfect answer so I appreciate that effort.

CHAIR GRGURINA: Jen.

MEMBER DEGHETALDI: You know, my one comment, we are running dozens of respiratory clinics, thousands of tests a day. Just to access to a PCR test or a point of care test is inadequate because turnaround time, if it is greater than two days the test is useless. So we can just keep in mind that we can provide timely access to a test, but if it is a seven day turnaround that is of no value to the public, to the patient and to the provider.

We are triaging patients based on clinical need. Are they in labor? Are they in the emergency room short of breath? Are they asymptomatic and just planning to travel. We are forced to triage patients to the 15 minute turnaround to the seven day turnaround and that's the real world and so keep that in mind. It is all about access to adequate testing supplies.

CHAIR GRGURINA: Jen.

MEMBER FLORY: Yes, just building off what Ted was saying. I mean, if this is really what the limits of what we can do under state law then I think it is worth having some conversations with the Governor's office on what can be done in terms of, can we, for example, force contracts between plans and some of these public testing sites? Because for essential workers in particular, they are by definition working. And so the idea that they can get to their provider and not have that be another interruption in work or another delay, that in itself is a challenge. So if there are ways that we can combine the forces of the plans and these other testing sites so that people can actually get tests when they are needed, it might be time for some more creative thinking and what we can do, you know, whether it is through I mean, we are about done with the legislative session so it leaves us with executive order and other things like that, so that we can look at, can we force contracts, can we come up with a reimbursement rate or, you know, just other ways that we can pool the resources of the plans and the public health dollars that are being spent.

CHAIR GRGURINA: All right. Amy.

MEMBER YAO: Yes. So just one more point. Back to what Larry and others are talking about. Maybe the timely access may not be enough to really address the issue. It is sounding like the timely turnaround of the results being available, that's really critical to make a difference. So I am wondering whether there should be some requirements from that perspective as well

MS. REAM: Can I ask a follow up question on that? So the results are coming -- maybe I am not -- I may be showing my naiveté here, but the results are coming from labs and those sorts of things. I am wondering what is

causing the delays in the lab results. Is it just the labs are overwhelmed? Are some labs doing better than others? Lack of testing material? I've read about it and I see lots of reasons thrown out but I would love to hear in your, from your experience what is causing the delay?

MEMBER RIDEOUT: Well, it is lab-specific and the two national labs, Quest and LabCorp are in different positions within terms of reagents and how fast they can process; and then a lot of the testing that's done now they are having hospital labs or more local labs take that on that can do it themselves.

MS. REAM: Okay.

MEMBER RIDEOUT: So where you're seeing like urgent care that have their own labs, they are saying, hey, come to us, we will give you results in two days. I am seeing this all over. They run it in their own lab but you have to pay for it yourself if that's what you want.

MS. REAM: Okay.

MEMBER RIDEOUT: So I think it depends on the supply chain supporting the testing labs themselves.

MS. REAM: Okay, okay. So it is not so much, it is not a health plan issue necessarily, it is more of a lab backlog, lab access to testing, reagents and those sorts of things.

MEMBER DEGHETALDI: Once you leave your system and rely on a vendor, the two that Jeff mentioned, you are entirely dependent on them. It is not transport from patient to the lab nor is it results back from the lab to the provider and patient. It is the, how long does the swab sit on the lab technician's desk?

MS. REAM: Okay, interesting.

CHAIR GRGURINA: Other questions --

MEMBER WATANABE: John, if I could just jump in here? John, if I could just jump in and mention really quickly, just in response to Dr. Mazer's question too. There's a lot of other activities and efforts happening within the state. We have the testing task force, obviously with CDPH this is a priority for them. I think we are a piece of that. But just wanted to acknowledge there's also a lot of other activities and efforts happening around testing and the frequency and the supply that are not necessarily, they are really not under DMHC's jurisdiction and so we are trying to figure out how we fit into that and how we can provide clarification. But wanted to just point that out.

CHAIR GRGURINA: Okay. Do we have questions, comments from the public? I know Sarah answered one of the Q&As that came up but are there others?

MS. MICHELETTI: Yes, we do have one. Sarah, you had mentioned that testing for essential workers is considered medically necessary under the Department's guidance. Does that mean testing for essential workers who have PPO is also medically necessary under the Department of Insurance's March bulletin which states that plans must "reduce cost-sharing to zero for all medically necessary screening and testing for COVID-19, including hospital, emergency department, urgent care, and provider office visits where the purpose of the visit is to be screened and/or tested for COVID-19."

MS. REAM: Yes, so thank you for this question. Just to clarify, our regulation applies only to products that are regulated by the Department of Managed Health Care. So with respect to products that are regulated by the Department of Insurance, the products issued by a self-insured or coverage from

a self-insured plan, the regulation would not apply to those entities so you would have to look to the Department of Insurance for that information.

MEMBER MAZER: If I could just respond, Sarah. And it is not the topic of the Financial Solvency Board, but therein lies one of the biggest problems for physicians and for patients because nobody knows who regulates which plans. I am saying it facetiously but it is true, and it means that a patient really gets no guidance from saying, that plan you have to go DOI and this plan you have to go to DMHC. And half the physicians' offices, or more, cannot answer that question either.

