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 15, 2023

10:00 A.M.

Reported by: Ramona Cota

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APPEARANCES

BOARD MEMBERS

Jeff Rideout, MD, Chair

Abbi Coursolle

Paul Durr

Mark Kogan, MD

Jarrod McNaughton

David Seidenwurm, MD

Mary Watanabe

DMHC STAFF

Pritika Dutt, Deputy Director, Office of Financial Review

Amanda Levy, Deputy Director, Health Policy and Stakeholder Relations

Sarah Ream, General Counsel

Shaini Rodrigo, Staff Services Analyst

Jordan Stout, Staff Services Manager I

Michelle Yamanaka, Supervising Examiner, Office of Financial Review

ALSO PRESENTING/COMMENTING

Bambi Cisneros
Department of Health Care Service, Health Care Benefits and Eligibility

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

Anete Millers
California Association of Health Plans

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1 PROCEEDINGS

2 10:01 a.m.

3 CHAIR RIDEOUT: Good morning. Welcome to this quarter's
4 Financial Solvency Standards Board. I am Jeff Rideout, the Chair, and CEO at
5 IHA. I would like to start by welcoming all participants and have our Board
6 Members in attendance please introduce themselves and say just a word about
7 it. So, maybe I will start with you, Paul.

8 MEMBER DURR: Hi, good morning, everybody. I am Paul Durr,
9 CEO for Sharp Community Medical Group, an IPA in San Diego.

10 CHAIR RIDEOUT: Thank you.

11 Abbi?

12 MEMBER COURSOLLE: Sure. Good morning, everyone. My
13 name is Abbi Coursolle, she/her, I am a senior attorney with the National Health
14 Law Program based in Los Angeles.

15 CHAIR RIDEOUT: Great, thank you, Abbi.

16 Jarrod?

17 MEMBER MCNAUGHTON: Well, good morning and thank you so
18 much for having me. I am Jarrod McNaughton, the CEO of Inland Empire Health
19 Plan, one of the 17 local health plans in the state of California.

20 CHAIR RIDEOUT: Thank you.

21 Mark?

22 MEMBER KOGAN: Yes. Hi, I am Mark Kogan and I am a
23 gastroenterologist in private practice in San Pablo and Berkeley.

24 CHAIR RIDEOUT: Great. Did I miss any other committee
25 members? We know one committee member will be absent today because of

1 illness, but we may get an addition late. So, any other committee members?
2 (No response.)
3 CHAIR RIDEOUT: Okay. Well, again, welcome. I need to start
4 and I want to start with our housekeeping. So, let me go through that as quickly
5 as we can; but it's important information for everybody that's attending.
6 First of all, for our Board Members, please remember to unmute
7 yourself when making a comment and mute yourself when not speaking. Again,
8 for our Board Members and the public, as a reminder, you can use the Zoom
9 meeting on your phone should you experience any connection issue.
10 Questions and comments will be taken after each agenda item.
11 And we will start with the Board Members for questions and comments and then
12 we will move to the general public, starting with folks on the Zoom first and then
13 going to folks on the phone.
14 For attendees on the phone, if you would like to ask a question or
15 make a comment, please dial *9 and state your name and the organization you
16 are representing for the record.
17 For attendees participating online with microphone capabilities, you
18 may use the Raise Hand feature and you will be unmuted to ask your question or
19 comment. To raise your hand, click on the icon labeled Participants on the
20 bottom of your screen, then click the button labeled Raise Hand. Once you have
21 asked your question or provided a comment, please click Lower Hand. That is
22 really important for us to know who has been heard already. All questions and
23 comments will be taken in order of raised hands. And again I will mention that
24 we will take committee members first then move to folks, the public on video, and
25 then folks on the telephone.

1 As a reminder, the FSSB is subject to Bagley-Keene Open Meeting
2 Act rules and guidelines. Operating in compliance with the Bagley-Keene Act
3 can sometimes feel ineffective and inefficient and frustrating, but it is essential to
4 preserving the public's right to governmental transparency and accountability.
5 Among other things, the Bagley-Keene Act requires the FSSB
6 meetings to be open to the public. As such, it is important that members of the
7 FSSB refrain from emailing, texting or otherwise communicating with each other
8 off the record during the FSSB meetings, because such communications would
9 not be open to the public and would violate the Act. As a best practice, this also
10 includes the Chat feature on Zoom.
11 Likewise, the Bagley-Keene Act prohibits what are sometimes
12 referred to as serial meetings. A serial meeting would occur if a majority of the
13 FSSB members emailed, texted, or spoke with each other outside of a public
14 FSSB meeting about matters within the FSSB's purview. Such communications
15 would be impermissible, even if done asynchronously. For example, member
16 one emails member two, who then emails member three, et cetera. Accordingly,
17 we ask that all FSSB members refrain from emailing or communicating with each
18 other about FSSB matters outside the confines of the FSSB meeting.
19 And I think that does it for the housekeeping and the welcome,
20 more housekeeping than welcome.
21 The next order of business is actually a review of the transcript,
22 which is quite lengthy because it is verbatim. Can I get a motion from any of the
23 members of the committee for either an approval or correction?
24 MEMBER MCNAUGHTON: So, moved.
25 CHAIR RIDEOUT: Is there a second?

