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, NOVEMBER 17, 2021

10:00 A.M.

Reported by: Ramona Cota

ALL AMERICAN REPORTING, INC.
(916) 362-2345

APPEARANCES

BOARD MEMBERS

John Grgurina, Jr., Chair

Larry deGhetaldi, MD

Paul Durr

Jen Flory

Theodore Mazer, MD

Jeff Rideout, MD

Mary Watanabe

Amy Yao

DMHC STAFF

Pritika Dutt, Deputy Director, Office of Financial Review

Amanda Levy, Deputy Director, Health Policy and Stakeholder Relations

Sarah Ream, Chief Counsel

Daniel Rubinstein, Associate Governmental Program Analyst

Jordan Stout, Staff Services Manager I

Michelle Yamanaka, Supervising Examiner, Office of Financial Review

ALSO PRESENTING/COMMENTING

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

William "Bill" Barcellona
America's Physician Groups

INDEX

		Page
1.	Welcome & Introductions	4
2.	Transcript and Meeting Summary from the August 11, 2021 FSSB Meeting	7
3.	Director's Remarks	8
4.	Board Member Selection	13
5.	Department of Health Care Services Update	17
	Public Comment	
	Bill Barcellona	39
6.	Financial Summary of Medi-Cal Managed Care Plans	43
	Public Comment	
	Bill Barcellona	51
7.	Legislative Update	52
	Public Comment	
	Bill Barcellona	57
8.	2020 Risk Adjustment Transfers	60
	Public Comment	
	Bill Barcellona	66
9.	2022 Rates in the Individual Market	69
10.	Provider Solvency Quarterly Update	72
	Public Comment	
	Bill Barcellona	79
11.	Health Plan Quarterly Update	80
12.	2022 Meeting Schedule	84
13.	Public Comment on Matters Not on the Agenda	84
	Public Comment	
	Bill Barcellona	84
14.	Agenda Items for Future Meetings	85
15.	Closing Remarks	85
Adjournment		85

Certificate of Reporter 87

PROCEEDINGS

10:01 a.m.

CHAIR GRGURINA: Before we go ahead and run through the agenda of the Financial Solvency Standards Board there are a few housekeeping notes. So first of all, for our Board Members, please remember to unmute yourselves when you are making a comment or a question and to mute yourselves when you are not speaking. And for our Board Members and members of the public, a reminder that you can join the Zoom meeting on your phone should you experience any connectivity issues.

Questions and comments will be taken after each agenda item. For the attendees on the phone, if you would like to ask a question or make a comment please dial *9 and when it is your turn state your name and the organization you are representing for the record.

For attendees who are participating online with microphone capabilities, you may use the Raise Hand feature and you will be unmuted to ask your question or comment. To raise your hand click on the icon labeled Participants at the bottom of the screen, then click on the button labeled Raise Hand. Once you have asked your question or provided a comment please click Lower Hand. All questions and comments are going to be taken in order of the raised hands.

And as a reminder, the FSSB is subject to the Bagley-Keene Open Meeting Act. Operating in compliance with the Bagley-Keene Act can sometimes feel inefficient and frustrating, but it is essential to preserving the public's right to governmental transparency and accountability. Among other things, the Bagley-Keene Act requires the FSSB meetings to be open to the public and as such it is

important that members of the FSSB refrain from emailing, texting, or otherwise communicating with each other off the record during the FSSB meetings because such communication would not be open to the public and would violate the Act.

Likewise, the Bagley-Keene Act prohibits what are sometimes referred to as serial meetings. A serial meeting would occur if a majority of the FSSB members email, text or spoke with each other outside of a public FSSB meeting about matters within the FSSB's purview. Such communications would be impermissible, even if done asynchronistically, meaning member one sends an email to member two, who then sends the email to member three, who then sends it on to number four, et cetera. So accordingly, we ask that all FSSB members refrain from emailing or communicating with each other about FSSB matters outside of the confines of the public FSSB meeting.

And with that, we are done with the housekeeping notes. I am glad that I don't have to give the instructions on where the bathrooms are because you all know where they are so please use them when you feel you need to.

With that let's go ahead and do the introductions and we will start with the board members. And why don't we start with Jeff?

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

CHAIR GRGURINA: All right, thank you, Jeff.

Jen.

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

CHAIR GRGURINA: Thank you, Jen.

Amy.

MEMBER YAO: Hi. I am Amy Yao, I am Senior VP of Blue Shield in charge of actuarial underwriting and risk analytics.

CHAIR GRGURINA: Thank you, Amy.

Paul.

MEMBER DURR: Good morning, everybody. I am Paul Durr, CEO for Sharp Community Medical Group in San Diego.

CHAIR GRGURINA: Thank you, Paul.

Larry.

MEMBER DEGHETALDI: Larry deGhetaldi, family physician in Santa Cruz with Palo Alto Medical Foundation, Sutter Health.

CHAIR GRGURINA: Thank you, Larry.

Ted.

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

CHAIR GRGURINA: All right, thank you, Ted.

And I am John Grgurina, CEO of the San Francisco Health Plan.

And with that, Mary, I will turn it over to you and your team.

MEMBER WATANABE: Sure. I am Mary Watanabe, I am the Director of the Department of Managed Health Care.

Pritika?

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

MEMBER WATANABE: And Michelle?

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

MEMBER WATANABE: And Amanda?

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

MEMBER WATANABE: And I will add I think we have Sarah Ream our Chief Counsel on the phone; and then Jordan Stout and Daniel Rubinstein I believe are on helping us with our administrative support. And that's it for DMHC, John.

CHAIR GRGURINA: All right, thank you very much, Mary, and the DMHC team.

We will move on to the transcript and the meeting summary from the August 11th FSSB meeting. Let me ask if there's any comments or questions from the Board Members? And I'll apologize, I've got to screen back and forth to see you all and I see some heads shaking, no. All right. With that do we have a motion to move the minutes?

MEMBER MAZER: So moved.

CHAIR GRGURINA: Thank you, Ted.

A second?

MEMBER DURR: Second.

CHAIR GRGURINA: Second, Paul. All right. All in favor say, aye.

(Ayes.)

CHAIR GRGURINA: Thumbs up. Any, any noes?

I don't see them. All right, passes unanimously, thank you very much.

With that we will move on and, Mary, it will be your Director's remarks.

MEMBER WATANABE: There, that's better. Can you hear me, hopefully?

CHAIR GRGURINA: Yes, we can.

MEMBER WATANABE: Thank you, John. I am having issues with our mute today. I will just start by, start with some of the bittersweet news. This is our last meeting with John and Jen Flory on the Board. I am sad to see you all go but, John, I wish you the best in retirement and Jen, of course, I know you have got a lot on your plate. I will just say, John, you have served on the Board for the last five years since January of 2017 and I think you have been the Chair for a good portion of that time; and Jen joined the board in 2019. I have really enjoyed having both of you on the Board and the unique perspectives you both brought to our conversations. I especially appreciate your support over the last two years as we have gone through a lot of transition on our leadership team and as I have transitioned into the Director's role, so it has really been great to have you on the Board.

In our next agenda item, which I will do after my update, I will talk about who our new Board Members will be that are joining us and I am excited for that. But, John, you have done a fantastic job as our Chair keeping our meetings running smoothly.

I am also excited to announce that Larry has agreed to take over the Chair responsibilities starting next year. So thank you very much, Larry, for being willing to take on that job. I think you have been on the Board since 2010 so you have had quite a bit of time to kind of watch what the Chair role involves and we will do, of course, everything we can to make sure that goes as smoothly as possible. So excited to have Larry taking over the Chair responsibilities going

into, into next year.

MEMBER MAZER: (Applauded.)

MEMBER WATANABE: Thank you, Ted. The rest of you are off the hook. (Laughter.)

So moving on to my updates really quickly. I did want to talk about the Centene-Magellan merger. As I mentioned at the beginning of the year, the Department is reviewing the acquisition of Magellan by Centene. We held a public meeting on October 27 to discuss the DMHC's jurisdiction and authority to oversee this proposed transaction and to solicit input from the public to inform our review of the transaction. Representatives from both Centene and Magellan were present and we accepted public comments at the meeting and written comments were due at the beginning of this month.

This is the first merger that meets the major transaction requirements since the law changed in 2019. We are required now to hold a public meeting, even though we have done this in the past, to really inform the public of the proposed merger and to hear public comments.

In addition, we were required to obtain an independent analysis of the impact of the transaction on California enrollees and the stability of the state's health care delivery system. This report is published on our website. You can Google or search, mergers, you will find our report there on our Merger web page.

This transaction is of particular significance at this time because it involves the acquisition of a behavioral health plan. As you all know, the isolation, job losses, school closures, loss of a sense of normalcy caused by the pandemic, have really had an impact on the mental health of all Californians and

has led to an increased demand for behavioral health services. So that's one of the things we will be considering is how this proposed transaction could improve access to behavioral health services for California enrollees.

We are finalizing our review of the transaction and expect to announce our decision before the end of the year.

Moving on to an update on our Health Equity and Quality Committee. As I have discussed before, the Department will be convening a Health Equity and Quality Committee to make recommendations regarding a core set of health equity and quality measures that the health plans will be reporting to us, this is both commercial and Medi-Cal, including setting annual benchmark standards for assessing quality and equity.

At the beginning of September we released a solicitation for candidates interested in participating in the committee and we are really looking for members that reflect the diversity of the state as well as those that have experience in quality measurement and equity programs.

I am excited to announce we had over 65 or about 65 applications, I believe, from a diverse set of knowledgeable and experienced candidates. We are currently reviewing those applications and expect to announce the committee members and more about those meetings next month.

We are also finalizing the selection of a contractor to help us facilitate those meetings and expect that we will start those meetings in February.

Quickly I will update you on our behavioral health-focused investigations. We have talked a little bit about this at previous meetings. We are conducting focused behavioral health investigations of all full-service commercial health plans regulated by the Department over five years. We are

wrapping up our investigation for the first year and we will be sharing our findings next year.

We also are getting ready to move on to year two of the investigation and we have identified the next five health plans that will be included in our review in 2022, and that includes Alameda Alliance for Health, Anthem Blue Cross, Kaiser, Sharp and Western Health Advantage.

So you can find more information about these focused investigations on our web site under Health Plan Compliance, but we will be looking for consumers and providers to talk to about these investigations as we head into next year.

I want to just provide a quick update on our COVID response as well. Obviously, this is something as we head into almost two years of dealing with the pandemic as something that is, I think, top of mind for all of us. As we head into the holidays and the winter months we are keeping a close eye on the COVID cases and hospitalizations. You are probably hearing, as I am, that there is some concern about a winter surge and what that will mean. In some regions hospitals continue to face a surge of patients due to COVID-19, which impacts their ability to provide care to other patients.

At the end of October we issued an All Plan Letter reminding health plans of the requirements to have adequate staff to ensure services are provided in a timely manner and to ensure the health plans' administrative processes don't unnecessarily impede a hospital's ability to efficiently admit, discharge or transfer patients. This obviously will continue to be a concern if we in fact see a winter surge and want to make sure we are being proactive to make sure the hospitals are able to respond appropriately.

The All Plan Letter that we issued also reminded plans of all of the All Plan Letters we have issued over the last two years and the ones that remain in effect. We have issued a lot of All Plan Letters and I think there's close to 40 that still are in effect.

One of the other areas we are keeping a close eye on is provider and staffing shortages. I think this is, you all are probably hearing about the great resignation or the great retirement, as John is familiar with. But this has gotten a lot of attention I think in the retail and service industries but we are starting to hear about this on the, on the plan and provider side. And I'd welcome the Board's input on this because it is something that we are, you know, keeping an eye on as it impacts access for enrollees.

But some of the things we are hearing about is just the shortages related to obviously retirements, resignations, increased demand in other parts of the state for clinical staff. And for those that maybe don't want to meet our vaccine requirements here in the state they are moving out of state. We are also hearing about higher labor costs to retain staff and some of the lower level providers like medical systems and other staff that are paid hourly, that maybe have more opportunities to make more money outside of the health care industry. And then obviously burnout from stress and exhaustion, which I think we are all feeling, is very real, particularly for our provider community. So something we are keeping a very close eye on as it impacts access for consumers.

And I am just going to quickly touch on our next item, which is our Board Member selection, then I will turn it over for comments from the Board.

But I am excited to announce that our two new members that will be joining in 2022. The first is Scott Coffin who is the CEO of Alameda Alliance.

Scott has over 26 years of experience in health plan and hospital administration and operations, specializing in turnarounds involving billion dollar health systems like Alameda Alliance, so I am looking forward to having his perspective on the Board and continuing to have a Medi-Cal managed care plan voice on the Board.

Our second member is Abbi Coursolle, a senior attorney with the National Health Law Program. Abbi has a law degree but also has done policy work related to both commercial and Medi-Cal and is a passionate consumer advocate.

We will formally introduce them at our meeting which is, I believe, scheduled for February of next year and let them tell you more about their background. John and Jen, while we cannot replace you I am pleased that Scott and Abbi will bring similar experience and perspectives to our conversation, so more to come.

And one final note, we have had some really good discussions over the last two meetings about the role of the FSSB and future priorities. We have a lot on our agenda today and with two new members joining next year I have decided to hold that over, so we will talk more about the feedback that you have given us at our first meeting in 2022.