MS. REAM: No, I hear you. I think some of the, a lot of their enrollees, a lot of the patients don't know either and they will call our Help Center and ask. And we have to unfortunately tell them well, you have a, you're a self-insured person or you need to go to the CDI. Obviously we direct them there, we give them, we transfer them there, we do everything within our power to help them get there, but we don't have authority over them. It is a function of our bifurcated system here in California.

MS. MICHELETTI: We do have another comment with regards to that from the public that health plans also have dedicated COVID-19 sites and literature that says what the co-pay would be if they have a PPO. So I wanted to share that as well.

MS. REAM: And recall that DMHC regulates, there are health plans under our jurisdiction that have PPO products and I think there has been confusion. Just, you know, everything's got to be a little more difficult, I guess, then you might think it otherwise needs to be. But yes, we have PPOs under our jurisdiction as well as CDI has some too. So just because an enrollee has a

PPO product doesn't necessarily mean they are under CDI, they may be under us.

MS. MICHELETTI: And we do have one raised hand so if we can unmute Diana Douglas.

MS. DOUGLAS: Hi, thank you so much, hopefully you can hear me. This is Diana Douglas on behalf of Health Access California. And first, just want to say we appreciate the Department's engagement with us so far on some of these issues and all the work that has gone into sorting out some of the COVID regulations throughout the pandemic. We would like to point out a couple of concerns that we have.

I think one going back to sort of who is covered and the definitions of essential health workers. Just wanting to acknowledge that during these times there are particularly many health workers that are either public employees who are inspecting work places, restaurants, so forth, and also a lot of our communities are especially relying on the services of nonprofit community based organizations right now. So we would hope that folks who are out there delivering food and providing outreach, home visits, et cetera, would be considered as essential workers as relates to coverage and availability of COVID testing.

And I think our second point gets to some of the cost-sharing issues and, you know. Particularly I hear what the Department is saying regarding what we are able or not able to do. I think specifically, though, it would be extremely helpful for consumers if plans were to possibly be more just transparent or have more public information available on their cost-sharing policies and amounts and also making information available where consumers

are able to get free tests if they would not be eligible for the waiver on cost-sharing. So I think, you know, really just making that information public. I know, you know, personally, a lot of people are having trouble figuring out exactly what is covered, what the cost-sharing is and where to go, if not. Thank you so much for taking comments.

MS. REAM: Sure. Thank you. Thank you for that.

CHAIR GRGURINA: Okay, are there any other comments? I see Jeff has a comment.

MEMBER RIDEOUT: It is just a question. And again, Sarah, thank you for wading in. Does anybody know whether the Department of Public Health has authority that might supersede any of the constraints that might exist within say Knox-Keene or federal legislation? And again, it is a version of what Ted asked about sort of the Governor and maybe a more higher level executive order on this?

MS. REAM: That I don't know that specifically, I am happy to go back and check with them. Have the benefit of having our former Deputy Director of our Office of Enforcement as the General Counsel over there now so I can definitely reach out to him and --

MEMBER RIDEOUT: (Overlapping) a public health emergency, which it is. That probably would supersede in a more expedited way some of the constraints of the enabling legislation or the Department, you know, CDI versus DMHC.

CHAIR GRGURINA: Okay. Well thank you for a very interesting and engaging conversation, definitely more to come. Sarah, you can come back and give us the updates on the additional pieces.

MS. REAM: Yes.

CHAIR GRGURINA: Checking into, we know that we will want to see this in November.

With that let's go ahead and move on. Sarah, you still continue to be up in the federal updates.

MS. REAM: Yes. All right. Let me pull up. I don't have a slide, I don't have a slide show here but I do have some talking points for myself. So I wanted to provide you with two updates regarding federal rules, federal regulations. A lot has been going on -- as you know a lot has been going on at the federal level. I could take up our entire FSSB meeting talking about it so I thought I'd just identify two that are I think fairly interesting and important and we can go from there.

So first, in June the IRS issued a proposed rule that would allow people to use money that their employers have put into Health Reimbursement Arrangements of pre-tax dollars to pay the fees for health care sharing ministries. So currently that money that is put in by the employer into an HRA can be used by the employee only for qualifying medical expenses and health insurance premiums. However, this rule would expand that and allow these folks to use it for health care sharing ministries.

There has been a lot of concern from various states and stakeholders that, first of all, health care sharing ministries, it is not actually a premium, it is not health insurance because you are not guaranteed coverage. You have coverage if essentially the health care sharing ministry approves your expense and there's money to pay for it. There's also concerns that doing this would be pushing people into health care sharing ministries and that they would

be -- it could degrade the risk in small group and individual coverage, so there's concerns there. It is a proposed rule, it is still going through the public comment process, but that's one that we are, we are tracking.

Let me stop. So I am going to go on to another bit of a lengthier discussion of a rule so maybe I will stop there just momentarily to see if there's any questions about this, the IRS proposed rule.

CHAIR GRGURINA: Jen.

MEMBER FLORY: There have been other interesting conversations about health care sharing ministries that has happened in Covered California, vis-à-vis whether their agents are allowed to sign people up for health care sharing ministries. And in that process there were a number of materials developed that would compare what an actual health plan offers versus the risks of health care sharing ministries, so I just put that out there in case any of that is helpful to anyone for public comments. Because health care sharing ministries by definition discriminate against people and offer no guarantee of coverage.