1 MEMBER KOGAN: Second.

2 CHAIR RIDEOUT: Okay. Any opposition to the transcript being
3 accepted as correct?

4 Okay, hearing none, we will move on to Mary and the Director's
5 Report. Thanks.

6 MEMBER WATANABE: Hi, good morning. Glad to be here with
7 you and see you all again. I am getting used to being virtual again. So, just a
8 couple of -- I am Mary Watanabe, the Director of the Department of Managed
9 Healthcare for anyone that doesn't know me. With me today we have Sarah
10 Ream, our Chief Counsel. Sarah is not formally presenting anything on the
11 agenda, but she is going to help me with some of my updates today. Obviously,
12 you know Pritika Dutt, our Deputy Director for the Office of Financial Review,
13 Michelle Yamanaka, Supervising Examiner in our Office of Financial Review.
14 Jordan Stout, as you know, is our facilitator and coordinator of all things, he is in
15 our Office of Financial Review. Shaini Rodrigo is an analyst in the Director's
16 Office and is also providing support. And then Amanda Levy, our Deputy
17 Director for Health Policy and Stakeholder Relations will do a legislative update.
18 So, that's the DMHC team that we have today.

19 So, just a couple of -- maybe a little quick housekeeping item
20 regarding our Board Member terms. So, Paul and Jeff's terms were up at the
21 end of this year along with Amy Yao's term. But given all of the changes that we
22 have had this year with our board and new members I have asked all three of
23 them to stay on for an additional year to give us some continuity. I am really
24 pleased to announce that Jeff and Paul have agreed to stay on for one more
25 year. However, Amy is going to be retiring so this was actually going to be her

1 last meeting on the Board and we were going to say lots of nice things about her.
2 So, unfortunately, she's not going to be able to hear that and she is not going to
3 join us, but this will this was going to be her last meeting. I have really
4 appreciated Amy's participation on the Board; I think it has been six years. She
5 has really brought a unique perspective as an actuary and really contributed to
6 our discussions, particularly about rates, medical loss ratio and risk adjustment
7 transfers. So, obviously wish her well in retirement but will miss her participation
8 on the Board. I will talk more about her replacement in another agenda item here
9 in a minute.
10 So, moving on to program updates. October was an incredibly
11 busy month for the DMHC. If you got our stakeholder newsletter you probably,
12 your head was spinning a little bit with all of our activity. I think we crammed
13 about two years worth of announcements into one month so I want to share
14 some of that with you today.
15 Probably the most significant one was an announcement about a
16 settlement agreement with Kaiser to make significant changes to the plan's
17 delivery of behavioral health services. This historic $200 million settlement
18 agreement includes a $50 million fine and requires Kaiser to take really
19 significant corrective actions to address deficiencies in how they deliver and
20 oversee behavioral health services. They have also pledged to make an
21 additional significant investment totaling $150 million over five years into
22 programs to really improve the delivery of behavioral health services for all
23 Californians, beyond just their existing obligations under the law.
24 You may recall, I think it was about this time last year, when we
25 talked about we had opened an enforcement investigation into Kaiser following or

1 during the NUHW strike. We also had opened a non-routine survey specifically
2 to look at timely access to behavioral health services. So, this settlement
3 agreement really is a result of both of those actions. I will just say if you have
4 heard me talk recently you have probably heard me say behavioral health is my
5 number one priority. And this really is an example of both my commitment and
6 the administration's commitment to holding health plans accountable for
7 complying with the very strong laws we have in California, and ensuring all
8 enrollees have access to behavioral health services.
9 We also announced the first results of our behavioral health
10 investigations. I think I have been talking about these for two years and saying
11 the report was coming. And just a reminder, the behavioral health investigations
12 were really intended to kind of look at the behavioral health delivery system from
13 the consumer perspective in the commercial market, to really understand where
14 the barriers and challenges were, whether those were violations of the law or just
15 barriers to accessing care. We are conducting behavioral health investigations of
16 all licensed full service commercial plans with an average of five health plans per
17 phase. During this first phase we identified 27 Knox-Keene violations and 14
18 barriers to care across those first five health plans. I won't go into all of the
19 details. You can find those reports on our website if you go to healthhelp.ca.gov;
20 I think they are linked under *What's New*.
21 But a couple, I think, significant findings in this first report is we saw
22 a lot of instances where the plans were not complying with their own policies and
23 procedures. So, they filed policies and procedures with us telling us how they
24 are complying with the law, and we found a number of instances where either
25 they were not complying with those policies and procedures or they were not

1 overseeing how their delegates were complying with those policies and
2 procedures, so that was significant.
3 One of the key barriers that the plans -- that we identified for I think
4 most of the plans was most of them did not have a process for providers to bill for
5 the integration of behavioral health into primary care. And I know there's a
6 number of initiatives across the state to really look at how we leverage that
7 primary care provider relationship to address some of the workforce challenges
8 and make sure we are connecting individuals with primary care. There's a lot of
9 innovation, I think, happening in this space, but we found that many plans just
10 didn't even have a process or a way to reimburse providers for that.
11 So, these will be ongoing. We are anticipating Phase 2 will be
12 released at the first part of next year and then we will likely be on more of an
13 annual cadence going forward. So, I will continue to bring that information to you
14 at our quarterly meetings.
15 So, in October we also reconvened our Health Equity and Quality
16 Committee. Just a reminder last year, we convened the Health Equity and
17 Quality Committee to recommend health equity and quality measures as well as
18 a benchmark for not just measuring quality but really with the goal of reducing
19 health disparities. The committee met nine times and ultimately recommended
20 13 quality measures which included 12 HEDIS measures, one CAHPS composite
21 measure, and they recommended that those measures be stratified by race and
22 ethnicity. We adopted those measures at the end of last year. The plans are
23 collecting those measures now for Measurement Year 2023. They will report to
24 us next year in 2024 and those measures will be in place until at least
25 Measurement Year 2027.