And with that, I will turn it over to John to take any questions or comments from the Board.

CHAIR GRGURINA: All right, questions or comments from the Board? If you can raise your hand as I spin through the screens. Any comments or questions for Mary? It looks like none. So Mary, I will just --

MEMBER DEGHETALDI: John?

CHAIR GRGURINA: I see Larry. Go ahead, Larry.

MEMBER DEGHETALDI: I couldn't get the Zoom hand up. Mary, just a couple of comments. You are spot-on on the particularly PCP burnout and PCP capacity, which at least in the Bay Area is really a problem. And I -- how we measure that and how we respond is sort of super important because if we lose, you know, PCP capacity and the teams that support them, I don't know what we do.

I did have one area of concern if you could just tee it up for a future conversation. I am hearing early concerns on SB 510 from many of the RBOs that are, you know, now seeing huge increases in COVID testing expenses. Because we, you know, we have empowered appropriately California consumers to access COVID testing wherever, whenever, without any limitations of, you know, requiring to go to in-network centers. But the Act, the law requires that if the testing laboratory is out of network that they meet certain fair market, local geographic costs, it is kind of a balanced billing thing. I am hearing a lot of concerns that it is not working. And maybe this is early but it is something I think we should watch because it is quite significant, the increased expenses, particularly when RBOs are obligated to pay at full charges. Just an area that is just emerging and I am hearing a lot of concerns.

MEMBER WATANABE: Yes, let me respond really quickly to that. We are tracking I think about 18 bills that the governor signed that have implementation activities for the Department. We are working on our draft guidance related to that legislation and Amanda is going to talk a little bit about that more later in the agenda. But, you know, trying to move quickly because some of these bills take effect on January 1st. Appreciate the concerns we have been hearing about COVID testing and vaccines and the lab costs. Where we

can we will provide guidance to try to control some of that. The federal CARES Act and FFCRA does prevail in some cases but we will try to address that in the guidance that we are working on; we will be looking for feedback. But thank you for that comment, Larry.

CHAIR GRGURINA: Okay, Paul and then Ted.

MEMBER DURR: Mary, I just wanted to reiterate what you talked about with regards to COVID-19 and the impact to providers. It certainly is increasing cost to them to retain staff. Those that want to continue to be in health care is a challenge in and of itself but we are hearing a lot of pressure being put on our providers with regards to giving increases to the staff. We are competing against each other for the limited resources that we have, which makes access even more challenging; that that additional cost needs to be borne somewhere within the health system.

I think the other thing that I would mention is regards to some of the patient activity and the difficulty with some of those patients and the I would say maybe abusiveness that comes with some of the maybe unvaccinated people and how they are accessing the system or wanting to access the system, maybe not in a compliant manner as to what we as a health system or even providers require, masking and things like that.

So I think all of those I just wanted to reinforce reaffirm your perspective on that, that that is a growing, growing concern amongst us and being able to provide the access and the care that is needed when we don't have the resources, staffing, as well as supply cost increases that are also taking place.

CHAIR GRGURINA: All right, thank you, Paul.

Ted and then Amy.

MEMBER MAZER: Yes, just to load on. Obviously the burnout question and early retirements are going to have a significant impact as well as people trying to flee from California or not come here because of some of the economics here.

One of the things I do think may exacerbate this and we should be tracking is the potential of 10% cuts on Medicare reimbursement across the board. That will translate in a lot of situations on managed care Medi-Cal to cuts in managed care Medi-Cal payments because they are predicated in a lot of contracts on Medi-Cal fee schedules. I worry that as physicians are still struggling financially through COVID, making a decision whether to continue on or not, they may opt to walk away from everything but commercial plans with these cuts, exacerbating access, particularly in the Medi-Cal population. So we should be keeping an eye on that and may have some comments to make on a federal basis if we see that happening.

CHAIR GRGURINA: Thank you, Ted.

Amy.

MEMBER YAO: Yes, so my question is a little bit different. So I think, Mary, you mentioned there were like 18 regulations we are trying to figure out. But with the passing of the infrastructure bill there could be lots of implications for the health care system as well so maybe in the future meetings can we, in your remarks, like a touch based on those implications.

MEMBER WATANABE: Sure. No, happy to do that, Amy. And we, we typically have had Sarah Ream here to do kind of a regulation and federal update. There's still a lot happening but not a whole lot of new

information to bring to you but we will continue to look to put that on the agenda as we have things to share.

CHAIR GRGURINA: All right. And then I will just add a thank you to Jen for her service on the Board and thank you, Larry, for stepping up to be the next Chair. We appreciate you offering to do so and then that means you need to stay on for a lot longer. All right.

With that, Mary, I think the next item is the Board Member selection but you had discussed that earlier so we can go ahead and move on to the Department of Health Care Services update and we have Lindy Harrington with us. Lindy, why don't you go ahead and take it.

MS. HARRINGTON: Good morning, everyone. Thank you for having DHCS and myself in particular here to present to you. If we can move to the next slide we will get started here. I was asked to present on, there's lots of exciting things happening at DHCS right now so we chose a few topics to provide some updates on.

And so the first topic is around CalAIM. If we can move to the next slide.

So under CalAIM I am going to provide an update on enhanced care management, community supports or the item previously known as in-lieu-of services. We are now considering and have rebranded those as community supports. We are going to talk a little bit about managed care benefits standardization, mandatory managed care enrollment, and shared risk/savings and our regional Rates proposals. If we can move to the next slide here.

So really as we look at enhanced care management and community supports, what we are really doing here is looking at taking our

current programs, which are both demonstrations, our Whole Person Care pilot programs, which again is a limited pilot program supported across delivery systems and it is administered by county-based local entities; and our Health Homes program, which is a benefit or a state plan service in select counties for Medi-Cal managed care members only and it is a health plan administered with care management contracted out to providers.

And what we are really looking to do, if we can switch to that next slide, is really bring together, and so what we are doing is we are building on both the design and the learning from those two pilot programs to move beyond county pilots to a standardized, statewide implementation of community-based care management and coordination spanning across physical health, mental health and social services. We are really looking to integrate this work into our Medi-Cal managed care delivery system and keep the interventions community-based by setting requirements on plans to contract with community-based providers and community-based organizations for both our enhanced care management and community supports.

And just so that everyone is on the same page, community supports are medically appropriate and cost-effective alternative to services are settings covered under the state plan that are optional for health plans to offer and for members to utilize.

And if we look forward to the implementation time line, so beginning on January 1st the enhanced care management will go live in stages while community supports will launch statewide; managed care plans in all counties may elect to offer additional community supports every six months.

And as we look at our go-live timing, if we can go to the next slide.

So really our timing will go live based on populations of focus and county. So in January of 2022 our whole person care and health homes counties will see this go live and it will be July 2022 for other counties. And really managed care plans in all counties are able to offer community supports for individuals and families experiencing homelessness, adult high utilizers, adults with serious mental illness, SMI, and substance use disorder, SUD.

If we go to the next slide. Beginning in January of 2023 we will bring on additional populations of focus and that will be our adults and children and youth incarcerated and transitioning into the community. Those at risk for institutionalization and eligible for long-term care and nursing facility residents transitioning to the community.

While in July of 2023 we will bring on our final population of focus, which would be our children and youth populations.

Now, it is important to think about, and we are at the Financial Solvency Board so I think it is important to think about what are those financial considerations?

So our Medi-Cal capitation rates for calendar year 2022 and beyond will include funding for enhanced care management, subject to a two-sided symmetrical risk corridor. Historical costs of in-lieu-of services that aligned to community supports and projected costs due to the addition of community supports capacity and infrastructure as well as the sunset and transition of whole person care.

We also have provided additional funding for enhanced care management and community supports investments that will be available. So funds going to our plans through the CalAIM Incentive Payment Program, we are

investing $1.5 billion over two and a half years. Now, the Department does expect that the plans will share these incentives with providers as providers will be key to meeting the measures and metrics required for payment. And then also separately, funds that would be available for providers through the Providing Access and Transforming Health or PATH program that we are asking CMS to support under our 1115 waiver renewal.

As we move on to talk about managed care benefit standardization. So today, Medi-Cal managed care exists statewide for Medi-Cal but it operates under six different model types that differ based on whether certain benefits are part of the Medi-Cal managed care plan's responsibility are provided through a different system. Our goal as we look at standardizing the benefits that are provided through managed care statewide, so that regardless of a beneficiary's county of residence or plan in which they are enrolled, they will have the same set of benefits delivered through their managed care plan as they would in any other county or plan.

So really this is, again, happening in phases as we look to bring in this standardization. So beginning on January 1, major organ transplants will be carved in for Medi-Cal managed care plans statewide.

The Multipurpose Senior Services program will be carved out from Medi-Cal managed care plans statewide.

And then in January of 2023 institutional long term care services will be carved in for Medi-Cal managed care plans statewide.

And then finally in July of 2023, specialty mental health services that are currently included for Medi-Cal members enrolled in Kaiser in Solano as a subcontractor of Partnership Health Plan, and Sacramento counties will be

carved out to the mental health plans in those counties.

Then our next big initiative under CalAIM is really mandatory managed care enrollment. So today the Medi-Cal program provides benefits through both a fee-for-service and managed care delivery system; and enrollment in one of these two systems is really based upon specific geographic areas, the health plan model and/or aid code for which the beneficiary is determined to qualify.

So really our goal here is that beginning in January of 2022, select aid code groups and populations will transition into mandatory managed care enrollment or mandatory fee-for-service enrollment.

And the changes. So again we are looking at beginning January 1 of 2022 we will have select populations and aid code groups, really non-dual beneficiaries living in rural ZIP codes, that currently receive benefits through the fee-for-service delivery system would transition to mandatory Medi-Cal managed care.

And select populations in aid code groups, for example, those covered under the Omnibus Budget Reconciliation Act or OBRA in Napa, Solano and Yolo counties that currently receive benefits through Medi-Cal managed care will transition into mandatory fee-for-service enrollment.

And so really more broadly going into, so January 1 of 2023 all dual population aid code groups except share of cost or restricted scope will be mandatory Medi-Cal managed care. And dual and non-dual individuals and long-term care will also be mandatory in Medi-Cal managed care.

Before we go on to the shared risk and savings. So really going into managed care we are looking at trafficking and crime victims assistance

program except those with a share of costs, individuals participating in accelerated enrollment, pregnancy-related Medi-Cal, beneficiaries with other health care coverage. Again, beneficiaries living in rural ZIP codes. And then moving into fee-for-service all dual and non-dual individuals eligible for long-term care services, all partial and full dual aid code groups except share-of-costs or restricted scope will be mandatory Medi-Cal managed care in all models starting in 2023.

As we as we move forward and start talking about some of these changes, as we make these changes we also need to think about how we are financing, how are we paying for these changes. And so really looking to implement a shared risk savings to provide financial protections that support investments in enhanced care management, community supports, and managed long-term services and supports capacity and infrastructure.

So no sooner than calendar year 2023, a blended capitation rate across our seniors and persons with disabilities and long-term care beneficiaries. The rate will be subject to a blend true-up, which will provide financial protections in case of significant differences between the actual and projected enrollment mix.

No sooner than calendar year 2023 we will have a time-limited, tiered and retrospective shared savings/risk financial calculation that will be performed by DHCS. This tiered model would be available for three calendar years.

And then no sooner than calendar year 2026 a prospective model of shared savings/risk will be incorporated via our capitation rate development once historical managed care cost and utilization experience is available that

reflects the implementation of enhanced care management, community supports and long-term care services statewide.

Now, I will, I will just preface all of that with we are still in the planning stages of how we roll that out and what that looks like, so as we move into questions I won't be able to get into a lot of specifics or details on that proposal. But I would flag for everyone that we will continue to work with our managed care partners as we develop the final details of how we implement that proposal.

Next we will be looking at regional rates so regional rates in targeted counties will begin in calendar year 2022. And really here under this targeted implementation we are looking to consolidate rate setting in counties where the same managed care plans operate across multiple adjacent counties.

And then no sooner than calendar year 2024 we will be doing regional rates statewide. As we look to establish what those regions look like we will consider health care market dynamics, including but not limited to health care cost and utilization data, across counties when determining those regional boundaries. We will also be considering appropriate county or managed care plan-specific adjustment factors to recognize geographic, population or other differences.

And I would just flag for everyone, one of the questions that has come up quite a bit is, do we know what those regions are? Can you tell us what those regions are? And we don't. And one of the reasons that we haven't established those yet is they will be influenced by our managed care re-procurement and so we want to ensure that that has been completed before we finalize any of those regions.

Another big initiative that has been undertaken at the Department is Medi-Cal Rx. And so as we think about Medi-Cal Rx, so really effective January 1 of 2022, pharmacy services billed on a pharmacy claim will be carved out of Medi-Cal managed care and provided through Medi-Cal Rx instead. Pharmacy service costs and a corresponding portion of administrative costs will be removed from the managed care capitation rates. Physician administered drugs will still be covered and funded through the managed care capitation rates as they are not billed on a pharmacy claim.

And really, as we look to the benefits of Medi-Cal Rx. You know, really transitioning pharmacy services from managed care to fee-for-service will among other things provide standardization to the Medi-Cal pharmacy benefits statewide under one delivery system based on the DHCS policies.