CHAIR GRGURINA: Thank you, Jen. Other comments?

Okay, Sarah, you want to go ahead and continue.

MS. REAM: All right. Yes. So then the next, this is breaking news. I am going to go back a bit. So in the case of *Walker v. Azar*; we are seeing Azar in a lot of cases now. This was issued by the federal district court in New York on Monday, just a couple of days ago, came out with a decision essentially saying that health care entities that receive federal dollars may not discriminate against people based on a person's gender identity or sexual orientation. So this is an issue that has been with us for quite a while. So I am going to go back in

time here for a second and just walk through how we got to where we are with this court decision, I am sure it is not the last word, but bear with me as I take us back through time just a bit.

So in 2016 the US Department of Health and Human Services under the Obama administration promulgated rules that among other things prohibited health care entities from discriminating based on sexual orientation or gender identity. They did this by saying that the ACA's prohibition on discrimination on the basis of sex included discrimination based on sexual orientation or gender identity. A month after that rule took effect a number of states and health care providers sued HHS in Texas district court and that court enjoined that portion of the Obama era rules that spoke to sexual orientation or gender identity.

So under other circumstances HHS might have appealed the district court ruling, but they didn't, and the reason for that is really that three weeks after the court came out with its really we have a change of administration. So HHS is now under a new administration at the federal level and HHS chose not to pursue that appeal. They also indicated that they were working on new rules that would replace the Obama era regulation.

So fast forward to 2019, HHS under the current administration issued proposed rules expressly saying that discrimination on the basis of sex does not include discrimination due to a person's sexual orientation or gender identity. They said that they were aligning the definition of discrimination, quote, on the basis of sex, to that definition as used in the employment context. And they believe that in both instances, in employment and in health care, that federal statutes did not prohibit discrimination based on a person's gender

identity or orientation.

But the Supreme Court disagreed. As we later learned in 2020 the Supreme Court had a different view on what 'on the basis of sex' means. So in June of 2015 the Supreme Court issued the case of *Bostock v. Clayton County, Georgia*. This is an employment case. But the Court said that it is impossible to discriminate against the person for being homosexual or transgender without discriminating against that person -- excuse me -- without discriminating against that individual based on sex. So they, the Supreme Court essentially affirmed what HHS under the Obama administration had said with respect to discrimination on the basis of sex.

Notwithstanding the decision in *Bostock*, four days later HHS, so just in June, published a rule that said that you may, they went ahead and published their final rules. The rules were scheduled to take effect on June 18. But on June 26 -- or excuse me on August 18. In the meantime on June 26 two transgender women filed suit in New York and this is the case at issue here. So on August 17 the New York District Court ruled against HHS. They cited the *Bostock* case from the Supreme Court and they held that HHS has acted arbitrarily and capriciously in promulgating its rules. And the court went one further and said that the prohibition against gender identity and sexual orientation discrimination in health care that was in the Obama era rule remains in effect.

So regarding discrimination based on gender identity and sexual orientation for health care entities that receive federal funds, the rules that were promulgated in 2016 remain. So that is, it has been an interesting journey to see how the interplay between the definitions and the employment impact the definition with respect to the health care sector.

And with that, that is the -- those are my two federal updates, I am happy to take any further questions.

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

MEMBER FLORY: Just a comment on that. Just some appreciation to DMHC for also getting word out quickly that regardless of what is happening at the federal level we also have state law here that protects people on the basis of sex. And I understand there still may be some ongoing issues about language access but again, here in California we have state law that protects people.

CHAIR GRGURINA: Thank you, Jen. Any other comments or questions from the Board Members?

Any comments or questions from the public?

MS. MICHELETTI: We don't have any at this time.

CHAIR GRGURINA: Okay. All right. Well, thank you, Sarah.

MS. REAM: Thank you.

CHAIR GRGURINA: Next we will be turning it over to Michelle for the provider solvency quarterly update and then Pritika. And I think we are a little bit behind time but hopefully we will make it up. All right, Michelle, you are up.

MS. YAMANAKA: Okay, thank you very much and good afternoon. Michelle Yamanaka, Supervising Examiner in the Office of Financial Review. Today I am going to give you an update on our risk bearing organization or RBO financial reporting for the quarter ended March 31st, 2020.

There's three types of filings we receive. Annual filings are due 150 days after the RBO's fiscal year end. For fiscal year 2019 we received 180

annual financial survey reports. For quarterly filings the revised RBO regulations went into effect on October 1st of 2019, which requires all RBO's to submit quarterly financial survey reports. The compliance statements, which were an attestation by the RBO if they were meeting the solvency criteria, are no longer allowed. And for the quarter ended March 31st, 2020 we have 192 RBOs filing with us. For monthly reporting Some RBOs are required to file monthly financial statements with us as a requirement of their corrective action plan or CAP. For month ended March 31st, 2020 we had 11 RBOs filing monthly financial statements with us.

Moving on to the financial reports. The last column on this table on the right shows the reporting results for the quarter ended March 31st and it shows that there were 175 RBOs reporting compliance with the solvency or grading criteria. Next slide please.