1 The committee recommended using the National Committee for
2 Quality Assurance or NCQA Quality Compass national Medicaid data for the
3 benchmark, but they did not reach consensus on what percentage to use. And
4 rather than just making a quick decision we took some time this year and spent
5 time meeting with a number of our stakeholders. We had a working group with
6 the health plans, we met with our advocate partners, the purchasers, and others
7 that have expertise in this area to really think through the benchmark. And we
8 reconvened the committee in the middle of October to really consider kind of four
9 different approaches to the benchmark percentile.
10 The first was increasing the benchmark over time. So, starting at
11 the 33 and a third and moving to the 50th percentile over say three years.
12 We also discussed a gap closure approach, which would give the
13 plans a kind of credit if they made incremental improvements year over year.
14 And again, this is not just at the aggregate level, but we are looking at the
15 subpopulation level by race and ethnicity.
16 And then the third option was a phase-in approach of the
17 measures. So, starting with a subset of measures. I think we selected, we
18 recommended six that would align with what CalPERS, DHCS and Covered
19 California are doing.
20 And then there was a glide path approach where the benchmark
21 would kind of be phased in over a longer period of time.
22 So, we received a number of written feedback in addition to a
23 robust conversation with the committee and we anticipate issuing guidance to the
24 plans by the end of the year with not just kind of the plan for next year, but also
25 with the benchmark. So, I really appreciate all of the thoughtful

1 recommendations and different approaches that came out of those conversations
2 but look forward to continuing those conversations with you as well in the new
3 year.
4 We also conducted listening sessions related to our Transgender,
5 Gender Diverse and Intersex Working Group during the months of September
6 and October. Senate Bill 923 actually required four listening sessions across the
7 state and so we did those. And I will say it was really an honor to be a part of
8 those conversations and I appreciate the TGI community members that came out
9 and providers as well to really just share their experience accessing all health
10 care through the healthcare delivery system, but really gender affirming care. I
11 will say I was just struck by some of the really poor treatment that they have
12 received and it really has highlighted for me, I think, the need for us collectively to
13 do a better job in serving this community and just treating them in a
14 compassionate and humane and culturally competent way.
15 So, looking forward to the recommendations from the working
16 group on training curriculum as well as a quality standard. The working group
17 actually met yesterday and had a really robust discussion around quality
18 standards. They will have one more meeting this year and then continue into the
19 first quarter of next year, culminating with their recommendations. So, it has
20 been really some good discussion and I just appreciate the willingness of this
21 community to have these discussions in a very public forum, given some of the
22 unfortunate events happening across the country for this community.
23 Finally, I am just going to highlight a few regulation packages that
24 are the furthest along in the process. As always, we have a lot going on in this
25 space.

1 The first regulation updates the way plans determine the average
2 contracted rate for the purposes of reimbursing noncontracted providers for
3 services delivered in contracted facilities. We sometimes call this the AB 72 or
4 the Average Contracted Rate, or ACR rate. AB 72 was enacted in 2016 and
5 plans must reimburse noncontracted providers who deliver services in a
6 contracted facility at the greater of 125% of what Medicare pays or the Average
7 Contracted Rate. For the purpose of calculating the Average Contracted Rate,
8 the new regulation adds an adjustment for inflation, adjusted to the date the
9 service was rendered, and this really aligns with what our California Department
10 of Insurance is doing. The Office of Administrative Law, which reviews and
11 approves all regulations, approved this regulation update in October and it will
12 take effect January 1, 2024.
13 The second regulation is the one that everybody is anxiously, I
14 think, waiting for. It is related to Senate Bill SB 855, which was enacted in 2020.
15 SB 855 made significant changes to California's mental health parity law. It adds
16 a host of protection for consumers, including ensuring plans use the appropriate
17 criteria when making utilization management decisions. It also requires plans to
18 arrange for out-of-network care if the plan cannot timely provide the services
19 through an in-network provider. If the plan fails to timely arrange for care, the
20 enrollee can go out-of-network on their own. So, this regulation has been in
21 formal rulemaking for almost a year. We have held three public comment
22 periods, and we are now finalizing the package to go to the Office of
23 Administrative Law for final review and approval. We plan to submit this in the
24 next few weeks, hopefully very soon, and we are hoping -- assuming the
25 regulation is approved, it will take effect April 1st of 2024.

1 The third regulation that is far along in the development process
2 concerns fertility preservation services. This implements SB 600, which was
3 enacted in 2019. It clarifies that fertility preservation services are basic health
4 care services and plans must cover when an enrollee receives a service that
5 could cause the enrollee to be infertile, such as undergoing chemotherapy. We
6 have shared a draft of this regulation with stakeholders, we are now finalizing the
7 package and hope to send that to OAL by the end of January and that will start
8 the formal rulemaking process.
9 I will briefly mention one more, which is provider directories. I feel
10 like I have been saying the regulation package is coming, for five or six years.
11 But for real this time, it is really coming. We have previously shared, I think, a
12 draft of this package with stakeholders. We are going to share another draft one
13 more time in a few weeks and then we are going to quickly move forward with
14 formal rulemaking. And this, for the most part, codifies our existing standards
15 and guidance that we have given.
16 The last one is general licensure regulation, which was enacted in
17 2019. This regulation defines various terms regarding risk. It requires an entity
18 that wants to assume global risk, which is both professional and institutional risk,
19 to either have a license or get an exemption. After we implemented the
20 regulation, we realized we needed to make some changes to the exemption
21 process. So, we currently have an expedited exemption request process in
22 place. That will stay in place until we update the regulations and make it clear
23 about when an entity needs a license versus an exception and when will grant an
24 exemption. We are hoping to share a draft of this regulation with stakeholders by
25 the end of the year so watch for that one too.