It will apply statewide utilization management protocols to all outpatient drugs as appropriate. And this really means that no matter where you live in the state or what health plan you belong to, if in managed care, the same utilization management policies apply. The people who review and adjudicate prior authorizations for Imperial County are the same that will review them for Humboldt County.

It will improve access to pharmacy services with a pharmacy network that includes the vast majority of the state's pharmacies and is generally more expansive than individual Medi-Cal managed care plan pharmacy networks.

And finally, it will strengthen our ability to negotiate state supplemental drug rebates with drug manufacturers as the largest Medicaid program in the country with approximately 14 million beneficiaries.

Now, if we look at the scope of Medi-Cal Rx, it includes all pharmacy services billed as a pharmacy claim, including but not limited to outpatient drugs, including physician administered drugs, pads, enteral nutrition products and medical supplies.

Medi-Cal Rx will not include pharmacy services billed as a medical or institutional claim. So things like durable medical equipment or other items one might be able to purchase at a pharmacy but are not billed by the pharmacy on a pharmacy claim.

There are some services that can be billed either way, a pharmacy claim or a medical claim, and for those the determining factor of responsibility for payment is the claim type. So if it is a pharmacy claim then it will be billed to Medi-Cal Rx, if it is a medical claim then it will be billed to either the fee-for-service fiscal intermediary for a fee-for-service beneficiary or to their respective managed care plan. Physician administered drugs are a good example. So if the medication is provided in the doctor's office and the doctor is the entity billing then the claim would go to either the managed care plan or the fee-for-service fiscal intermediary. However, if the doctor ordered the medication from a pharmacy and provided it in their office and then the pharmacy would be the billing entity they would Bill Medi-Cal Rx. There is also a really helpful scope document on our Medi-Cal Rx transition webpage that has a listing of what is in and what is not.

As we look at the Medi-Cal Rx we have a 180 day transition and the purpose of this transition period is to reduce potential friction a managed care beneficiary may otherwise experience when trying to obtain their medications due to the transition from their health plan to Medi-Cal Rx.

So during this 180 day transition to Medi-Cal Rx we will utilize grandfathered prior authorizations from the managed care plans to authorize the payment of claims for drugs and medical supplies that would otherwise require a prior authorization. In addition, Medi-Cal Rx will utilize historical claims from the managed care plan to look back for continuity of care and therefore authorize payment of claims with drug or medical supply that would otherwise require prior authorization. And again, there's much more on this policy including an array of scenarios on our Medi-Cal Rx transition webpage.

And then finally as we think about kind of next steps, both DHCS and our contractor Magellan are continuing targeted outreach efforts to increase provider participation in our provider registration portal. And this outreach includes a phone campaign to providers and prescribers, direct outreach to key trade associations, surveying prescribers and providers to understand how they submit claims and prior authorizations today.

It is important to note that registering for the secure portal is not required in order to submit claims and prior authorization requests. There are actually four modalities prescribers can use to submit a prior authorization. CoverMyMeds, an app-based tool used by more than 55% of Medi-Cal prescribers, fax the Medi-Cal Rx portal, and finally, the US mail. Registering and using the portal will allow prescribers access to helpful tools related to Medi-Cal Rx such as tracking prior authorization status on their own without having to contact a customer service center, but again, there is no requirement to do so.

And then finally, an implementation update. So we are finalizing the January 1, 2022 readiness activities. Medi-Cal beneficiaries will receive 60 and 30 day notices and our Medi-Cal Rx call center was fully staffed as of

November 1st, operating 24/7 and that date was to coincide with the 60 day beneficiary letters. And I would note those beneficiary -- copies of those, the language associated with those beneficiary, with that 60 day beneficiary notice is on the Medi-Cal Rx transition website.

And then we just included for you all some helpful information and resources on the next slide for where you can go for more information on the Medi-Cal Rx transition.

And then moving to my last topic, is really that managed care procurement that I mentioned earlier. And so on February 2nd of 2022 or 2/2/22, so if anyone ever needs to remember the date for the release of the RFP we have made it memorable. So on that date we plan to release a Request for Proposal or RFP to re-procure all commercial Medi-Cal managed care plans effective January 1 of 2024. Updates regarding the RFP schedule are posted on our website.

Seventeen counties have requested to change their model type, mostly to transition from a multi-plan county to a single-plan county.

This process will impact rate development for calendar year 2024, particularly, as I mentioned, as we look to fully implement regional rate-setting methodologies.

We have conditionally approved all 17 counties and six managed care plans that submitted a letter of intent for county model changes. And so really single plan county, so Alameda County will become a single plan with Alameda Alliance, Contra Costa County will become a single plan with Contra Costa Health Plan, and Imperial County would become a single plan under California Health and Wellness.

Counties that will become COHS with Central California Alliance for Health are Mariposa and San Benito counties.

And then counties that will become COHS by joining Partnership HealthPlan: Butte, Colusa, Glenn, Nevada, Placer, Plumas, Sierra, Sutter, Tehama and Yuba counties.

And then finally under two-plan with HealthPlan of San Joaquin acting as the local initiative we will have Alpine and El Dorado counties.

Additional information is available on our website at County Plan Model Changes.

And with that I will open up for questions.

CHAIR GRGURINA: All right, thank you, Lindy. Are you sure you don't have another 10 or 15 slides to go over with us? (Laughter.) Thank you for your very in-depth presentation.

All right, Larry, you first.

MEMBER DEGHETALDI: I am talking on mute again. That's a $20 fine at the AMA, sorry.

Lindy, just a specific question about regional rates. First of all, I fully support CalAIM. It is ambitious, it is bold, it is needed, it is scary, though. The question I have, as we look at Partnership HealthPlan, which looks like will have 24 counties, CCH which will have 6, they will each include, for instance, CCH will have the county with the highest wage index in the country and Mariposa the lowest in the state. Similarly, Partnership will have Marin and Modoc. How will you set rates across geographies that are as heterogeneous as any in the country?

MS. HARRINGTON: Again, I think it is important to note that as

we, as we looked at that slide, I mean, those are some of the factors that we will take in as we look to establish what those regions are. We will look at things like the cost of providing services in those areas.

MEMBER DEGHETALDI: Yes.

MS. HARRINGTON: And the other thing that we will look to do, so even if we are establishing the regional rate we will likely have to provide some considerations for the plan-specific rate that is ultimately paid to account for some of those differences. So again, part of that is the process that we will continue to work through with our managed care plan partners as we look to finalize regional rate setting. But those are all considerations and things that we are looking at.

MEMBER DEGHETALDI: And my concern is that when you talk about identifying costs, and this is true for the Medicare program as well as the Medi-Cal program, we know what hospital costs are because they have to report them. And you can determine the adequacy of the Medi-Cal fee schedule or nationally the Medicare fee schedule for hospitals but you can't do it for physicians.

And I agree with Dr. Mazer that there is a looming, with the rising costs for ambulatory care, I view the next three to five years as there is a catastrophic decline in access in California for government patients because of the inadequacy of payments for Medicare and Medi-Cal. And that you have heard doctors complain about this for decades but this is very, very real and I welcome Dr. Mazer to refute me on that. But that is a very real concern. How do you measure adequacy of payments to physicians giving the inability to see their true cost structure, and it will show up as declining access.

MS. HARRINGTON: So, I mean, again, I think that is a challenge that we face in the industry regardless of whether we move to regional rates or not. I think we are continuing to work with our health plans to gather data to understand changes, what's occurring. And I think it is important as we talk about access to think, to think about our monitoring is not only on the financial side but we also have our network adequacy monitoring and activities that we do. And so we work really closely with our partners within the Department to understand what's happening at the plan levels around that access, network adequacy, those requirements.

And again, I think as John, John can testify to, we do a lot of work with our plans to understand what is happening. We do things like special data requests or supplemental data requests as part of our rate-setting methodology where we are gathering information about more current data or looking at different activities so that we can ensure that we are doing all we can to be setting appropriate rates for our plans. But again, we also acknowledge that there are definite unknowns as we come out of the public health emergency and the changes that have occurred to understand what those look like. So lots of work to come and continued partnership with our managed care plans.

CHAIR GRGURINA: Okay, Ted, then Amy, then Jen.

MEMBER MAZER: Thank you for that very, very in-depth presentation, which unfortunately yields a lot of questions. And no, I am not going to refute Larry at all about the dangers that we are facing with access with low and ever decreasing reimbursements. So let me kind of stack a couple of quick questions on you and I can repeat them if you forget them.

I am worried about the network adequacy on two sides with some

of the shifts and I don't know from what you presented how many patients are affected in these counties. But particularly moving the patients in Napa and the related counties into fee-for-service I worry about how many providers are going to be able to see them outside of a managed care contracted network. And likewise in the rural areas I am a bit concerned of whether there is going to be an adequate contract for those rural doctors to get onto a network and be able to serve those patients. So once again kind of like when we went into the dual mandatory I worry about how the shift is going to affect access to care for those patients.

On the financial side, going back to Larry's point, you have got incentives going to the managed care plans but you have got shared risk and what I am not hearing is where is the downside risk, what encouragement is the Department giving to the managed care plans to share up-side risk to attract and maintain their networks and what risk might those plans be putting on the physicians on a down-side basis that might scare them out of the network, given all of the financial considerations?

And then my last question, if you remember these, just the implementation of CalAIM. I was on a recent call with Molina Health Plan talking about what options they have opted into come January, each plan taking on different options. It gets very complicated for the provider office to determine what they need PAs for, what they don't, what's covered under the CalAIM, for each one of these plans. And I would just encourage the Department to make sure that there is continual communication to make it easy for a physician or their staff to find out for a given patient on a given managed care plan contract, what is the matrix that that plan is using in their CalAIM compliance? Thank you.

MS. HARRINGTON: Sure. I am not sure I heard a lot of question. A lot of comments, I'm not sure there's a lot of questions in those. But no, I think what I would say is when we talk about the transition into managed care or into fee-for-service, when we talk about like the OBRA population, it is a small population, it is not a large population. As we talk about moving those individuals into managed care there are, you know, readiness activities and things that my partners on the health care delivery system side are going through to ensure that we are providing those appropriate networks.

As we look at the implementation of CalAIM and the requirements under community supports and the allowance for there to be different selections, it is voluntary for plans to take on these community supports but we are continuing and will continue to provide information about what those services that have been elected by those plans and the teams are continuing to work on ensuring we have good transparency and communication around those.

MEMBER MAZER: Could you address the question about down-side risk and incentives of plans to incentivize their physician network with any up-side incentives?

MS. HARRINGTON: Under the incentive payment program that we have we do not have the ability to require the sharing of those. It would violate federal rules to provide explicit direction to the plans regarding those incentive payments and so the way we have established the metrics and the needed requirements, the expectation is a good portion of those dollars will have to be shared in order for the plans to earn those dollars and receive those funds and so the plans themselves have an incentive to share those dollars with their plans.

As we look at the broader contract and broader payment

arrangements between plans and providers, you know, we are thinking about what are different ways we can help incentivize more value-based payment arrangements and others and so more information likely to come.

I think one thing that helps with that is as we move into calendar year 2023 rate-setting we have, you know, publicly made clear that we will be including as part of our final rate-setting methodologies to be incorporating quality and equity metrics into that final rate process and I think those activities help to incentivize plans to work with their providers to meet those quality goals and equity goals.

MEMBER MAZER: I'm sorry, with apologies to the other people trying to ask questions. I haven't heard anything addressed yet, down-side risk. Is there significant down-side risk, when does that occur and what protections might be able to be placed so the down-side risk isn't shifted to physicians, which would then scare them from continuing with their networks?

MS. HARRINGTON: And, Ted, I think what you are hearing from me is I don't currently have the ability to tell a plan how to pay their providers. What we have done is continued to set up what we hope are incentives to ensure plans are working with their provider communities.

MEMBER MAZER: Thank you. I would like to know more about the down-side but I will move on.

CHAIR GRGURINA: All right, Amy and then Jen.

MEMBER YAO: Okay. So, Lindy, yes, so appreciate the presentation. Gosh, there's definitely lots going on at the DHCS, no shortage of challenges. So I have a couple questions and then if it is not enough I have another ask. So one is related to the rates. Really appreciate the consideration

for the risk corridors and I heard it is for three years. So my first question is related, what is covered under that risk corridor? I heard you mention about the ECM, community support, the long-term care, but there's another one is a transplant. Is it going to be moving over to the health plan's responsibility? A transplant is high-risk. So I didn't hear whether that's going to be part of the risk corridor, that's one part of the question.

The second one is, I heard the risk corridor is first three years. Just reflecting on what happened in the ACA market. That was the initial, like the rate insurance provision under ACA was initially for three years, then it phased out. Then we started seeing some fluctuation in the rates and actually the rate insurance is coming back with the infrastructure bill. So I wonder whether DHCS will, giving all the changes that are going to happen, this is a lot of changes, whether there is a consideration for a potentially longer period of risk corridor? So that's my first question related to the rates.

And then my second question is related to the --

CHAIR GRGURINA: Amy, why don't we let Lindy answer that one and then come back to the next one?

MEMBER YAO: Okay. Okay.

MS. HARRINGTON: Sure. So the risk corridor that I mentioned was really, so there's a, there's a couple of different things that are kind of getting blended together. So yes, for ECM we have created a subject to a two-sided symmetrical risk corridor that will be specific to the enhanced care management component of the rate and expenditures associated with enhanced care management.