The Department has four categories that can be assigned to each filing, Superior, Compliant, Monitor Closely, and Non-Compliant or CAP. For the quarter ended March 31st there were 55 or 29% of the RBOs captured in our Superior category, 100 or 52% of the RBOs were captured in our Compliant category, 20 or 10% of the RBOs were captured in our Monitor Closely category, and 17 RBOs or 9% of the RBOs reported Non-Compliance or on a Corrective Action Plan. Next slide please.

Moving on to Corrective Action Plans or CAPs. Again, the column to the right has the reporting results for quarter ended March 31st, 2020 and it shows that we currently have 23 active corrective action plans that we are working with the RBOs. Next slide please.

Of the 23 CAPs, 17 are continuing from the previous quarter and 6

were new as of quarter ended March 31st. For those 17 continuing CAPs, 14 of those CAPs are improving from a previous quarter and 3 were not. For those 3 we have been working with the RBOs and for the months ending May and June those RBOs have reported compliance with the grading criteria.

There is also a handout or an attachment called CAP Review Summary and it is sorted by MSO and it reflects the duration of the CAP monitoring. There are 17 RBOs that filed 23 CAPs; 6 of the RBOs have two CAPs. And again, this represents 9% of the RBOs. Of the 23 CAPs, 19 CAPs are approved, 4 are in review. Of those 4, 2 are continuing from the previous reporting period and 2 were new as of March 31st, 2020. Next slide, please.

The revised regulations went into effect on October 1st, 2019. One of the changes included was a new minimum TNE requirement. The previous requirement was positive, which meant it needed to be $1 or more. The new requirement is the greater of 1% of annualized health care revenues or 4% of annualized health care expenditures. There's a phase-in period for the RBOs and they have until October 2nd of 2020 to comply with the new TNE requirements.

This table represents the RBO status With the new TNE requirement that is broken down by enrollment ranges. Based on quarter ended March 31st financial data 20 of the RBOs would not meet the new TNE requirements and that is represented in the far left column titled <100%. Of these 20 RBOs, 9 of them are currently on a Corrective Action Plan. Next slide please.

Another change included the change in the Cash-to-Claims Ratio. Specifically the change included, the change reduces the type of assets that can

be used in the calculation. And again, the RBOs have until October 2nd of 2020 to comply with the new Cash-to-Claims Ratio requirements. Based on March 31st data, 3 of the RBOs would not meet the new Cash-to-Claims Ratio and currently all 3 of those RBOs are on a corrective action plan. Next slide please.

Another change to the RBO regulations included modifications to the financial survey reporting forms. These forms require the RBOs to disclose any sub-delegated enrollment that was received from another RBO. Based upon our review we identified 12 RBOs that received sub-delegated enrollment. There are approximately 124,000 enrollees that are sub-delegated from one RBO to another and one of the 12 RBOs is currently on a Corrective Action plan. Next slide, please.

The Office of Financial Review conducts an analysis of RBOs that have Medi-Cal lives assigned to them. There are approximately 4.5 million Medi-Cal lives assigned to 85 RBOs. We took the top 20 RBOs and there is approximately 3.4 million lives assigned to them, which is an average of 171,000 lives per RBO. The remaining 65 RBOs had 1.1 million Medi-Cal lives assigned to them, which is an average of 16,000 lives per RBO. So going back to the top 20, 13 of those RBOs had no financial concerns, 3 are on our Monitor Closely list and 4 RBOs are currently on a Corrective Action Plan.

Moving to the 65 RBOs that have 1.1 million lives assigned to them, 51 of those RBOs have no financial concerns, 6 are on our Monitor Closely list and 8 are on a Corrective Action Plan. Next slide please.

The Office of Financial Review receives annual enrollment information from health plans. This slide represents the five year trend of enrollment by line of business that is assigned to RBOs. As of fiscal year end

2019 the plans reported 8.6 million RBO lives, which includes 3 million commercial lives, 4.5 Medi-Cal lives and 1.1 Medicare lives. Overall in 2019, 2019 shows a slight increase in commercial and Medicare lines of business and a moderate decline in Medi-Cal enrollment from the prior year. Next slide please.

This slide shows the total enrollment of all products for the past five years. Overall enrollment is up slightly from 8.4 million lives in 2015 to 8.6 million lives in 2019. Next slide please.

The Office of Financial Review conducts audits of RBOs and these include claims and provider dispute audits and financial audits. For the year 2020 we have 24 audits scheduled. Four audits have been completed, 8 are currently in progress, and of those 8 field work has been completed on 5 and 3 are scheduled. In March of 2020 when we began teleworking the audits were converted to desk audits. It has been a smooth transition, the RBOs and their MSOs have been working with us. The audits are taking a little bit longer to complete, however, we are still on track to complete 24 audits in 2020.

And with that, that concludes my presentation and wanted to see if there's any questions.

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

MEMBER MAZER: Thank you. And thanks, Michelle, for the presentation. There is a creep going on in terms of how many of the RBOs are either non-compliant or on CAPs right now. It is gradually increasing. The number of RBOs has increased that are under DMHC's authority. You are still doing 24 audits a year, from several years. Is there a pattern that we are

missing? Is there some reason behind this up-creep in finding more and more of them on some kind of a review or on a CAP? And should we be even more worried with the potential impacts not reflected in these numbers, as COVID has hit? I am just concerned. I will get into more detail when we get into the individual plans in the next presentation but I am just concerned that we are tracking and tracking but losing ground.