1 And then in some late breaking news yesterday, we released our
2 All Plan Letter regarding SB 510 and coverage of COVID services. I think this
3 came up at our last meeting. I know a number of you are very interested in this
4 issue. So, I have asked Sarah to join and do a quick overview of this guidance
5 and she can help answer some questions too. So, with that I will turn it over to
6 Sarah and then we will go back to taking questions.
7 MS. REAM: Thanks, Mary. I am Sarah Ream, I am the Chief
8 Counsel for the DMHC, it’s a pleasure to be here. So, as Mary said, we issued
9 an APL yesterday afternoon that concerns reimbursement for COVID testing
10 services that were delivered between March 4 of 2020, so the beginning of the
11 pandemic, through December 31, 2021. That time range is key here because
12 post -- in 2022, starting January 1, 2022, SB 510 took effect going forward. Sort
13 of a different -- there's a different look-back for going back, pre-SB 510 or
14 enactment of SB 510.
15 So, what this APL does, it does essentially three things. It tells
16 plans, you must reimburse or have reimbursed providers at the greater of either a
17 specifically negotiated rate for COVID testing, or 125% of what Medicare pays for
18 the service. So, what we are doing is we are setting the floor. Plans must have
19 reimbursed or reimburse for this amount. The plan also must pay interest on the
20 claim and that interest begins to accrue on June 27 of 2023, for DMHC’s
21 purposes. So, if a plan pays interest accruing as of June 27, 2023, the DMHC
22 will consider the plan to have complied with the APL. June 27 Is a key date here,
23 because that was the date when a preliminary injunction that had been issued in
24 CAHPS’ lawsuit regarding SB 510 was lifted, so we identified that date.
25 And then finally, the APL directs plans to reimburse providers by no

1 later than February 12 of 2024. So, plans have essentially 90 days to get that
2 payment made if they have not already.
3 Another key provision in the APL is that, like I said, it sets a floor for
4 DMHC enforcement purposes. It does not preclude a provider from bringing a
5 lawsuit against a health plan, engaging in arbitration with a health plan, if the
6 provider believes that they are entitled to greater reimbursement for testing or
7 they believe they are entitled to interest dating back further than June 27 of this
8 year. So, really, we are setting the floor, like I said, for our enforcement
9 purposes. I know there was a lot of -- people have been anxious for us to get
10 this APL out, so, I am very pleased that we did.
11 Finally, just one other note, the APL directs RBOs, restricted health
12 plans, if they have reimbursed downstream providers for testing, the RBO or
13 restricted plan or fully licensed delegated plan needs to look to the upstream
14 health plan for reimbursement for the COVID testing services. Rather than the
15 restricted plan going to the downstream provider who may have actually
16 delivered the service and saying, hey, give us our money back, you go to the
17 plan and try to seek reimbursement. And we have had a few anecdotal
18 instances where the ultimate provider, the one who on the ground provided the
19 testing, has said, hey, this intermediary is coming to me and telling me I need to
20 repay them the amounts I was paid and then go after the plan. That is not our
21 expectation. Our expectation is that the upstream RBO or health plan will go to
22 the ultimate payer to get that reimbursement.
23 So, with that, I am happy to take any questions.
24 CHAIR RIDEOUT: Thank you very much, Sarah.
25 Let me first acknowledge that David Seidenwurm joined quite close

1 to 10:00 o'clock so he is in attendance as well.
2 Let's go to committee members with any questions for Sarah or
3 Mary at this point.
4 Okay, seeing none, I will make just a couple of quick comments.
5 MEMBER WATANABE: Jeff, Jarrod and Paul have their hand up.
6 CHAIR RIDEOUT: I’m sorry, I didn't said that. Jarrod, please.
7 MEMBER MCNAUGHTON: Yes. Thanks so much, Jeff and Mary
8 and Sarah, really appreciate the updates. Just a quick question on clarification
9 regarding the AB 72 piece, Mary. For that inflation piece, is the average rate
10 based on the provider’s average contracted rate that they have contracted or is it
11 the average contracted rate of the payer? Which one will that be applied to? If
12 that makes any sense.
13 MEMBER WATANABE: It does. Sarah, I think it's the health plan’s
14 average contracted rate or 125% of Medicare and the inflator will be on top of
15 that.
16 MS. REAM: Correct.
17 MEMBER MCNAUGHTON: Gotcha. Thank you so much.
18 CHAIR RIDEOUT: Paul.
19 MEMBER DURR: Yes. My question, Mary; and thank you for the
20 nice overview, and Sarah as well. It had to do with Kaiser and the mental health
21 services, as we know that mental health providers are significantly lacking in our
22 state, certainly in San Diego County. Wanted to know, because you mentioned
23 that the settlement was more broad, to look at what Kaiser could do to help
24 create some more for other people in our state overall. Could you share a little
25 bit about that? I haven't read the details, so any insight you could share? I