And so again, as you talk about major organ transplants, I did not

include really a discussion around the rate components there. Yes, we have been talking to our plans about including a risk corridor associated with the major organ transplants and we are working to finalize the details of those, of that corridor with our plan partners.

I think the other component that you kind of were blending together there was as we look at shared risk and savings components, as we look to do that we would have no sooner than calendar year 2023 we would be doing that blended rate. Really looking to do a true-up of the projected versus the actual case mix to ensure that we got that right. And then that, and then again, we would have kind of a calculation that would happen associated with those. And then no sooner than 2026 the prospective model, so we would do kind of that shared, and then we would move to prospective. So I think that's where the three years is coming in.

MEMBER YAO: Yes. So my question is, will there be a consideration if we see lots of fluctuations, maybe pushing out the prospective payment beyond 2026?

MS. HARRINGTON: So again, it is no sooner than then 2026.

MEMBER YAO: Okay.

MS. HARRINGTON: And it is really after that. We would be providing that for that three year, that tiered model is kind of available for the three calendar years, that's based on our statute currently and so that is the way that we have established those activities. And again, you know, more information to come on those as we continue to develop them.

MEMBER YAO: Thanks, Lindy.

So John, can I ask more questions?

CHAIR GRGURINA: Yes.

MEMBER YAO: Okay. So my next question, there has been lots of noise -- not noise. You probably heard in the news about pharmacy side, like the gene therapy drugs. They are really expensive. I think Medicare Part B just increased the Part B premium materially because of Alzheimer drugs. So with those emerging high cost drugs I am trying to understand who is the responsibility going to be? Is that going to be carved out or is it going to be under the medical coverage?

MS. HARRINGTON: So again, it really comes down to how that, how that drug is billed. If it is billed on a medical claim it would be the responsibility of the health plan; if it is billed as a pharmacy claim it would go to Medi-Cal Rx. And again, I think, you know, a lot of those, as you start talking about some of those high-cost therapies and drugs, it really is dependent on the actual drug or therapy and where that lands and the Department has a process that we go through as these new activities come on board to kind of evaluate where those land. That happens in another area, it does not fall under my purview so it is hard to get into some of the nitty gritty details. But yes, the Department is, you know, paying close attention to those, you know, emerging technologies and making sure that we are accounting for those and thinking about those in our processes.

MEMBER YAO: Okay. Yes, the reason I bring it up, because if you are separating the responsibilities there could be potential gaming going on and those are really expensive drugs.

So my last ask here is a question about the Medi-Cal redetermination. So do you have an update on that? I know you have covered

so many topics but I am just adding more.

MS. HARRINGTON: So what I will say is the Medi-Cal redetermination process, the Department is working actively on the unwinding of the public health emergency and preparing for what the process will look like. I do not have an update that I can share today associated with that but no, it is forefront in the work that is happening, especially our health care benefits and eligibility team is working very closely with our federal partners to ensure that we are prepared for that unwinding and that we have processes in place and so more information to come on those.

MEMBER YAO: Okay, thanks Lindy.

CHAIR GRGURINA: Lindy, I might add that I know the state and DHCS have done a nice job of pushing CMS to get at least 12 months to be able to run through the redeterminations. And my understanding is they have acquiesced to that so that is at least one positive.

And then the second, Amy, will be is, how long does the public health emergency go on? Right now it is through the middle of January, will it be extended? Here I would say DHCS has done a really nice job of pushing hard and we need to. We are the largest state with the most folks on Medicaid and it will be a huge process to do redeterminations; and the last thing we want is for anyone to be able to lose their coverage because it happens at such a fast time.

So with that, Jen, why don't you go ahead and go. You are on mute, Jen.

MEMBER FLORY: Just to add on to that, we've heard otherwise from the Department that the redeterminations will look similar and that they have that entire 12 months so it wouldn't be you know, everybody needs to be done in

a certain amount of time so we were comforted by that as well.

But, Lindy, you know, in looking at the total effort to move towards plan standardization and the fact that re-procurement is coming up. I know Western Center has raised this on many occasions but given that I am sitting in a Department of Managed Health Care meeting right now, we would highly encourage the Department to require all COHS to be Knox-Keene licensed because that is another thing that does really matter for consumers. Which side of a county line depends on whether you have access to a DMHC IMR and it depends, you know, other things that have to do with the regulation of the plans and so we would really encourage the Department to have all Medi-Cal plans be Knox-Keene regulated plans.

MS. HARRINGTON: Thanks, Jen.

CHAIR GRGURINA: All right, thank you, Jen.

And it looks like that is it from the Board so I will just add one piece which, Lindy, you have heard me say before, which is, as you look in the regional rates for 2024 really needs to be done very, very carefully because you could imagine combining multiple counties and seeing dramatically different rates for different plans for some very good reasons. The one I always give in our plan is we have very little costs on non-emergency medical transportation because of the great public transportation we do have in the city. So when you look at our numbers you think, boy, that's incredibly low, particularly compared to everyone else. If we were put together with five other counties, if we got the average we would actually end up getting more money on that, but we have other categories where we are much higher for good reasons. So very, I appreciate no sooner than 2024 and I would encourage not opening it until you are ready, because

what we don't want to see is large decreases at some plans and providers and big increases in others. Anytime you make a big change you have got to see what the unintended consequences are.

So thank you very much for all your work and your presentation and now, Jordan, why don't we turn to online and see if there are folks who have any comments or questions about this item or previous items.

MR. STOUT: Yes, we currently have one. When prompted please unmute yourself and state your full name and organization.

MR. BARCELLONA: Thank you. This is Bill Barcellona from America's Physician Groups. Lindy, I have got six questions for you, I will try to run to them pretty quickly. First of all, I was made aware last week that the Department of Health Care Services is also going to issue formal guidance on the implementation of SB 510 under Medi-Cal managed care. Can you confirm that and can you give us an idea of when that guidance would be forthcoming?

MS. HARRINGTON: Unfortunately, Bill, that is not under my area of purview so I do not have details on the implementation of SB 510 so the Department would have to get back to you. But I think, I think I would, I would suggest I can take that back and share with my delivery system partners your interest in that, in that guidance.

MR. BARCELLONA: Thanks very much, that's great.

I wanted to pick up on some comments by Dr. Mazer around downside risk. Last week I got briefed by Peter Lee, Covered California, on their proposed quality transformation initiative and he informed me that this is a joint effort with California's Medi-Cal system, with CalPERS and maybe some other payers as well to establish a joint core set of performance measures. I just

wondered if DHCS has indicated formally that it is part of this and how are you going to proceed with that transformation initiative?

MS. HARRINGTON: So I can say the Department has been participating in activities to think about how do we establish core metrics that are the same across various delivery systems or activities so that we can all be rowing a boat in the, in the same direction, but I don't have more information than that, Bill, unfortunately. Again, another component that is outside of my specific purview.

MR. BARCELLONA: Okay, Lindy, thanks.

And since I didn't get a chance to come after Director's comments I'd just like to note that that was a similar question for Director Watanabe about whether or not this joint effort by some of these other agencies, kind of asking how that fits in with the Department's intention to do the quality and equity committee stakeholder process starting in February so maybe we can address that at the end of the session today.

Okay, other questions. We are a little concerned about these increasing COVID testing costs. I know that Dr. deGhetaldi mentioned this at the beginning of the meeting today, I don't know if you were online for that, but in the Medi-Cal groups what we are seeing is a $4 PMPM hit for testing costs on Medi-Cal risk bearing providers. And so if you are going to carry something back to the Department staff on this SB 510 implementation, that's really one of the most important points is that this is disproportionately affecting the lower paid Medi-Cal managed care risk bearing groups because that's where most of the testing is occurring in the Medicaid population.

And then we had previously submitted a request to the Department

to consider ICE's effort on the coded DOFR and I just wanted to follow up with you to see where the Department was in in consideration of that?

MS. HARRINGTON: I don't have an update for you on that, Bill. It would -- I would recommend that you send a follow-up to an inquiry that you had provided.

MR. BARCELLONA: I will do that. All right, thanks very much. That's all I have.

CHAIR GRGURINA: All right, thank you, Bill.

Jordan, do we have anyone else online with questions or comments?

MEMBER WATANABE: John?

MR. STOUT: At this time, no.

CHAIR GRGURINA: Jordan, do we have anybody on the phone with questions or comments?

MR. STOUT: We do not.

CHAIR GRGURINA: I'm sorry, Mary, you had something to say?

MEMBER WATANABE: Yes, maybe if I can respond quickly to Bill's question about quality. So, Bill, I am aware of Covered California's initiative with a couple of the other purchasers and excited about, I think, the narrowing of focus and really trying to focus, focus on a core set of measures. And as we have talked about with the health equity and quality initiative our goal is to really kind of build consensus around this core set of measures. So I think the work that the purchasers are doing, the work that NCQA is doing around equity, give us a good starting place, but of course we will be looking to our quality committee to make those recommendations and have those discussions, which will include

our state partners and purchasers. So look forward to that discussion next year but I think there is some excitement building around focusing on a maybe smaller set of measures and so look forward to having that continued discussion next year.

MR. BARCELLONA: Thank you, Mary.

MEMBER WATANABE: Thanks a lot, Bill.

CHAIR GRGURINA: Larry, you have a comment or question? You're on mute.

MEMBER DEGHETALDI: I just -- for 20 years California has really emerged as the quality place in the country, mostly due to IHA's work. And to the extent that we can build off that chassis and not rely on claims-based information in order to do the health equity disparity work we need really the medical, the provider organizations to work closely with the plans. So let's just keep in mind that we do have a chassis that's been driving the car pretty well. I had say that before Jeff said it, so anyway.

MEMBER RIDEOUT: Not my place to say it but thank you very much, Larry. Just as long as the car is running, we are happy.

CHAIR GRGURINA: All right, well thank you very much, folks.

Lindy, thank you very much for your time and presentation, we appreciate it. And either you or René or someone else from the Department, we will love to see you again in February.

MS. HARRINGTON: And one of us will be here, John.

CHAIR GRGURINA: All right, thank you.

With that, we will go ahead and move on to the financial summary of Medi-Cal managed care health plans with Pritika.

MS. DUTT: Good morning, I will provide you a quick update on the financial summary report for quarter ended June 30th, 2021. A copy of the detailed report is available on our public website in the Financial Solvency Standards Board section. This report is prepared by the DMHC on a quarterly basis and it highlights enrollment and financial information for local initiatives, county organized health systems and non-governmental Medi-Cal plans. Non-governmental Medi-Cal plans are plans that report greater than 50% Medi-Cal lives but are neither an LI or a COHS. The report is divided into three distinct areas first focusing on LIs, next COHS and then we look at the non-governmental Medi-Cal plans. We made some changes to this report for this current quarter which included adding three additional tables in each section. We included the Medi-Cal expense ratio table, administrative costs ratio, and profit or net income ratio, which shows what percentage of Medi-Cal revenues were spent on medical expenses and administrative costs and net profit.

One of the things I wanted to point out here that it includes all revenues and all expenses that was reported by the plans on their financial statements so it includes all their lines of business because like -- there's a few plans that have, that provide administrative services functions to their county partners and those revenues and expenses were included in both ratios, so that's something we need to look at, make adjustments in the future report to exclude these pass-through revenues and expenses. Next slide.

There are nine Local Initiative plans that serve 5.6 million Medi-Cal beneficiaries in 13 counties. LA Care, the largest LI plan, had 2.4 million enrollees. Their enrollment increased by 2% over the last quarter. Overall the LI plans' Medi-Cal enrollment increased by almost 115,000 lives from March 2021

to June 2021. There was an increase in medical expenses due to increase in utilization of services. However, the increased medical expenses did not result in net losses for all the LIs.

For the second quarter of 2021 the LI plans reported total net income of $101 million. All LI plans except for Health Plan of San Joaquin reported net profits for the second quarter. And all LIs met the Department's reserve requirement or tangible net equity requirement. TNE to required TNE range from 517% to 779%. So I want to point out here that the minimum required for health plans is 100% but ideally we want plans to maintain TNE of over 200% so we don't have much concerns (indiscernible). Next slide.

There are six COHS plans that serve 22 counties. And of course, as Lindy mentioned, that might change in the future quarters.

So we received financial reports from five COHS. Gold Coast Health Plan does not report to the DMHC because they are only, they only serve Medi-Cal beneficiaries and their Medi-Cal line of business is exempt from licensure. The five COHS that report to the DMHC serve over 2.1 million Medi-Cal beneficiaries. All COHS plans experienced enrollment growth for the last six quarters. CalOptima and Partnership HealthPlan reported the highest enrollment numbers. Compared to prior quarter, COHS plans Medi-Cal enrollment increased by almost 40,000 lives.

For the second quarter of 2021 the COHS plans report net income of $362 million. All COHS plans reported net income of except SenCal Health Plan. SenCal reported net losses of over $1.5 million for the current quarter and they have reported net losses for six consecutive quarters due to increases in their medical expenses. We did reach out to SenCal about when they expect to

turn their net loss trend around. And in-person Cal with the increased capitation rates from DHCS effective January 2022 the health plan now anticipates operating, turning the operations around and being profitable starting in January of 2022, so that's good news there. So SenCal's TNE to required TNE at June 30th, 2021 was 510% so still way over the minimum required. All COHS plans report over 500% of required TNE for June 2021. TNE to required TNE ranged from 510% to 1298% of required TNE.