MS. YAMANAKA: Sure. Each RBO has a reason for non-compliance and there isn't just one single thing to say for example, if there was a, there was one single issue that would affect the majority of them, that's not the case. I agree with you, there has been an increase in the number of corrective action plans, but we are monitoring them. We are trying to determine the root causes for those deficiencies so then they can be addressed and the RBOs could demonstrate and maintain compliance going forward. So we are monitoring them on a close basis.

The majority, many of them are on corrective action plans and so that's where we are. The majority are tracking their corrective action plans. When we find a group going south that they are not tracking, again, for example, the three CAPs that did not meet their approved projections, we were working directly with them and they were able to obtain compliance in the months in the second quarter. With COVID going on, next quarter, we have received a majority of the financials. We are looking at them, we are looking at them very closely to determine the impact of COVID in the second quarter of 2020.

CHAIR GRGURINA: Michelle, also can I ask, is a part of the increase in the number of CAPs, because as you mentioned we have had two changes, one is in the tangible net equity of the reserves that they need to have

the bar is higher, and then in addition as you describe, the claims ratio has also changed. So is that part of the reason why several now were on CAPs where under the old rules they wouldn't have been. Under the new higher bar they are now under either Closely Monitor or Corrective Action Plans.

MS. YAMANAKA: You know, I wish I could say they were but those two grading criteria technically do not go into effect until October 2nd, 2020. We are monitoring the groups. One of the previous, one of the slides shows, for example, TNE 20 RBOs. If the solvency criteria were in effect currently, at March 31st or at June, there -- I couldn't speak for June but at least for March 31st there would be 20, a total of 20 CAPs. Excuse me. Of those 20, 9 are currently on CAP so we would have an additional 11.

But there was a change in the working capital requirement, which does not allow affiliate receivables to be used -- current affiliate receivables to be used in the calculation, that caused a couple of the CAPs. In addition, with leases there was some guidance from the AICPA in the recording of leases and that also caused an impact on a couple of RBOs as well.

CHAIR GRGURINA: Okay, thank you. Other questions, comments from board members?

Okay, questions or comments from members of the public?

MS. MICHELETTI: Yes, we have four. The first question is: Have any RBOs closed down due to insolvency during the past reporting period?

MS. YAMANAKA: At this time no, we don't -- we are not -- we have not been notified of any.

MS. MICHELETTI: Okay.

MS. YAMANAKA: Yes.

MS. MICHELETTI: The second question is: The Superior category is undefined. It would be helpful to know - I guess it is a comment - what the Department's criteria is to obtain "superior" status relative to "compliant" and who these RBOs are.

MS. YAMANAKA: So a two-part question. So there are higher thresholds to determine the Superior category from the Compliant and at this time we don't disclose that information.

MS. MICHELETTI: Okay. And: It would be helpful to know which RBOs are sub-delegated so that payers and the public can determine whether there is value in such arrangements and whether such organizations score well under the IHA AMP program, et cetera. A comment.

MS. YAMANAKA: Again, we will look into that but the information that we receive from the RBOs is confidential.

MS. MICHELETTI: Okay. And the fourth question is: Will contracted health plans need to do any additional oversight related to TNE of RBOs or will this be monitored and enforced by the DMHC?

MS. YAMANAKA: So the health plans are responsible for the RBOs that they delegate risk to so they should be looking at the requirements to ensure that their delegated providers are meeting the solvency metrics.

MS. MICHELETTI: Okay. And one more did come in: Can you explain how many groups have failed after going on to CAP over the past decade? The DMHC data does not reflect this metric. Our review of Cattaneo & Stroud did not reflect great concerns.

MS. YAMANAKA: I don't have that information at this time but we can definitely look and provide that information in subsequent meetings.

MS. MICHELETTI: Okay. And I do have one raised hand so if you can go ahead and unmute, Bill. Bill, you are unmuted, did you want to say something else?

MR. BARCELLONA: Hello?

MEMBER WATANABE: We can hear you; go ahead, Bill.

MR. BARCELLONA: Thank you. Just a quick question. APG had a couple of grad students go through the records that are presented in each of these FSSB meetings going back to the very beginning. We completed the survey late last year. We'd like to present it at a future meeting because it does show that there have been hardly any insolvencies since SB 260 has been fully implemented. And the data that's presented in these reports is somewhat ambiguous. It raises a specter of non-compliance but then when you try to dig deeper to determine what lessons can be learned, what improvements can be made to the system, you can't get information to really aid that process. And I think the primary role of the Financial Solvency Standards Board as anticipated in SB 260 originally was to provide a venue for improving the performance of risk bearing entities in California and I think we have gotten away from that.

CHAIR GRGURINA: Thank you, Bill.

Other comments, questions from members of the public?

MS. MICHELETTI: There are no comments or questions outstanding.

CHAIR GRGURINA: Okay, all right. Well, thank you, Michelle, and I know next time we will have additional pieces that you will bring back from questions that were asked earlier today.