1 applaud you for coming up to that settlement, so, thank you.
2 MEMBER WATANABE: Yes, no, thank you, Paul, I appreciate the
3 question. So, the settlement agreed on -- we have a press release that is posted
4 on our website with a link, it is a very lengthy settlement agreement. Included in
5 the settlement agreement is a robust kind of corrective action plan that Kaiser will
6 be taking steps over the next few years to really make corrections to their system
7 to come into compliance with the law, including appropriate oversight of the
8 delivery of behavioral services. But the $200 million settlement agreement
9 includes $150 million in investments to really think creatively and innovatively
10 about how we tackle some of these issues, like some of the workforce
11 challenges, and just think about maybe new models of care. This is not intended
12 for Kaiser to get a credit for investing $150 million to correct what they should
13 already be doing under the law. So, this is really thinking about some innovative
14 approaches that could serve as models for the entire state. So, that's part of
15 what we will be working with them on over the next probably couple of years. So,
16 that was the intent behind that.
17 MEMBER DURR: I think that's fabulous. And I also want to
18 applaud you for your leadership on the health equity and the transgender and
19 making a difference for our more vulnerable people in our community, so I really
20 applaud the direction that you were taking with DMHC on that, so thank you.
21 MEMBER WATANABE: Appreciate that. Thank you, Paul.
22 CHAIR RIDEOUT: Other questions from committee members?
23 I don't see any.
24 I will just make two passing comments that reflect on some of what
25 Mary said. Many years ago, we actually -- I was involved with a study that was

1 done by UC Davis that paid primary care physicians double payments for double
2 bookings for the same patient with depression, so it was for better screening and
3 better compliance. So, that was quite successful in terms of leveraging primary
4 care physicians. But it's kind of ancient and maybe it was, you know, not the
5 easiest way to do it but it was successful.
6 Also I would like to reinforce what Paul said about the DMHC
7 leadership on the equity measurement. When we present the IHA Atlas
8 information in the new year we will highlight the critical role of both encounter
9 data and clinical data, not only to the performance scores overall, but also to
10 getting to as full an accounting of health equity status as we can. And there's
11 clearly a wide range of plan-derived understanding of race and ethnicity and that
12 can be supplemented by either third-party sources, or also importantly, by clinical
13 sources. So, we will be happy to highlight that. We have done that for our board
14 and several industry groups already.
15 All right. Now we go to questions from the public. First on Zoom,
16 are there any?
17 MR. STOUT: There are none at this time.
18 CHAIR RIDEOUT: Okay. And questions for anyone on the phone?
19 Okay. Hearing none, I think we will move on to the next item.
20 Mary, you are up again.
21 MEMBER WATANABE: This is really short. As I mentioned, Amy
22 will no longer be on the Board, so after this meeting we will be releasing a
23 solicitation for a new Board Member, with a due date probably of the end of the
24 year. So, again, share that broadly. It would be great to have another actuary on
25 the Board, but not a requirement, and we have a pretty broad description of who

1 is eligible to apply. So, watch for that, share with anybody that you think would
2 be interested, and look forward to having a new Board Member join us in
3 probably our February Board meeting. That's it.
4 CHAIR RIDEOUT: Any questions from committee members for
5 Mary on that item?
6 Any questions from the public, either on Zoom or by phone?
7 MR. STOUT: None at this time.
8 CHAIR RIDEOUT: Okay, we will move on to the Department of
9 Health Care Services Update; and I believe we have René Mollow and Bambi
10 Cisneros to provide that update to us.
11 MS. CISNEROS: Great. Thank you, everyone, for having us here
12 this morning. So, on the next slide we have a just a quick outline of the things
13 that we want to get through for this morning. And so I will tee up the Managed
14 Care Plan Contract for 2024. Kind of give an overview there, as well as touch a
15 little bit on the Kaiser Direct Contract. And then I will turn it over to René to then
16 talk about Medi-Cal Redeterminations and the January 2024 Expansions. And
17 so we can go on to the next slide, please. Thank you.
18 So, there are many exciting changes happening in managed care
19 for 2024. But I think the focus for today's presentation will really be on the
20 changes that are happening in regards to the managed care contract, which is
21 really the result of three pillars of change that we see here on this slide.
22 So, in December, the Department announced that we would
23 contract with five commercial managed care plans to serve Medi-Cal members in
24 21 counties starting in January 2024. And important to point out here that all
25 managed care plans, including those commercial plans, were required to

1 undergo an extensive operational readiness process, which has been underway
2 since the start of this year. And in September, the Department did approve all
3 managed care plans to go live in 2024 so we are full steam ahead from that
4 perspective.
5 The second piece here is really about a model change, which was
6 a county led process. So, counties were able to go to their board and petition for
7 their plan model type to change in that county. The Department then sought and
8 received federal approval to move forward with those changes. So, there are
9 going to be 17 counties in California that's going to be changing their managed
10 care model, which includes a new Single Plan Model, and then some plans are
11 expanding their model as a COHS. So, that's another piece that's happening
12 there.
13 And the third piece is the direct contract with Kaiser. And so here it
14 is going to happen in 32 counties in which Kaiser operates. And it is really based
15 on a plan and provider linkage or certain kinds of population criteria for default
16 assignment. And all of these kinds of requirements were set forth in AB 2724.
17 And what we would say is that regardless of the plan change, all
18 managed care plans will be under one contract, so this was really the benefit of
19 doing this all together. So, that we are able to hold all managed care plans under
20 the same standards.
21 And then for the member, it would have a better experience for
22 them because that means their benefits structurally will be the same regardless
23 of which county they live in. And so as a result of these new contracts, Medi-Cal
24 members can really expect improved, you know, health equity, quality, access,
25 accountability and transparency. So, that is the why to our changes.