There are eight non-governmental Medi-Cal plans that serve over 3.4 million Medi-Cal beneficiaries in 37 counties. All NGM plans reported an increase in Medi-Cal enrollment in June 2021 compared to the prior five quarters. For the second quarter of 2021 the NGM plans reported total net income of 252 million. TNE to required TNE ranged from 118% to 802%.

So some of the takeaways from the report that we did this quarter: In 2020 and half, the first half of 2021 the Medi-Cal managed care plans reported an increase in Medi-Cal enrollment and that was largely due to the suspension of annual Medi-Cal redetermination requirement during the public health emergency. LI and COHS and NGM plans reported a slight decrease in their medical expenses in the second quarter of 2020 compared to first quarter of 2020 because of the decrease in utilization of services during the COVID-19 pandemic. In the second half of 2020 through who first half of 2021 the Medi-Cal managed care plans reported slight increases in medical expenses due to an increase in utilization. And we also saw enrollment going up there.

A majority of the Medi-Cal managed care plans reported positive net income June 30th, 2021. Medi-Cal managed care plans continue to meet or significantly exceed the minimum TNE requirement. We will continue to monitor

the financial trends and enrollment growth of all the Medi-Cal managed care plans.

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

CHAIR GRGURINA: All right, thank you, Pritika.

Any comments or questions from Members of the Board? Jen.

MEMBER FLORY: I mean, I guess just on what we were talking about before about starting redeterminations over again. I mean, it strikes me that during this period, even though the what medical services would be provided I think was really volatile and there was a lot in the air. On the other hand, the enrollment should have been much more stable with people not dropping off Medi-Cal as easily; they had to pretty affirmatively say they no longer wanted Medi-Cal or they stayed on. So with that in mind, is there any additional concerns or scrutiny you might have on certain plans, particularly ones that were posting a loss in this, in this time?

MS. DUTT: So that's a good question, Jen. We continue to work with these plans, we communicate with them frequently on their financial trends. As soon as the financials come in those are the ones we pay close attention to, the ones that have been reporting consistent net losses. So we do reach out to the plans and then we ask them questions around their profitability, look at their projections. If we need to reach out to DHCS to get further information we do that as well. Lindy, I am not sure if you have anything to add there.

MS. HARRINGTON: I don't at this time.

CHAIR GRGURINA: All right, thank you.

Larry.

MEMBER DEGHETALDI: You know, Mary reminded me how old I am today. One of the challenges is we tend to look back a year and not ten years, you know. Because I have seen a sine wave of profitability, at least as measured by the TNE. You know, with dips in Alameda Alliance, we lived through that. What's the, what's the horizon look, you know, what can we learn from the past ten years to predict the next five or is that a useful exercise, you know?

MS. DUTT: So, Larry, that's something we used to, you know, capture more at, more yearly data in this report but after COVID we switched it more of looking at what is happening quarter after quarter. So that is something we are looking at, the plans' TNE levels over the years.

Like one of the things I pointed out, all of the Medi-Cal managed care plans, both Local Initiatives and the County Organized Health Systems, their TNE levels have been over 500%; that's a safe zone, right? And then we keep observing their, you know, profits and losses and just the enrollment growth. We have attended their board meetings in the past so we are hearing what's happening at each plan at county level. So we still have concerns but right now with the reserve requirements as high as 500% it is not as concerning as it was two years back.

CHAIR GRGURINA: Amy and then Paul.

MEMBER YAO: Hi, Pritika. You know, one thing that caught my eye is on your last page on the non-government plans and you had one plan, I think the lower end is 118% TNE. That seemed awfully low. So which health plan is that and what are we going to do about that health plan?

MS. DUTT: So if you look at page 38 of the detailed report it is

California Health and Wellness; California Health and Wellness is owned by Centene. And one of the things we do look at how it's a public -- Centene is a publicly-traded company so we do look at the publicly traded company's financial statements to see how they are doing, if they have reserves, just in case California Health and Wellness needs additional funding, you know, Centene would likely put that in. So that is one of the things we look at, how the publicly traded plan is performing as well.

CHAIR GRGURINA: All right, Paul.

MEMBER DURR: Yes, thank you, Pritika, for a great overview. My question was looking more at the detail. I had two questions. One is the administrative expense ratio, comparing the different categories. And it may be more unique to the different types, whether it is an LI or a COHS or, you know, a government, non-government plan. I didn't know the variability that exists there and how that comes about. I don't know if you have any insight that you can provide to that.

MS. DUTT: So I know it includes for non-governmental Medi-Cal plans they have other lines of business. Some of them have plan-to-plan enrollment and administrative service-only contracts too, so we need to do a detailed dive there to see if they need to make any adjustments and exclude any pass-through that are included.

MEMBER DURR: Makes sense. My other question, if I might, John, is that I noticed the medical expense ratio on the COHS plans in the third quarter very much -- or the second quarter, I should say, drastically reduced, pretty much all of them across the board. CalOptima went from roughly around 95% down to 72%, as one example. Do you have any insight in that, Pritika?

MS. DUTT: Paul, I do not but I can take that one back.

MEMBER DURR: Okay, thank you.

CHAIR GRGURINA: All right.

Ted.

MEMBER MAZER: A good segue from Paul because I am looking at the same for the NGOs, the non-government plans, and particularly California Health and Wellness, which you just mentioned, with the low TNE for at least several quarters in the past year. In the last two quarters reported their medical expense ratio is below what we would expect. I don't know if you combine those with their other programs but standing alone it looks like they are in trouble monetarily and they are not expending what they should be on medical care. So I don't know if you have any comment to that, Pritika, much like the previous question, but that certainly needs to be looked at.

MS. DUTT: Thank you, Ted, we will take that one back.

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

So let me just add two comments from my. One is going back to Larry's comments about the concern about the history and TNE and plans' ability to be strong financially. This is where I would say an example of Lindy's presentation for us is there's an awful lot of new programs coming in in Medi-Cal, coming to the plans. And, you know, the actuaries do the best they can, and Amy will tell us, they are really good but you still have to make a lot of assumptions and you may be wrong. And that's why you heard Lindy talk about that they are working with the plans of having risk corridors on ECM as well as also talking about the transplants, Amy, that you were raising. To make sure that

there isn't something that goes really terribly wrong financially on one of these new programs. It is a fail-safe and it is important to have it in there so I appreciate that.

And then just a technical one that I can't help myself, Pritika knows about this, which is Paul was appropriately raising. Hey, look at the admin percentages and different of the plans and they really look different of what's going on. I have to admit that when I saw the page that had ours I had a mini heart attack, I thought there's no way we have 9% administrative. And it is what Pritika talks about is we also have what's referred to as a third party administrative business where we run programs for the city behind the scene where we are just paid to run those programs and that gets counted as part of our admin and counts as part of our revenue, where it is 100% spend on admin and that changes our overall number. So we will be working with Pritika's folks to be able to make sure that as we put things that are publicly out and is our admin on our insurance lines of business? We have this unique piece for us and I don't want anyone else having a mini heart attack like I had when I saw our numbers and thought, that can't possibly be right. So I appreciate Pritika and her team and working with some of us that have some unique circumstances with our financials.

With that I will turn to Jordan, is there anyone from online that would like to have a question or comment?

MR. STOUT: Yes, Bill Barcellona has a question.

Bill, when prompted please unmute yourself.

MR. BARCELLONA: Thanks, Jordan. Bill Barcellona with America's Physicians Groups. Yes, looking at this report and then Lindy's

previous comments about the re-procurement where it looks like we are seeing a significant downsizing of the competition between plans at the regional level and increasing county monopolies or COHS plans, just a couple of quick comments there related to financial solvency and transparency. I'd like to reiterate what Jen Flory mentioned about requiring COHS plans to be Knox-Keene licensed. In fact, all MCP plans being Knox-Keene licensed so the DMHC can, can monitor their operations and financial solvency.

And second, if we are going to have less competition at the regional level and more monopolies at the county level for Medi-Cal delivery, it seems like there is less reason to shield the state's cap rates to these plans. You know, since we will be dealing more frequently with single plans at a region it would be a lot more beneficial to risk bearing providers to know where plans are with respect to their cap rates and their MLRS so that they can negotiate financially solvent rates as well. Thanks.

CHAIR GRGURINA: All right, thank you, Bill.

Jordan, do we have anyone on the phone who would like to make a comment or a question?

MR. STOUT: There are none at this time.

CHAIR GRGURINA: All right. Well, thank you very much, Pritika, thank you for your presentation.

And we will move on with Amanda and the legislative update.

MS. LEVY: Great, thank you all for having me here today. I am going to present a legislative update and if we can move on to the next slide.

As we have discussed before, 2021 was a very busy legislative year and the governor signed 18 bills that will directly impact the Department of

Managed Health Care. We will be working with our stakeholders on implementing many of these bills. And I will provide a more detailed overview of the bills that we believe to be of most interest to the Board but I did want to mention these bills, this slide, at least, quickly mention some of the other bills that we are tracking but I won't go into greater detail.

Just to say AB 326 by Assembly Member Rivas relates to our Consumer Participation Program. AB 457, Assembly Member Santiago, related to telehealth coverage. AB 570, also by Santiago, related to dependent health care coverage expansion. AB 1184 relates to medical confidentiality. SB 255 And SB 718 by Senators Portantino and Bates relate to association health plans. And SB 428 relates to adverse childhood experience screenings. So we are looking at all of these and will provide greater details on the next ones. Yes, perfect, next slide.

AB 342 by Assembly Member Gipson relates to colorectal cancer screening and effective January 1, 2022 this bill requires health plan contracts and health insurance policies to cover at zero cost-sharing a colorectal cancer screening exam test assigned with either a Grade A or B by the United States Preventive Services Task Force. And this, this bill is consistent with the May 2021 USPSTF recommendations. Next slide.

AB 347 by Assembly Member Arambula related to step therapy exceptions. And effective January 1, 2022 a health plan or insurer must expeditiously grant a request for a step therapy exception if a prescribing provider determines use of the drug required under step therapy is inconsistent with good professional practice for the provision of medically necessary covered services, while also considering the enrollee's circumstances.

SB 221 by Senator Wiener related to timely access, we might have talked about this one before. Effective January 1, 2022 SB 221 places portions of the timely access standards previously adopted in regulation by the DMHC into the Health and Safety and Insurance Codes. The bill specifies a 10-business day timely access standard for follow-up appointments for certain mental health and substance use providers. And that's beginning on July 1, 2022 and this bill covers Medi-Cal managed care.

SB 242 By Senator Newman relates to provider PPE reimbursement and says effective January 1, 2022 the bill requires health plans and insurers to reimburse contracting physicians and dentists for the cost of personal protective equipment, what we all know as PPE, and additional supplies, materials and clinical staff time made necessary by a future public health emergency due to a respiratory-transmitted infectious disease. And most notably, this bill does not apply to the COVID-19 state of emergency so this is a future. Hopefully we won't have to work on implementing that in our lifetime but we have the legislation should it happen.

SB 306 By Senator Pan relates to STD home test kits. Effective January 1, 2022 this bill requires health plans and health insurers to cover sexually transmitted disease home test kits. And the bill further updates California's current expedited partner therapy statute to include provider liability protections and to permit pharmacists to provide EPT treatment.

Also by Dr. Pan, SB 326, the Affordable Care Act codification. This says effective January 1, 2022. This bill codifies many of the federal Affordable Care Act consumer protections in our Health and Safety Code and Insurance Code by deleting certain language commonly referred to as "tiebacks." The

protections now in statute in California include guaranteed issuance and renewability; ban on pre-existing condition exclusions; rates based solely on age and region; and requirement to provide all ten essential health benefits.

SB 368 By Senator Limon relates to out-of-pocket maximum tracking. Effective July 1, 2022 this bill requires a health plan contract or health insurance policy issued, amended or renewed in the individual or group market, to monitor an enrollee's accrual balance towards their annual deductible and their out-of-pocket maximum.

The bill requires health plans to provide an enrollee with their accrual balance for every month in which benefits are used and until the accrual balance equals the full deductible or out-of-pocket maximum amount.

SB 510, also by Senator Pan, relates to COVID-19 Cost Sharing. Effective January 1, 2022 this bill requires health plans and insurers to cover the costs associated with diagnostic and screening testing for and immunization against COVID-19 without cost-sharing, prior authorization, utilization management or in-network requirements. The bill has dates effective retroactively to March 4, 2020, the date the governor declared a state of emergency for COVID.

And the bill also prohibits health plans from delegating such costs to providers without a renegotiation of contract terms and applies a similar framework for testing and immunization during future public health emergencies.

We will be working on many of these bills and including SB 510. We will be working with our stakeholders on guidance shortly.

And then I think the last bill we have on here, SB 535 by Senator Limon relates to biomarker testing. Effective July 1, 2022 this bill prohibits plans

from requiring prior authorization for non-experimental biomarker testing for an enrollee with either advanced or metastatic stage 3 or 4 cancer; or progression or recurrence with advanced stage 3 or 4 cancer. And this bill expressly includes Medi-Cal managed care.

And so that was the overview, a very, very, just the highlights of all the bills. Like we said, there's 18 bills so we will be doing a lot of work on implementing in the next several months. I am happy to take any questions at this time.

CHAIR GRGURINA: All right, thank you, Amanda.