MS. YAMANAKA: Thank you.

CHAIR GRGURINA: All right, next up we have Pritika with the health plan quarterly.

MS. DUTT: Hi, good afternoon. I am Pritika Dutt, Deputy Director for the Office of Financial Review. The purpose of this presentation is provide you an update of the financial status of health plans at the quarter ended March 31st, 2020. At July 10th, 2020, that's when we pulled the data for this presentation, we had 131 licensed health plans. We licensed 6 additional full service plans, which included 2 Medicare Advantage, 3 restricted Medicare Advantage plans, 1 restricted commercial and 1 specialized plan, which was a restricted vision plan. One full service plan and 1 discount plan surrendered their license.

We are currently reviewing 12 applications for licensure; 8 are full service and 4 specialized. Of the 8 full service 4 are seeking licensure to be Medicare Advantage plans, 3 are for restricted Medicare Advantage and 1 for restricted Medi-Cal. And for the 4 specialized, 2 are looking to get licensed for dental and 2 are looking to get licensed to offer employee assistance programs to its enrollees. So one thing I wanted to point out for the Medicare Advantage licenses. For those plans we look at their financial solvency and certain administrative capacities and then the network and how their oversight is done by CMS. Next slide.

At March 31st, 2020 there were 26.8 million enrollees in full service plans licensed with the DMHC. Total commercial enrollment includes HMO, PPO/EPO and Medicare supplemental products. As you can see on the table, compared to the same period last year, total full service enrollment increased by 80,000 enrollees and that was mainly due to the increase in commercial

enrollment.

This slide shows the makeup of HMO enrollment by market type. All markets saw a slight increase in HMO enrollment. Overall HMO enrollment increased by adding 250,000 additional lives when you compare to the same period last year.

This slide shows the makeup of the PPO/EPO enrollment. So right now we are not getting PPO/EPO enrollment separated out so that's something that we would be capturing in future enhancement to the financial statement templates. As you can see on the table, the large group EPO saw a slight increase while the small group and individual PPO market so slight decreases in enrollment. Overall when compared to the same period last year total PPO enrollment decreased by only 10,000 enrollees.

This table shows government enrollment, which is Medi-Cal and Medicare. Overall government enrollment decreased when compared to last year and previous years. Medi-Cal enrollment decreased by 380,000 lives while plans with Medicare enrollment experienced a slight increase adding about 190,000 lives. And this is based on the information received for March 31st, 2020.

So this slide shows the plans that are on our Closely Monitored list. We are currently monitoring 34 health plans closely due to various reasons, including but not limited to, declining financial health, issues with claims processing or plans going through claims system conversions, issues identified during our financial audits, newly licensed plans, concerns with parent entities, low enrollment, et cetera. Compared to last year we had more plans on the watch list.

A majority of the restricted plans are on the watch list. That is either because they are recently licensed within the last couple of years or because of low reserves. Of the 28 full service plans on the watch list 14 restricted licensees are being monitored closely; 4 are restricted commercial, 6 are restricted Medicare Advantage plans and 4 are restricted Medi-Cal plans. And again for restricted licensees, these are plans that do not contract directly with enrollees, employer groups, CMS or DHCS, they get their enrollment through contracts with other fully licensed health plans who are directly contracted with enrollees, employer groups CMS or DHCS. A majority of the restricted licensees come from the RBO world where the reserve requirement is significantly lower.

There are 4.5 million enrollees in the closely monitored full service plans. Of the 28 closely monitored full service plans 14 are restricted licensees and had 1.2 million enrollees assigned to them. The total enrollment for the 6 specialized plans is 1.7 million lives.

This slide shows the plans that were TNE deficient at March 31st, 2020. So 3 health plans did not meet the Department's minimum financial reserve or tangible net equity requirement. The 3 plans were Oscar, US Behavioral and Vitality. Oscar and US Behavioral were able to obtain cash infusions from their parent entities and the TNE deficiencies have been corrected. Vitality remains TNE deficient and we are working with CMS and the Department's Office of Enforcement on further action. So this is a Medicare Advantage plan and we have to coordinate with CMS on our review on the TNE deficiency.

So the DMHC issued a cease and desist order on June 30th, 2020

that prohibits Vitality from accepting new members effective July 2nd, 2020. Due to the severity of Vitality's TNE deficiency and the ongoing financial viability concerns the DMHC issued an accusation on July 31st, 2020 to revoke Vitality's license. Vitality had 15 days to request a hearing, which it did, so we are currently working with Vitality and the Office of Administrative Hearings on a hearing date. We have continued to work with CMS through the process.

This chart shows the tangible net equity of plans by enrollment category. Sixty-eight health plans or almost half of the total licensed plans reported TNE of 500% of required TNE.

This chart shows the breakdown of the 27 plans in the 130% to 250% range. So, I think at the last meeting back in -- the last in-person meeting in February there was some interest in looking at the plans in the 130% to 250% range so we went back and provided further details on that. So if I health plan's TNE falls below 130% the plan is placed on monthly reporting. We also monitor the plans closely if we observe a declining trend in their financial performance, their tangible net equity, net income and enrollment.