1 And so the next slide just kind of gives a quick overview on the
2 transition that is going to be happening. And so based on the commercial plan
3 and county model changes that I had mentioned, we anticipate that over 1 million
4 members will need to transition to a new managed care plan in January in the 21
5 counties that are listed here. And then the important point I would make here is
6 that even with the plan changes, the members' Medi-Cal coverage and benefits
7 will stay the same, so there should not be any loss of coverage there. And we
8 are doing everything that we can to really, you know, do some careful planning
9 around building and protections to minimize member impact as much as
10 possible, such as continuity of care. And then our focus has really been on
11 operational readiness to make sure that the receiving plans are really ready to
12 take on new lives.
13 And then the next slide is really just a visual depiction of what the
14 current plan models look like today on the left side; and on the right is what the
15 mix of plan model types will look like in 2024. And you will notice that the
16 northern region of the state has transitioned to a COHS or Single Plan model,
17 and that we no longer will have the Imperial or San Benito model. So, this is just
18 a good visual.
19 Going on to the next slide, here we just have kind of the key
20 themes that really is pervasive throughout the contract. And so we are projecting
21 99% of Medi-Cal members to be enrolled in a managed care plan in 2024. And
22 so we have really built in policies and protections and requirements in place to
23 really improve kind of that member experience. As I had mentioned, the 2024
24 contract will apply to all Medi-Cal managed care plans regardless of the plan
25 model type. And then the themes from the contract, as we see here, we will go

1 through in more detail in the next, in the next few slides. Next slide, please.
2 Okay. So, in the next few slides I will provide high level examples
3 or contract provisions that are tied to the themes in the contract, kind of from the
4 previous slide. So, for transparency, we really did a lot in the space in requiring
5 plans to routinely and publicly report on many different types of reports pertaining
6 to access, quality and health equity activities. And the idea is that this
7 transparency will really promote accountability and also help inform members in
8 their choice of health plans. And so specifically managed care plans will be
9 required to post their CAHPS survey results, which is the member satisfaction
10 results, MOUs or memorandums of understanding with third parties, their
11 annual -- some other things that's not listed on this slide but they are also
12 required to post are things like the Annual Quality Improvement and Health
13 Equity Transformation Plan, their utilization management policies and
14 procedures, and their annual Community Reinvestment Plan and Report.
15 The new contract also strengthens the quality expectations on
16 managed care plans by requiring that they not just meet but exceed the quality
17 improvement benchmarks. They are also required to maintain a population
18 health management program that aligns with NCQA, as well as engage members
19 through a new requirement, which is to really engage members using their
20 community advisory committee, and the development of their population needs
21 assessment. So, the idea here is that they would be engaging input and
22 feedback from families and communities, really running through this community
23 advisory committee and just having like a feedback loop with how they are really
24 intaking that feedback.
25 We are also increasing our expectations for plans in the role and

1 providing access across the continuum of care, which includes social services.
2 And so this includes additional requirements around care management services,
3 transitional care, and implementing CalAIM initiatives such as ECM or Enhanced
4 Care Management, and community supports.
5 And then, there's also provisions related to the coordination and
6 integration of care that we have strengthened in the new contract, and so we are
7 requiring plans to really systematically coordinate services. So, for example, the
8 contract requires that managed care plans have MOUs with third-party entities to
9 coordinate health and social services, such as WIC, you know, child welfare for
10 the foster population, and IHSS, as examples.
11 And of course, increasing health equity and reducing health
12 disparities is one of our central goals and so for managed care plans, they will
13 need to meet health disparity targets determined by the Department.
14 We are also requiring them to get an NCQA accreditation for the
15 health equity accreditation by 2026. And also require that they appoint a Chief
16 Health Equity Officer, a senior level staff, that would be responsible for the health
17 equity activities for the plan.
18 And then there's also new training and monitoring requirements
19 around diversity and equity, including cultural sensitivity training. So, that's
20 something that we strengthened in the contract. And I know someone had
21 mentioned earlier the TGI workgroup that DMHC is leading. And so based on
22 the recommendations from that workgroup, we will be looking to issue additional
23 guidance for managed care plans on care around that required training.
24 And then tying this to CalAIM, which plans already implement. We
25 will, of course, continue to work with them to ramp up community support

1 offerings. Because today it is a waiver service so it is not statewide as of yet so
2 there's some county variance there. But we are working with plans to really kind
3 of ramp up their networks, build those relationships with CBOs and continue to
4 provide the community support services.
5 One of the highlights of the contract is a new community
6 engagement section, which includes requirements for plans to develop a strategy
7 for member and family engagement. I kind of mentioned this in the earlier slide.
8 So, it really just involves partnering with the community, including like any
9 community-based organizations and, you know, entities serving the member, as
10 well as ensuring that member and family input is incorporated as part of the
11 decision-making. So, we want to see how they are not just hearing input from
12 members and families in the community, but they are actually putting that as part
13 of their kind of decision-making as they work on developing and creating policies.
14 The contract also includes a new Children's Services subsection. It
15 just really highlights children as a member population and requires plans to
16 implement methods for care management and coordination with appropriate
17 programs. So, as an example here, there are specific provisions for plans to
18 partner with local education agencies to provide medically necessary behavioral
19 health services, including mental health and substance use disorder treatments,
20 services across settings, including the home, school and in the community.
21 And then the next slide kind of talks about when it comes to
22 behavioral health services, the contract does reference the No Wrong Door
23 policies that went live earlier this year, so that members can get access to
24 treatment regardless of the delivery system in which they came through.
25 Because as you may all know, Medi-Cal does have a split delivery system for