Any comments questions from the Board Members for Amanda? Amy.

MEMBER YAO: I just have a comment on the SB 10 (sic)? Obviously, we are really heavily involved with that, we are working on it. And one of the interpretations we had of that bill is it applies to 100+ employer groups, it is not, you know, everybody. So can you clarify that?

MS. LEVY: Did you say, could you repeat, did you say SB 10?

MEMBER YAO: Yes, SB 10. This is what we understand, that's a kind of amendment to one of the federal requirements; what the federal requirement really focused on is 100+ employer groups. So by definition our interpretation is this requirement that, you know, health plans cover for all the testing and vaccination costs is only for the 100+ employers.

MS. LEVY: Okay, so you're talking about SB 510, not SB 10?

MEMBER YAO: Yes, sorry, SB 510. Sorry, what did I say? I meant SB 510, sorry.

MS. LEVY: No, no problem. On the 100+ employer groups, I don't

have the information. I don't know, Sarah Ream, if you have that? If not, we can get back to you. I don't know that there --

MS. REAM: Sure, I can jump in here. So no, the bill should apply, it applies to all health care service plans except for, you know, I have it right here, I don't believe it applies to the Medi-Cal plans, I would have to go back and re-review it. But no, it should apply to large group, small group and individual plans.

MEMBER YAO: Okay, thank you.

CHAIR GRGURINA: All right. Paul.

MEMBER DURR: Yes, thank you for your presentation, Amanda, a very good overview. I am amazed at the work you are going to have to do in kind of working through all that stuff. But I did want to voice support for your guidance on SB 510. It is definitely very important from us as the provider groups to be able to work through that. I think it is going to be very interesting and challenging to see where it goes and what the health plans do, no offense, Amy. But I do think that there are going to be challenges with regards to that and I just wanted to reiterate our support of that from the provider side and the guidance and the efforts that the Department has done on behalf of the provider groups. Recognizing that this public health emergency was certainly that, unthought of as to additional costs that we were bearing and the medical groups and the provider side of that, and something that was not previously contemplated in our negotiations with the health plans and certainly look forward to your future guidance.

CHAIR GRGURINA: Thank you, Paul. Any other comments or questions from members of the Board?

All right. If not, Jordan, comments or questions from members

online?

MR. STOUT: Yes, we currently have one from Bill Barcellona. Go ahead, Bill.

MR. BARCELLONA: Hey, guess what, it is Bill Barcellona from America's Physician Groups. And I just did want to clarify Sarah's statement a few minutes ago that she didn't believe SB 510 applied to Medi-Cal managed care. It is certainly my understanding and the author's understanding that it does and that's why I had asked the previous question about -- from Lindy about whether DHCS would be issuing SB 510 guidance in the near future.

MS. LEVY: Bill, we have been talking to the Department of Health Care Services. I believe it does include Medi-Cal managed care. However, vaccines were previously carved out so they are researching to see what is included.

MR. BARCELLONA: Thanks for that clarification.

CHAIR GRGURINA: All right, thank you, Bill.

Jordan, any -- actually, Amy, you have a comment or question on this?

MEMBER YAO: Yes, I have a comment. Sorry, guys, I just want to go back to my previous question. I think, yes, maybe I didn't ask the right question. For diagnostic and screening, yes, we understand, you know, we are responsible for all population, I think it is the occupational testing. Our understanding is only for 100+ employer groups. I just want to clarify my question.

MS. LEVY: Okay. I don't believe -- we will go back and take a look. I don't believe that was carved out necessarily between diagnostic and

screening, I am not certain, for occupational testing. But I think we have your question down and we can get back to you.

CHAIR GRGURINA: All right, thank you.

Jordan, anyone else online who has any comments or questions?

MR. STOUT: Hearing none at this time.

CHAIR GRGURINA: Okay. Anyone on the phones?

MR. STOUT: None on the phones as well.

CHAIR GRGURINA: All right, great.

Well, Amanda, thank you very much and we look forward to get a couple of the answers sent back as you and Sarah are doing the further research.

MEMBER WATANABE: John, if I could just jump in maybe here for a moment?

CHAIR GRGURINA: Yes.

CHAIR GRGURINA: Yes, no. And I just want to acknowledge. I think SB 510 has created a lot of concern and anxiety and interest and I just want to acknowledge that our folks are really being very thoughtful in the guidance that we are putting together and we will be looking to stakeholders to help to give us input on that, too. So I would just, you know, for all of those that are interested in this, make sure you are working closely with Amanda. There's a lot that we know that we have to give guidance on quickly. Also acknowledging the federal requirements, the CARES Act and the FFCRA. So again, want to provide guidance where we can but it is helpful for us to know what questions we may need to address in our guidance. Sarah, do you want to add there too?

MS. REAM: Yes, I just wanted to reiterate, essentially, Mary, what

you said that this is really a helpful conversation. We are working on guidance now and we can incorporate that.

I did want to circle back to Amy's question about the 100+ employers and make sure I am understanding, understanding the question. So there -- I know the federal law or the Biden administration's order and Cal-OSHA requirement would impose a, you know, vaccine or testing requirements on employers with 100 or more employees. But SB 5 -- so that would apply to those larger groups. But SB 510 does not contain a carve out for smaller employers so it simply says that screening, the health plans must cover screening/testing for people who are asymptomatic for COVID-19 and screening/testing includes workers in a work place setting, students, facility or staff in a school setting, and it goes on from there. So there's no limitation there on health plan coverage with respect to just the larger groups. Wanted to provide that clarification.

MEMBER YAO: Okay, thanks.

CHAIR GRGURINA: Thank you, Sarah.

Larry.

MEMBER DEGHETALDI: Sarah, just to give you the real world experience with this right now. Testing sites have, you know, cropped up all over the place. It is very difficult for patients to find out where to get tested so they are going to wherever they can find a test site. Many of them are operated by organizations that won't return our phone calls, send us full bill charges, expect us to pay it and then they hide and so it is very difficult for us to try to, you know, find that equitable payment to protect patients from out-of-pocket expenses and yet still not be subject to, frankly, exorbitant prices. I think that's the thing we are confronting right now.

CHAIR GRGURINA: All right, thank you, Larry.

Okay, with that let's go ahead and move on to risk adjustment transfers for 2020 with Pritika.

MS. DUTT: Thank you, John. I will provide you an update on the 2020 risk adjustment transfers; and for the detailed report look at the Risk Adjustment Transfers handout that was included as part of the meeting packet.

CMS released a more comprehensive report back in June, the end of June, so if anybody is interested that's available on the CMS website and you can look at all the risk adjustment transfers for all the individual and small group plans and the various things.

The Affordable Care Act included three premium stabilization programs, the risk corridors, reinsurance and risk adjustment. The risk corridor and reinsurance programs lasted from 2014 to 2016 and the risk adjustment program still continues today. The risk adjustment transfer program is intended to transfer funds from health plans and insurers with low actuarial risk to those with high risk for both on- and off-exchange plans. The purpose of the program is to discourage cherry-picking. The plans that end up with a healthier population must compensate plans that have more costly enrollees.

For benefit year 2020, $1.36 billion was transferred between California health plans and insurers.

Four DMHC plans were on the receiving end. Blue Shield received $1.16 billion, Anthem received $144 million, Sharp received $12 million and Ventura County received $150,000.

Eleven DMHC health had to end up (audio cut out) with Kaiser paying the largest with $740 million.

Overall, the PPO plans ended up on the receiving end while the HMO plans ended up paying. The results have been consistent compared to previous years, the same plans on the receiving end and the same plans to end up paying each year.

In 2018, CMS added a high-cost risk pool to the risk adjustment transfer methodology. The high-cost risk pool will help ensure that risk adjustment transfers better reflect the average actuarial risk while also providing protection for insurers with exceptionally high cost enrollees. To fund these, these payments, the high-cost risk pool collects a small percentage of an insurer's total premium. The high-cost risk pool charge was 0.24% of premium for the individual market and 0.38% of premium for the small group market nationally so the charge for each plan was less than $1 -- less than a penny on $1.

The high-cost risk pool reimburses issuers for 60% of an enrollee's aggregated paid claims cost exceeding $1 million. The DMHC plans received $133 million through this program. Blue Shield received $58 million, Kaiser received $42 million and Anthem received $26 million. The CDI-regulated health insurers received over $10 million through this program.

On this slide I will touch briefly on the impact of the risk adjustment program on premium rates and medical loss ratio. The risk adjustment transfers represent an average of approximately 8% of premium or $40 per member per month, assuming a statewide average premium of $500 per member per month. The amount of risk adjustment assumed in setting rates varies by plan depending partly on the relative risk score, which is health status of its members compared to the statewide average risk score, which is health status of members across all

plans.

The 2020 risk adjustment transfers for CMS, from CMS may be used by health plans to estimate the 2022 risk adjustment amount that they use for 2022 rate setting. So the 2020 data was used for the 2022 rate development. Similar to other assumptions used in rate setting, an over- or under-estimate in risk adjustment, payment or receivable may impact rates and plans' profits and their medical loss ratio.

For medical loss ratio purposes, if a plan receives risk adjustment payment from CMS the plan would reduce its current year's incurred claims for medical expenses by the amount received from CMS, which would receive -- which would reduce the plan's MLR. If the plan paid for its adjustment the plan would increase its current year's incurred claims for medical expenses by the amount that they received in payment, which would increase the plan's MLR. So with that I will take any questions.

CHAIR GRGURINA: Okay, thank you, Pritika.

Comments or questions from Members of the Board? Jeff.

MEMBER RIDEOUT: Hey, Pritika, this is Jeff. A wildly loaded question and I am struggling with how to ask it. We see the same directional transfer of money quarter after quarter, year after year. Is there any attempt to understand whether this risk transfer adjustment assessment matches what the plans themselves feel about their risk populations? And maybe a related question, how would a plan that is on the receiving end, and I am not asking Amy to comment but if she wants she can, how does this affect how you set rates, how does this affect how you assess your own risk assessment? Because it feels like the directionality is pretty consistent now, it wasn't early on, but it seems

pretty consistent and I am wondering, is there anything that the Department thinks it needs to do or validate it with other sources of clinical risk adjustment? Sorry, it is kind of open-ended.

MS. DUTT: It's a good question, Jeff. I will put Amy on the spot because Blue Shield has been receiving the highest amounts through the years so maybe Amy could chime in there.

MEMBER YAO: Yes, I kind of anticipated that question, that's why I am here for today. Yes. So I will say the risk adjustment has been working as designed. Blue Shield definitely has attracted the highest risk members because we are the only PPO player in the ACA market. And if you are looking at -- there's another way we think about it. You know, if without this risk adjustment payment the premium that we are going to offer are going to be much higher. So actually, we kind of priced to an up-front lower premium knowing that we are potentially going to get compensated at the back end. So when we are looking retrospectively, you know, after you restate all the risk adjustment money to the right years, combining with the premium we have, what kind of profitability we have been getting. I think for 2021, we are going to be very, very close to the margin we think we should get and not really exceeding what we anticipated. If you look at our premium increases for Blue Shield for 2022 and 2021 has been pretty close to like zero because we definitely priced up front for this expectation.

CHAIR GRGURINA: All right, thank you, Amy.

Larry. You're on mute Larry.

MEMBER DEGHETALDI: Yes, another $20. Amy, let me just applaud Blue Shield and your commitment to serving sicker Californians. And this has been true, I think the 8% and Blue Shield's position as the provider of the

sickest Californians has been true since this started five or six years ago and I think that 8%, Pritika, has been the number as I recall, the share of the redistribution of dollars and it is very heartening to hear you say that from your perspective it is fair.

The question on, this is all based on HCC coding, or expanded HCC coding and we know that there's a lot of mischief in the Medicare Advantage world. And I don't think that's happening in the risk adjustment commercial world but is there an opportunity to capture through an HCC kind of a model social determinants so that we, so that, to the extent that you are caring for, you know, the 60 year olds with cancer, who, who, you know, or who are low-income or, you know, of certain racial, ethnic groups in certain geographies. Is there a way to capture that from a health equity perspective or is that, am I just dreaming?

MEMBER YAO: Yes, so Larry, that's a really good question. I thought, you know, CMS is working on proposed changes to the ACA risk adjustment model. I haven't seen the social determinants being considered but that's a really good question. I think it is the perfect timing for us to comment on the CMS methodology on ACA so I will make a note definitely adding to our comments back to CMS. Thank you.

CHAIR GRGURINA: All right, thank you. And I will just add to the conversation. Jeff started us off with how can we tell how this is working? The most rudimentary place to see where it is working is the plans continue to participate. Both of those, as Amy has pointed out, keeping a PPO available as an option, as well as Kaiser with its large payments, continuing to stay in. That kind of gives us the sense that this is working.

Larry, earlier you made kind of a crack of, Mary was talking about your age. Well, I was around back in 1994 when we had the old HPAC (phonetic) and we started one of the early risk adjustment models and it wasn't strong enough to keep a PPO in that small group marketplace for the employers. Here it is impressive, as Amy points out, that they have a PPO offering, and there are folks who really want to have that option. And if it wasn't for the risk assessment process, the risk adjustment, that wouldn't be offered in Covered California.