This chart shows the TNE of the health plans by line of business. A majority of the plans with over 500% of required TNE are specialized health plans. And as I have previously mentioned in past presentations, this is because the required TNE for the full service plans are higher, and that's due to the medical expenses or risk is higher for full service plans. For most plans required TNE is driven by their medical expenses. The higher the plan's medical expenses the higher the reserve requirement for these plans are.

So this chart shows the breakdown of the 27 plans in the 130% to 250% range by line of business.

And this chart shows the TNE by enrollment for the plans being closely monitored by the Department. Four plans on the watch list have more than 500% TNE. So again, as I had previously mentioned, these plans may be on the watch list due to various reasons. There could be an increase in complaints that we received at our Help Center, a claims backlog, a claims system conversion, and significant findings during our routine examination.

And this chart shows the TNE by line of business for plans that are being closely monitored. A majority of the plans on our monitor closely list are Medicare Advantage plans. So again, we continue to monitor them and where needed we coordinate with CMS on these reviews.

Okay, so this chart shows the corrective action plans that we are working on for health plans. There are 18 plans that are on corrective action plans and these are mainly due to the routine financial exam findings. Most of these CAPs are due to claims processing issues that are identified during our exams.

Okay, so this chart shows the number of exams that we have conducted since 2017. So on average we conduct about 46 examinations each year and each plan might be on a three to five year cycle. So for fiscal year 2018 to 2019 we completed 47 examinations, for fiscal year 2019-2020 we completed 43 routine examinations, and for fiscal year 2020-2021 we plan to complete 47 routine examinations.

Starting March 2020, as Michelle mentioned, we have converted all field examinations to desk audits so it has caused some delays in our work flow since health plans have to submit all the documents electronically. So we have been receiving large data files from plans so we are setting up SharePoint sites,

working with the health plans to get these files uploaded and making adjustments when necessary. So we have been very flexible and so far the process has been working good. There have been some delays but we are working through with the health plans and RBOs similarly to get our reviews done.

Okay, so this brings me to the end of the presentation, I will take any questions that you have.

CHAIR GRGURINA: Questions or comments from the Board Members? I just have one. Pritika, thank you for putting the chart in where you broke up the TNE at 130% versus kind of the wider band that was there before. It is helpful for us to be able to see the differentiation. We appreciate that you are hearing us and making changes in future meetings.

With that, do we have any questions from the public on the health plan quarterly update?

MS. MICHELETTI: I see no hands raised and I see no questions submitted.

CHAIR GRGURINA: Okay. Ted, I think you had a question you wanted to raise.

MEMBER MAZER: I did and I apologize to the group. This is my second meeting and I forgot that we don't publicly show the CAP review summaries, I thought it was coming up after the last presentation by Michelle. I have some concerns I raised last time, I'll try to make it quick.

As you go through the listing that we were sent there are three RBOs using MedPoint Management that have been on CAPs for a significant amount of time. There's 4 RBOs with Network Medical Management, also all on

CAP. There are four RBOs using Primary Provider Management, all on CAP. We have Community Care IPA, which serves Imperial and Riverside, has been on CAP for failure to meet claims timeliness requirements for four quarters, now it is also failing on TNE, WC and CC requirements for the last two quarters.

And this also concerned something I mentioned earlier, which is there's an IPA there that is now taking people, taking primary cares off of CAP just when they need the cash flow. Finally, and most importantly, and I guess I should not mention the health plan, but MSO is the Advanced Medical Management. They have been on CAP for failure to meet FSSB requirements for seven consecutive quarters for various failures on solvency criteria.

My question is, what is the status of corrective action plans, particularly for the last one but for any of these groups, that continue to either not get off or get worse over courses of several quarters? At what point after almost two years of not meeting financial solvency does enforcement action begin?

And it takes us back to the last presentation with a plan that we were watching and the feds had to step in and now we are kind of back working with the plan because the feds took action. If we have solvency standards that are not being met quarter after quarter after quarter what is the commonality of how we behave towards them and when does DMHC take action? And I realize we are kind of running over time. If we could get some answers now I'd appreciate it but I'd really like a more in-depth presentation on what the triggers are and what the actions are instead of just continuing to monitor?

MEMBER WATANABE: And maybe -- let me step in because I think you raise a very valid point that's been raised, I think, at the FSSB meetings for many years. I would like to propose that maybe we come back at the next

meeting and talk about some of our oversight activities and the triggers and kind of the role the plans have in that process and really kind of try to answer your question holistically about what are the steps that we can take. I'd like to do that in a very thoughtful way rather than trying to answer it in about 30 seconds. If you don't mind I'd like to do that.

MEMBER MAZER: I don't mind at all, Mary, I just would like to see how we go from monitor-monitor to action-action.

MEMBER WATANABE: Sure. And I appreciate the fact that this list seems to keep growing and you are asking for an answer to that. So we will work on trying to put together something responsive for the next meeting.

MS. MICHELETTI: Okay, we do have one question that came in: Which IPA is converting physicians to fee-for-service? And this is a question to Dr. Mazer.

MEMBER MAZER: My understanding is that it is Community Care IPA, which is, as I know -- the information I've got, is a California Health and Wellness managed care Medi-Cal IPA that has sent some notices out in San Diego to that effect.

MS. MICHELETTI: Okay. I see no additional questions or hands raised from the public.