1 behavioral health services. So, our Medi-Cal managed care plans cover non-
2 specialty mental health services, and our county mental health plans provide for
3 specialty mental health services.
4 The contract also significantly strengthens the Department's
5 expectations related to accountability and oversight of delegated entities. So, we
6 have heard a lot in the space in terms of, you know, how the Department
7 establishes policies for our plan partners who we have a contract with, and of
8 course, they can subcontract with other entities. And then the idea is that these
9 Medi-Cal policies would be pushed downstream to those subcontractors and
10 delegated entities. And so for operational readiness and future forward ongoing,
11 plans are to submit a delegation and compliance plan where they identify the
12 subcontractors they are using and describe the reasons for why they are using
13 that subcontractor. So, this is very new in this space. And this is just kind of one
14 piece tied to how we are looking at delegation in the Medi-Cal program. So,
15 there's this requirement in the contract that they have this delegation and
16 compliance plan. But we also certify our networks to the federal government, so
17 to CMS annually. This is the first year we also conducted network certification at
18 the subcontractor level. So, we did that for reporting year 2022 and we
19 submitted that to CMS. So, I think there's a lot happening in the space with how
20 we are just ensuring that with all of the various partners that the plans have, that
21 there's still some strong oversight there and we have an understanding of where
22 members are getting care and ensuring that, you know, everyone has a piece in
23 ensuring that members get access to services.
24 And then just touching quickly on emergency preparedness. I think
25 here we are just requiring the plans have -- ensure that members have access to

1 essential services before and after emergencies. And the key piece here is
2 making telehealth available for covered services. I think this is where we learned
3 a lot from the public health emergency in terms of how to really have this
4 emergency response response plan, and so that's what that speaks to in the
5 contract.
6 And then finally, managed care plans will be required to report on
7 how their payment models will link to value. And so we set that in the form of
8 higher quality of care, better health care outcomes and lower cost of care. And
9 so we are wanting plans to provide more visibility into how they make -- are
10 making those payments for value. So, we are having them report on their
11 primary care spending, including what their proportion of overall spending is tied
12 to primary care. So, again, that's another kind of new requirement.
13 And then what I would say here, and I know you may have seen an
14 asterisk next to emergency preparedness, but what I would share is that there
15 are still pieces of guidance that we need to issue to help manage care plans
16 comply with these requirements. So, for example, emergency preparedness is
17 one. There are certain MOUs that are required for 2025. So, for example, the
18 First 5 continuum of care, for example, as well as the school-based services
19 policy. So, those are all things that we have punted for additional guidance for
20 2025; and so there's going to be more coming from the department in this space.
21 And then the next slide is really more about just the Kaiser direct
22 contract. Today, Kaiser is a subcontractor to 12 of our Medi-Cal managed care
23 plans in 17 counties, and we also have a direct contract with them in 5 other
24 counties. And so with the direct contract with the DHCS, Kaiser will become a
25 prime plan in those 22 counties plus 10 additional counties where Kaiser has an

1 existing footprint. This means that Kaiser will be under the same contract and
2 held to the same requirements that we just talked through as all the other
3 managed care plans in 2024. And this also means that Kaiser will no longer
4 have certain exemptions that they have had with the Department. So, an
5 example of that is -- so for today for purposes of the annual network certification
6 that I had mentioned, Kaiser has what we call a delivery system exemption rather
7 than an alternative access standard. So, that means that when they don't meet
8 time or distance or geographic access requirements, they are able to submit that
9 delivery system exemption rather than submit the full AAS or Alternative Access
10 Standards package as all other plans. And so in 2024 they will be required to
11 meet all of those network adequacy requirements, including submitting those
12 alternative access standards if they are not able to demonstrate compliance with
13 time or distance standards. So, that's just an example of how we are really trying
14 to use this contract to standardize benefits across plans and across kind of plan
15 model types.
16 And then from a member perspective, certain members will have
17 Kaiser as a plan choice. That's kind of here in -- I'm sorry if it's really small--the
18 banner in the bottom of the slide where it says that members can choose Kaiser
19 through active choice if they have been enrolled with Kaiser at any point in 2023
20 or are currently with Kaiser today; they have family that is linked to Kaiser; or
21 they are a dual-eligible member. So, they have Medi-Cal and Medicare, or they
22 are a foster care child or youth. So, those individuals will be able to be enrolled
23 in Kaiser through active choice.
24 And then members that are already assigned to Kaiser through the
25 subcontract with the managed care plans, they will be able to stay with Kaiser, so

1 we are not going to be moving members there.

2 There is a Medi-Cal matching policy that the Department has,

3 which means that if the member is already in a Medicare Advantage plan, we will

4 then automatically assign that member to the same family -- what are we calling

5 it -- like a family plan or the partner plan. So, in this particular case, if a member

6 is in a Kaiser Medicare Advantage plan, we will automatically assign them to a

7 Kaiser Medi-Cal managed care plan.

8 And then finally, for those members who do not make an active

9 plan choice, we will undergo a default assignment process for Kaiser, which is

10 what we do with other plans as well, which is that we will first try to assign

11 members that have linkage to Kaiser, you know, whether through enrollment

12 history or a family member or kind of like the linkages that we had talked about

13 here, before assigning them to the plan. And so that's typically what we might do

14 is really try and find that linkage before just doing, you know, having the member

15 undergo that default enrollment process.

16 And then separate from the eligible members, Kaiser will also need

17 to accept new members based on growth targets that are set by the Department.

18 And there's additional detail between -- there is an MOU between DHCS and

19 Kaiser that's posted on our website. And then these enrollment growth targets

20 will also be posted as well. So, I just wanted to briefly mention that.

21 And then the next slide just kind of gives you some resources

22 information that we have developed to really help support members, plans,

23 providers and the public writ large on the transition. You know, it's a pretty big

24 change. And so, on the DHCS webpage there's a lot of transition support

25 materials including FAQs, some very robust information about continuity of care.