So I think it kind of gives us that directionally where we are, we have something that's powerful, and the question becomes more to the folks who work in the intricate details of it, how can we make it even better? But I do think that, you know, in the comments, we take a look. And Jeff said earlier, it does seem to be consistent over time, the plans are continuing to participate and it is working, we continue to have multiple different options and choices to the members so this is really, really good outcome. And saying from where it once was more than 25 years ago it has come a long way.

MEMBER YAO: So John, maybe I have one more kind of insight to just add.

CHAIR GRGURINA: Yes.

MEMBER YAO: If you look at the past years the risk transfer directionally has been the same but we are anticipating that is going to change next year. It is because CMS removed one of the drugs from the calculation. Unfortunately, I think that is going to change some of the dynamics, were lowered. The receiving end is going to have a lower payment. It is a hydroxychloroquine drug. You know that -- the reason, you know, they moved it

because people during the COVID year used it for other purpose, not just for treating the specific disease. But unfortunately, you know, we are taking care of more proportionally the patients with that disease and is not being counted going forward. Definitely going to hurt our ability to keep the PPO plan affordable. So I just -- I am not complaining but I just give you a heads-up on that dynamic.

CHAIR GRGURINA: It is a great comment, Amy, about even some minor changes how they could change the model. Then of course, obviously, I am sure you and others will be arguing as we get through the pandemic to be able to get it back in when it is being used for its appropriate, appropriate use.

Okay with that, Jordan, do we have members online who have comments or questions?

MR. STOUT: Yes, we have a question from Bill Barcellona. Bill, go ahead.

MR. BARCELLONA: Thanks, Jordan. Bill Barcellona, America's Physician Groups. Just wondered if the Board had any opinions about whether it is appropriate for risk bearing providers to bear the downside risk of these risk adjustment transfers by health plans.

CHAIR GRGURINA: Any comments from Board Members?

MEMBER YAO: Maybe I could just add a comment.

CHAIR GRGURINA: Amy, go ahead.

MEMBER YAO: So yes, for the risk bearing entities. So maybe my question is, if it truly is because they've got lower risk or it is because the healthier population enrolled in those plans, I will say it is fair. But I do believe sometimes it is because of lower risk or it is not because of that, it is because the risk bearing entities, they are not submitting all the data they are supposed to

submit.

MEMBER DEGHETALDI: Yes.

MEMBER YAO: But that's, but that to me is still maybe we should work with those risk bearing entities to help them to understand the dynamics. To help them, to make sure there's accuracy around their submissions.

MR. BARCELLONA: Thank you. My concern is that the Department's not capturing that added level of risk at the RBO level when it is imposed by a health plan and it can be significant, especially among smaller IPAs.

CHAIR GRGURINA: Thank you, Bill.

Larry, do you have a comment?

MEMBER DEGHETALDI: Yes, I just, I alluded to mischief in the Medicare Advantage world. But clearly with the 26 year history in MA, provider organizations have figured out the importance of diagnosis capture. I don't believe that's true for, Amy, for the risk adjustment in the commercial space. That may be good from the perspective of potential mischief but I do think it may penalize Blue Shield to the extent that we don't, we don't really focus as providers on a full comprehensive risk adjustment capture in the commercial world that we do in the Medicare Advantage world. So just keep that in mind, you know, as we try to get this right. That I think we are understating the risk, whether or not you have social determinants in there or not, of your population because I just don't think we pay attention. And maybe I am wrong on that but I don't think we do in the commercial space.

MEMBER YAO: Larry, I completely agree with you. That's what we discovered as well for our ACA HMO clients. We are trying to look at their

encounter utilization and we priced them based on our typical rates. We could see some provider has a huge gap between encounter repriced claims versus the capitation payment. We just don't believe that kind of gap is reasonable. So I, you know, I think most of providers understand the Medicare side but when they come to commercial, yes, there is definitely lots of education to do there.

CHAIR GRGURINA: All right, thank you.

Jordan, are there any other members online who have comments or questions?

MR. STOUT: There are none at this time.

MEMBER RIDEOUT: John?

CHAIR GRGURINA: Yes, Jeff.

MEMBER RIDEOUT: Just a shameless plug. IHA is monitoring commercial encounter data at the plan provider level across volume in about ten different subcategories. So those reports are, we are going to start to put those into production soon, if that's helpful.

CHAIR GRGURINA: All right, thank you, Jeff.

Jordan, any members on the phone who have any comments or questions?

MR. STOUT: Not at this time.

CHAIR GRGURINA: All right, thank you.

All right. Well, thank you, Pritika, we appreciate that. And actually, why don't you just go ahead and stay with us and take us through the 2022 rates in the individual market.

MS. DUTT: Thank you, John. So the purpose of this presentation is to provide an update of the 2022 rates in the individual market. For this

presentation you can refer to the 2022 rates in the individual market report that was included with the meeting handout. In addition to the 2022 rate changes it also includes the 2021 rate changes in there as well.

We received and reviewed the 2022 individual rate filings from 13 health plans. The average rate change ranged from a decrease of 3.2% to an increase of 9.1%. Overall the average rate change, rate increase was approximately 1.8% across all health plans. The averages you see here may differ slightly from what Covered California posted on its website because the rate filings submitted to the DMHC include both on- and off-exchange products from the health plans.

Twelve of these health plans offer individual products on Covered California's Health Exchange. The average premium for the DMHC plans ranged from $434 to $830 per member per month. The next three slides show the average rate change and projected enrollment for the 13 plans for 2022. The list is sorted by plans with the highest average rate change to lowest.

This slide shows the plans with the highest average rate change in 2022 except Universal Care. Universal Care is a new health plan on the Exchange for 2022 and will begin offering coverage on January 1, 2022 in Contra Costa County.

Oscar reported an increase of 9.1% and had, and projects an average premium of $454, which is the second lowest average premium amongst the 13 plans. So although they have the highest average rate change they have the second lowest average premium.

Valley Health Plan reported an average increase of 5.9% with projected enrollment of 27,000 lives.

Health Net will have an average rate of 5.4% with projected enrollment of 144,000 lives in 2022. Sutter Health offers all non-exchange or Health Exchange individual products and has a projected enrollment of 3,700 members. An average, the annual average rate change was 3%.

In this slide here Kaiser has the most projected lives in the individual market so they are the largest plan on the individual market with an average rate change of 2.1%.

Blue Shield is the second-largest plan in the individual market with 714,000 lives and an average increase of 1.6%.

Western Health Advantage's average rate change for 2022 is 3% with projected enrollment of 12,000 lives.

And Chinese Community will have an average rate change of 1.9% in 2022 with projected enrollment of 5,500 members.

This slide shows the rate changes for four health plans with the lowest average rate change, so all these four plans have right decreases. Molina's average rate change for 2022 is decreasing by 0.1%. And as you may recall from the 2020 Federal MLR presentation at the August FSSB meeting, Molina was one of the two health plans that paid MLR rebates for 2020 in the individual market.

Sharp had an average decrease of -- has an average decrease of 0.3%.

Blue Cross with a decrease of 2.6%.

And L.A. Care will have a decrease of 3.2%. And L.A. Care was the other plan in the individual market for 2020 that paid MLR rebates.

The rate changes for 2022 are driven by medical costs trends

including emerging and projected experience, changes in risk adjustment, administrative cost changes anticipated changes in the market-wide health status of covered population. Health plans were also asked to provide the estimated impact of COVID-19 on their proposed rates. While there were a couple of health plans that included changes in their rates as a result of the pandemic, several health plans stated that there wasn't enough data at the time of the rate projection to forecast the impact of COVID-19 on 2022 rates.

While the DMHC does not have the authority to deny rate increases, the DMHC's rate review efforts hold health plans accountable and ensure consumers get value for their premium dollars, which ends up saving Californians money. Since 2011 through the DMHC's rate review program, consumers have saved $296 million in premium savings. We also look at the plan's rate filings to ensure that the plans project to meet the required medical loss ratio requirements. If the plans fail to meet the MLR requirement they are required to pay rebates to enrollees. So in addition to the premium savings enrollees have received $454 million in MLR rebates when plans fail to meet the MLR requirement. So that concludes my presentation; I will take any questions.

CHAIR GRGURINA: All right, thank you, Pritika.

Any comments, questions from the Board Members? Amy.

MEMBER YAO: I just have a comment. I think this data also affirms that the risk adjustment is working. If you look at it, both of us and Kaiser, we come in around the average rate increase. So without the risk transfer our rate increase will be materially higher. So I think it is working to help to make the PPO option affordable.

CHAIR GRGURINA: All right, any other comments or questions

from Board Members?

Okay, if not Jordan, any comments or questions from members online?

MR. STOUT: None at this time.

CHAIR GRGURINA: Okay. What members on the phone?

MR. STOUT: None at this time as well.

CHAIR GRGURINA: All right, thank you.

All right. Well, thank you, Pritika; and we will call upon Michelle for a provider solvency quarterly update.

MS. YAMANAKA: Thank you, John. Good afternoon. My name is Michelle Yamanaka and I am a supervising examiner in the Office of Financial Review. Today I am going to give you an update on risk bearing organization or RBO financial reporting for the quarter ended June 30, 2021.

Let's start with a summary. We have 210 active RBOs that filed, need to file financial information with the Department. Of these, 209 have filed for the quarter ended June 30th. There was one non-filer and we requested administrative action for that non-filer.

For the annual survey reports we have received two survey reports for the, for the fiscal year end March 31. A majority of the RBOs have a fiscal year end of December 31st and those are due 150 days after the RBOs fiscal year end.

For quarterly reporting, as I mentioned, we have 209 RBOs that filed. And for monthly reporting, we have 5 RBOs filing monthly reports as a requirement of their corrective action plan or CAP. For the number of RBOs that are reporting we had an increase of 4 that started reporting as of quarter ended

June 30th and then we had 4 RBOs inactivate at quarter end June 30th, which is a net increase of zero. And we have 21 RBOs that are on corrective action plans and I will discuss a little bit more detail of those CAPs in an upcoming slide. Next slide please.

So for those RBOs that became inactive as of June 30th, we keep track of these RBOs on their last submission. If there were Financial Concerns, which is they are non-compliant with one or more grading criteria, if there's No Financial Concerns or if they are another category, which is a catchall, in Other. So for the quarter ended June 30th we had 4 RBOs that were inactive and 3 were captured in the No Financial Concerns category, and 1 was in the Other category. Next slide please.

So for those inactive RBOs we also track their enrollment as the last financial submission submitted. For the 4 RBOs inactive, 1 was in the category of 10,000 to 30,000 enrollees and 3 were in the zero to 5,000 category.

One other thing to note is that for the 118 RBOs that we have inactived over, since 2005 when we started collecting the financial information, 69% have had less than 10,000 lives assigned to them.

Moving on to enrollment as of quarter ended June 30th. The RBOs file enrollment information with their financial survey reports. And as of June 30th there was approximately 8.9 million lives assigned to the 209 RBOs and this is just a slight decrease from the previous reporting period of about 13,000 enrollees. Next slide, please.

This slide represents the financial survey reports submitted as of June 30th. The last column to the right, we have 188 RBOs that are reporting compliance with the grading criteria. within that category there are 8 RBOs on

our monitor closely list and we have 21 RBOs that are non-compliant with one or more of the grading criteria. And as I mentioned, there is one non-filer as of June 30th, 2021. Next slide, please.

Moving on to the corrective action plans. We have 25 active corrective action plans are CAPs filed by 21 RBOs. There are 2 RBOs that have 2 CAPs and 1 RBO that has 3 CAPs. Of the 25 CAPs, 22 are continuing from the previous quarter and 3 were new as of June 30, quarter ended June 30th. Of the 22 continuing CAPs, there were 17 RBOs or 21 CAPs that were improving from the previous quarter and are meeting their approved projections and 1 RBO that was not meeting its projections at June 30th. We continue to monitor this 1 RBO, reviewing their monthly financial statements, and as of August and continuing in September that RBO is meeting all grading criteria. And of those 25 CAPs, 24 are approved and one is in review. And as of, I checked last night, 17 of the 25 CAPs have been completed so we currently have 8 active corrective action plans filed by 7 RBOs.

And then I want to conclude with the -- one other thing I wanted to mention, there is a handout of the details of the corrective action plans, which lists the RBOs and their MSO or management services organization if they are contracted with one, but it also includes the contracted health plans or RBOs that the RBO contracts, with the enrollment ranges, the quarter the CAP was initiated, if the RBO is meeting their approved or final projections, and the deficiencies that the RBO reported. Okay, next.

Now I want to conclude with the RBOs that had Medi-Cal lives assigned to them. As of June 30, there were approximately 4.9 million Medi-Cal lives assigned to 90 RBOs. This represents approximately 56% of the total lives

assigned to the 209 RBOs that filed. Of those 90 RBOs, 71 had no financial concerns, five were on our monitor closely list and 14 were on corrective action plans. And then next slide please.

We took the top 20 RBOs that have greater than 50% of Medi-Cal lives assigned to them. These top 20 RBOs had roughly 76% of the Medi-Cal lives assigned to them. Of those top 20, 12 had no financial concerns, 3 were on our monitor closely list and five RBOs corrective action plans.

So that concludes my presentation. I wanted to see if there's any questions.

CHAIR GRGURINA: All right. Well, thank you, Michelle.

Any comments or questions from the Board? Ted?