CHAIR GRGURINA: Okay, thank you.

Are there any comments or questions from the public on matters that were not on the agenda?

MS. MICHELETTI: There are nothing -- nothing is submitted so far and no hands are raised.

CHAIR GRGURINA: Okay. Hold on a moment, Jeff, because I

think this probably answers it is, which is for the Board Members, are there agenda items for the future Board, like in November where I think we have already lined up four or five topics for the Department. Are there, you know. So we talked earlier about risk assessment, we talked about digging deeper into the rates, we want to take a closer look at the health plan financials, which we will be doing in November. We would like Sarah to come back, she is checking a couple of answers on the COVID regulations. And in addition Ted has raised and Mary has said she will come back and we will look at the over-arching how do we deal with plans and/or are we looking at risk-based organizations that are on CAPs for an extended period of time, of how the Department deals with that. So those are the ones that I heard today. Here's our opportunity to go ahead and provide more. And here, Jeff, I saw your hand up. I hope this was what you were looking to get into.

MEMBER RIDEOUT: Yes. And again, I was just reflecting on Bill Barcellona's comment and the history of this committee and even its name. So maybe in a more, in a positive vein, maybe one of the topics would be, we covered such a wide range of things and we do every meeting, has the purpose or the charter of this group outgrown sort of its original intent, or are we spreading too far afield from its original intent? And it is just an open question.

Because I do think there are a lot of changes, especially in the risk bearing physician group community. We do spend some time on that but I don't know that we spend even the majority of our time on that. And to Bill's point, I am not, I am not sure what we look at is necessarily the tip of something bigger or more problematic, necessarily. I mean, we do have sort of a holistic view of the industry, especially during times of COVID. So it would be interesting to kick

that around a little bit. Sounds like a strategic planning item more than a meeting item but, you know, I am intrigued by where we go with that.

MEMBER WATANABE: It is something I will say we have had a lot of discussion internally about so happy to take that one back.

CHAIR GRGURINA: It is also good timing given that there will be a changeover in the in the board coming up in January of 2021. Larry than Amy.

MEMBER DEGHETALDI: Yes. Ted's concern about sort of the perennial RBOs or health plans that may be at risk. Looking at them holistically I was intrigued by the IHA AMP performance question. Because if a health plan is struggling but provides tremendous clinical quality access and service to the members, to look at them holistically you have to understand the -- and I know it may be beyond the scope of this board, but if the plan is producing or the RBO is stellar on quality service and access we need to know that. I said that before. Anyway.

MEMBER RIDEOUT: And Ted, I know Shelley did undertake to try to map our IHA results on quality, total cost of care and access to any of the concerns with the RBOs that are having financial challenges and there really wasn't any connection. Although remember, the RBO classification is a step more or less granular than what we look at in terms of plan provider contracts.

CHAIR GRGURINA: Amy.

MEMBER YAO: Yes. So my question is, in the industry there's more and more push for value-based payment. So with that movement there's going to be more and more providers risk-bearing so how that will change how we look at the provider solvency issue.

CHAIR GRGURINA: Okay. Ted.

MEMBER MAZER: Yes. And it kind of goes to what Jeff was saying about where are the parameters of this group. There's a period of time every year where there is renegotiation in contracts going on between plans, IPAs, hospital systems, and it seems like every year it is getting worse and worse with threatened terminations. Just in the last couple of weeks in San Diego, for instance, UCSD termed a Molina contract, Molina termed a contract with Scripps, and just two days ago we learned that Scripps is terming the contract with Aetna.

And that affects patient access, it affects practices who are aligned with IPAs with these various plans or hospitals, and creates a tremendous disruption. Whether or not they successfully renegotiate a contract or they, you know, they walk away, we have patients in the middle of care. It is not so much a solvency issue but it is a network adequacy issue as these plans and hospital systems flip around back and forth on contracting at the end of a contract term and I think it has great implications for the ability of stability within a patient's access to care. So maybe something we can look at going forward if you feel it is within the purview of this group.

CHAIR GRGURINA: All right. Larry, did you have your hand up?

MEMBER DEGHETALDI: No.

CHAIR GRGURINA: Okay, thank you. All right, very good. The wonderful staff at the Department will be working on all of those and we will see how we are going to manage to keep the November meeting within sight of three hours.

So just as a heads up, the next meeting is November 18, Wednesday, it will be from 10:00 to 1:00. Most probably it will be just like the

one today.

And I would just want to at the end give a thank you to the DMHC staff for doing such a good job with today's meeting. Thank you to everybody who's been on with the ability to be flexible and understanding and patient. Overall, it went pretty well, a lot of good comments, a lot of good insight, a lot of good work that we will be doing and coming back again in November.

And with that, we are done. Thank you to the board members for attending.

MEMBER WATANABE: Thank you, everybody.

(The meeting was adjourned at 1:06 p.m.)

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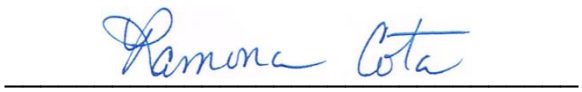
CERTIFICATE OF REPORTER

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

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

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

IN WITNESS WHEREOF, I have hereunto set my hand this 4th day of September, 2020.



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