MEMBER MAZER: Thank you. Thanks for the report. My usual question at all of these meetings. So when we look at the detail of the plans that are on corrective action plans right now, three plans stand out as having been basically since the second quarter of 2020 on corrective action plans, two of which are under the same management company, and one of which seems to have pretty much every category out of compliance even though they are in compliance with their final CAP. I guess the question is, what action aside from keeping them on a CAP plan that they continue to extend out and remain on CAP, what other action can be taken? I guess a couple of these plans you're talking 100-150,000 lives in those plans so they are not small. One of them is a very small plan, I can understand why they might be in trouble.

MS. YAMANAKA: Sure. So what we do is -- for the corrective action plan process we continue to monitor the RBOs on a monthly basis to ensure that they are tracking their approved projections. Their approved

projections have an end date showing when they are going to attain compliance. If there is any material deviation, that's what we will have to look at and work with the RBO and their contracting health plans to determine if the RBO and their contracting health plans to determine if the RBO can get back on track or if there is going to -- if they are just not meeting their corrective action plan, then we have what we can do is we can take administrative action. At this point the RBOs that you are looking at are meeting their approved projections so we want to allow them that time to complete their corrective action plan that was approved by the Department as well as the contracting health plans.

MEMBER MAZER: Michelle, thank you for that but just in following up on that, they may be meeting it but for how long do you let them continue to meet the corrective action plan and yet stay below compliance on all of these different categories before something else has to happen?

MS. YAMANAKA: So part of it, it does take time for the RBOs and we see that in the projections. So gradually they continue to improve but it just takes, it does take time. In addition to the projections they also have to project out, we also ask for additional projections subsequent to the compliance date to ensure that they are going to continue to meet the, meet the solvency criteria.

CHAIR GRGURINA: Okay, Paul,

MEMBER DURR: Michelle, always a great report. My simple question is for the non-filer. What administrative action can you take? Is it just to terminate their, their RBO, their license?

MS. YAMANAKA: Sure, that, that is -- the one -- there are two options and the first is to freeze the enrollment so at that point there is no additional enrollment that could be passed down to that RBO until they meet the

requirements. The addition, the other option is to have the health plan take back the risk, to basically say they are unable to pass down additional risk to them.

MEMBER DURR: And my follow up, thank you for that, is, do you feel that this will become a filer? Will they file? Is it just sort of learning how to do what they need to do?

MS. YAMANAKA: Sure, yes. And so that's a great question, because we have been working with the RBO. Our estimate is that we will get the, receive the financials probably in the next two weeks. But in the, in the event that they don't file we do have that administrative action working on the other end, yes.

MEMBER DURR: Great. Thank you.

CHAIR GRGURINA: Jen. You're still on mute, Jen. Are you there? I see you're working with the computer.

MEMBER FLORY: Sorry. I hade a double mute because of the phone line.

CHAIR GRGURINA: There you go.

MEMBER FLORY: Yes. My question is it does seem like a higher percentage of the Medi-Cal RBOs are on corrective action plans by far and just, if I am reading that correctly or your thoughts on that and how we can reverse that?

MS. YAMANAKA: So, you know, each RBO has their own contracts with their health plans and so it is those contracts that really drive, you know, the risk that they are taking. So the one thing is that the RBOs that are on corrective action plans have been working with their health plans to determine if there's additional things that can be done regarding their, their contracts. So

that's one thing. But in addition to that we do, we do monitor those RBOs that have Medi-Cal lives assigned to them. And so just right now in this period these RBOs just need a little bit of additional time to get through their financial concerns.

CHAIR GRGURINA: Okay, Larry.

MEMBER DEGHETALDI: Again, you know, the theme of looking back maybe ten years. We have seen there is a perennial problem with plans that are really on the cusp. What are the characteristics of those plans or RBOs and what are the as we -- you know, Lindy talked about the six types of managed Medi-Cal models. Are one of those models more successful supporting their RBOs versus others as we move forward and we are betting the farm on the, you know, the single county plan model versus, versus others? So what have we, what have we learned as we transform managed Medi-Cal?

And the other, the only other thing that I've talked about for a while, how are these plans doing on quality? Those plans that are really struggling financially, do they provide substandard, compared to other plans, on measurable quality? We have never really looked at, you know, the total value perspective from the patient's perspective. Because if I -- I bet you if an RBO is struggling they're not going to do colorectal screening quite up to a plan that is adequately resourced. Or RBO, you know what I mean.

MS. YAMANAKA: Yes, going back ten years I think, right now we are in a little bit at a different time with what's going on. We would have to look a little bit more into that analysis.

And then regarding the total value, the quality, we do have access to the report cards as well but that's also a look back period. But on a quarterly basis we don't, for the provider solvency we don't have that information we would

have to, we would need to go in and obtain that information. But it is a good question that we can look into.

CHAIR GRGURINA: All right, thank you, Michelle.

Jordan, any comments, questions from members online?

MR. STOUT: Yes, we have a question from Bill Barcellona. Bill, go ahead.

MR. BARCELLONA: Thanks, Jordan. Bill Barcellona, America's Physician Groups. I just want to thank the staff again for changing the forms to show the plan affiliations with these groups. I think we have been doing that now for almost three quarters; we are getting to the point where we can start looking at some characteristics of, of this constant 10% of RBOs that have been non-compliant since the very beginning of RBO monitoring over the past 15 years.

Still want to ask the Department to schedule an agenda item in a future meeting to really do a deep dive on why we have seen 10% of the RBOs be non-compliant over the past 15 years. What are the underlying causes so that we can learn from it and hopefully we can decrease that percentage over time once we have learned some clear lessons.

CHAIR GRGURINA: Thank you, Bill.

Jordan, any other members online comments or questions?

MR. STOUT: Not at this time.

CHAIR GRGURINA: Okay, what about on the phones?

MR. STOUT: None at this time as well.

CHAIR GRGURINA: All right, thank you.

All right, Michelle, thank you very much.

MS. YAMANAKA: Thank you.

CHAIR GRGURINA: We will move on with Pritika and the health plan quarterly update.

MS. DUTT: Thank you, John.

I will provide you an update of the financial status for health plans the quarter ended June 30th, 2021. We have been tracking the health plan financials and enrollment trends very closely and working with the health plans if we see any unusual trends that would raise concern with their financial solvency. We also included a handout that shows the enrollment at June 30th, 2021 and TNE for five consecutive quarters from June 30th, 2020 to June 30th, 2021 for all licensed health plans. The information is broken into three categories, first looking at full service then restricted full service and specialized.

As of October 1st, 2021 we had 141 licensed health plans, which is one more since the last FSSB meeting.

We are currently reviewing seven applications for licensure, five full service and two specialized. Of the five full service one is seeking a DMHC license for Medicare Advantage so they can they can contract with CMS directly and offer products to Medicare beneficiaries. Two are looking to get licensed for restricted Medicare Advantage and two are looking to get licensed for restricted Medi-Cal. For the two specialized plans, one is looking to get licensed to offer employee assistance program benefits and one is looking to get licensed and operate as a dental plan. We have seen a lot of activity with Medicare Advantage applications in the recent years. Next slide.

At June 30th, 2021 there were 27.96 million enrollees in full service health plans licensed with the DMHC. Total commercial enrollment includes HMO, PPO, EPO and Medicare supplement products. As you can see in the

table, compared to previous quarter, total full service enrollment increased by 276,000 enrollees and with majority of the increase coming from government enrollment.

We added this trend chart to show the enrollment trend since 2017. So as you can see, the gap between commercial and government enrollment widened until 2019 where commercial lives were surpassing the government enrollment. And in 2020 government enrollment surpassed commercial enrollment, so there's more government enrollment compared to total commercial enrollment in the DMHC licensed plans.

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

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

This table shows the government enrollment, which is Medi-Cal and Medicare. Overall the government enrollment increased. The majority is due to Medi-Cal enrollment which increased by 228,000 lives.

This slide shows the breakdown of the health plans that are being monitored closely. There were 4.6 million enrollees enrolled in closely monitored full service plans. Of the 30 closely monitored full service plans, 16 are restricted licensees and had 1.2 million enrollees, so these are very small plans that are being monitored closely. The total enrollment for the three specialized plans is 88,000 lives.

Two health plans did not meet the Department's minimum financial

reserve or tangible net equity requirement. One of them is Golden State Medicare Health Plan. The plan did not cure the TNE deficiency as of to date. The DMHC issued a Cease and Desist Order on April 27, 2021 that prohibits Golden State from accepting new members effective May 1st, 2021. So what ended up happening after we issued the Cease and Desist Order? CMS placed a similar sanction so no, you know, additional Medicare beneficiaries can sign up for Golden State Health Plan. The DMHC issued an accusation on July 1st, 2021 to revoke Golden State's license. Golden State had 15 days to request a hearing, which it did. The hearing date is set for February 2022.

Vitality is the second health plan that is TNE deficient. The plan remains TNE deficient and we continue to work with CMS and our Office of Enforcement. The DMHC issued a Cease and Desist Order forbidding any additional enrollees getting added to Vitality on June 30th, 2020. At the end of December, Vitality notified the DMHC that it had filed for Chapter 11 bankruptcy. Vitality is currently working with a buyer through the bankruptcy court and this change in control will have to go to through the DMHC's review and approval. We did receive the change in control filing from Vitality last week and my team is currently reviewing the filing.

This chart shows the TNE of health plans by line of business. A majority of the health plans with over 500% of required TNE are specialized health plans. Next slide.

This chart shows the tangible net equity of full service plans by enrollment category. Sixty-five health plans or over half of the total licensed full service health plans report over 250% of required TNE.

This chart shows the breakdown of 17 full service plans in the

130% to 250% of required TNE range. If a health plan's TNE falls below 130% the plan is placed on monthly reporting. We also monitor the health plans closely if we observe a declining trend in the financial performance such as TNE, as we see net income declining, and also if we see any changes in enrollment, whether it is decreasing or increasing substantially.

This chart shows the TNE of full service plans by quarter. For detailed information on health plan TNE levels please refer to the handout that was provided with the meeting materials. So this chart, this table pretty much summarizes the information in the handout.

And that brings me to the end of the presentation. Any questions?

CHAIR GRGURINA: All right, thank you, Pritika.

Any comments or questions from the Board Members?

You did such a nice job, Pritika, none.

All right, Jordan, do we have any comments or questions from members online?

MR. STOUT: There are none.

CHAIR GRGURINA: Any comments or questions from folks that are on the phone, Jordan?

MR. STOUT: There are none at this time?

CHAIR GRGURINA: All right. Well, thank you very much. Pritika, you are released, thank you very much.

All right, the next item is the 2022 meetings schedule update. I believe, Mary, you are going to take this?

MEMBER WATANABE: Yes. I don't know, Jordan or Daniel, if we have a slide for the meeting dates but we are proposing February 23rd, May

19th, August 10th, and November 16th, which I believe most of those dates will work for the majority of our Board Members. But please let us know if there's any issues with these dates, otherwise we will we will move forward with posting these on our website and getting those scheduled for next year.

I will just say, as of this point, we will need to resume holding in-person meetings starting in February of next year absent further action from the legislature or otherwise to allow us the flexibility to hold virtual meetings. We will do our best to try to continue to accommodate public participation, participation virtually. I think I have mentioned before too, we have a new conference room on our fifth floor, which we will be using in the event that we need to meet in-person in February, so more information to come on that. We also will need to follow any of the state and local or building guidelines around testing and vaccines and masking so we will provide more information in advance of the meetings. But that's it on the meetings, John.

CHAIR GRGURINA: All right, thank you, Mary.

Next on the agenda item is any public comments on matters that were not on the agenda. Jordan, do we have comments from members online? I see one.

MR. STOUT: Yes, we have one from Bill Barcellona.

Bill, go ahead.

MR. BARCELLONA: Thanks, Jordan. Bill Barcellona, America's Physician Groups. Hey, I just wanted to thank and congratulate you, John, and Jen, for your service on the FSSB and wish you the best in the future in all your endeavors and thanks so much.

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

congratulations, I think you won the contest of most questions in one item where you had your six (laughter), although I think Larry and Ted and Amy were in competition with you with Lindy's presentation. So thank you for the kind comments.

Jordan, any other comments, questions from members of the public?

MR. STOUT: Not at this time.

CHAIR GRGURINA: Any on the phones?

MR. STOUT: None as well.

CHAIR GRGURINA: All right, great. Okay, well, the next agenda item is to the governing or the, yes, the Board Members, things that you might want the Department to bring for future agendas in 2022.

Oh, it is quiet, this is unusual. All right.

Well, with that then we are set to go ahead and close and thank you to Jordan and Daniel behind the scenes for running this. Thank you to Mary and her great team at DMHC and to the Board Members and I would just say that it has been an absolute honor and pleasure to be on the Board for the last five years and to be with these Board Members. And, Jen, congratulations to you as well and to the new members coming on as well as Larry taking over.

So with that, we actually will finish a little early, give you a chance to go have a nice 20 minute lunch. Have a wonderful day and good luck with the Board going forward in 2022. Thank you everyone.

(The meeting was adjourned at 12:40 p.m.)

.

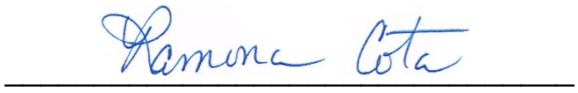
CERTIFICATE OF REPORTER

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 6th day of December, 2021.



RAMONA COTA, CERT*478

.