1 We have gone above and beyond even the Knox-Keen continuity of care
2 protections for some special populations tied to this transition; as well as posted
3 the notices that the members have received or will receive; as well as the Notice
4 of Additional Information, which is kind of an FAQ format. Typically, it's an insert
5 in the member notice. And then wanted to call your attention to this county look-
6 up tool. So, if you go on this website and, you know, type in the county, it will
7 show you the plan that's going to be there in 2024. So, the new plans and then
8 the exiting plans as well. And then kind of what the member would expect in
9 terms of what would be in the notice. So, I think it's a really nice cheat sheet.
10 And then the last slide I was just going to share was just something
11 that the DHCS team previously shared with the DMHC's Help Center team in
12 terms of just resources. This is where the resources from the previous slide
13 would be helpful in particular, that county look-up tool. So, if members are likely
14 asking about the transition, we do have healthcare options that folks can direct
15 them to and we are certainly available to kind of help assist as well.
16 And so I think that takes me to the end of my segment. So, maybe
17 I will pause here and see if there are questions before I turn it over to my friend
18 René.
19 CHAIR RIDEOUT: Thank you, Ms. Cisneros, for that.
20 Are we going to continue or take questions on this, Mary, what
21 would be better?
22 MEMBER WATANABE: Bambi, can you stay on until the end or do
23 you need to hop off?
24 MS. CISNEROS: I can stay on, Mary.
25 MEMBER WATANABE: Why don't we get through René's

1 presentation, then we will do questions on all of it from both the Board and the
2 public.
3 CHAIR RIDEOUT: Okay.
4 MEMBER WATANABE: Thank you.
5 CHAIR RIDEOUT: Thank you.
6 MS. MOLLOW: So, hi, everyone. So, I am René Mollow, and
7 hopefully someone is going to advance the slides. Okay, very good, thank you
8 so much. So, I am René Mollow, Deputy Director for Healthcare Benefits and
9 Eligibility here at the Department. So, I am happy to be here again to share the
10 work that we are doing for the continuous coverage unwinding and the
11 resumption of renewals under the Medi-Cal program.
12 So, just as a backdrop before I go into the slides, just as a reminder
13 to everyone, and I think it has been a while since I have been here to present.
14 But, you know, the federal government required the states to start resuming the
15 renewals of individuals that were enrolled in Medicaid coverage. And states had
16 options as to the starting point for when they were going to, when they were
17 going to resume the renewals. For California, that starting point for us was April
18 of 2023. We started in April for renewals that were then due in June of 2023.
19 And as a reminder, we do have a runway that we start with in terms of doing the
20 renewal activity. So, we tend to start our renewal effort somewhere between 60
21 to 75 days in advance of the renewal for our Medi-Cal members. For California,
22 our renewal process is based upon the original date in which the individual
23 became eligible for the Medi-Cal program. So, we were just taking people in
24 order by their month of eligibility in the Medi-Cal program. And then that process
25 will cover a 12-month period. We have a total of 14 months that we can do the

1 unwinding period. And we have to within that time period, have started and
2 initiated those renewals for our Medi-Cal members.
3 So, for us in California, given our caseload size, which is still
4 approximately 15 million individuals, it equates to a little over a million renewals
5 that have to be done on a monthly basis by our county partners. And so in terms
6 of the work that we have to do, we have released an unwinding plan that is on
7 the DHCS website, which gives a very detailed review of the work that we have
8 to do for the unwinding; both in terms of some of the flexibilities that were put in
9 place for the Medi-Cal program writ large, and then there is a very specific
10 section in terms of the eligibility work that we had to do and the process that we
11 were going to be taken for the unwinding. So, I just wanted to give people that
12 context. And also in that unwinding plan, which is also, you know, which is online
13 on the DHCS website. That unwinding plan also gives, like, a schedule of the
14 timeframes for when renewals would be initiated, based upon the month of
15 eligibility for individuals. So, again, it just takes us through a 12-month cycle.
16 So, next slide, please.
17 So, for California, given all the work and given just our size and the
18 complexity of our program, we looked to leverage as many federal flexibilities as
19 we could with the unwinding. What CMS did is they offered opportunities for
20 states, recognizing the challenges that states will be facing just generally
21 speaking, because of the length of time in which people had been continuously
22 covered in Medicaid programs, recognizing that there were new individuals
23 coming into coverage, who may have never experienced a redetermination.
24 They also wanted to offer flexibilities to states to help smooth that process of
25 conducting the renewal determinations.

1 And so California has received approval for 17 waivers and
2 flexibilities from CMS. That information is contained on our website. Some of
3 those flexibilities include doing an asset waiver for individuals that are subject to
4 assets; and I will talk a little bit more about that when I cover some of our
5 expansion work that we are doing.
6 We also have some flexibilities as it relates to income reporting and
7 looking at what people report to us like zero income. We can use their self-
8 attestation of that. Or looking at people who have income that is at or below
9 100% of the federal poverty level. And a lot of these flexibilities just help to
10 minimize the touch that we have to make with our Medi-Cal members.
11 And where we can, we have also programmed some of these
12 flexibilities into the county eligibility and enrollment systems to help support our
13 county partners in terms of the work that they have to do for the unwinding.
14 But in total, we have approximately 17 waivers from CMS to help
15 support the unwinding effort and we have been utilizing those provisions
16 throughout the continuous coverage unwinding. We did receive some additional
17 flexibilities just this month, so we will start to see the full breadth of all of these
18 flexibilities as we start looking at renewals that are still in process and/or
19 renewals that are going to be upcoming in the month of December. It does take
20 time, one, to get the federal review and approval. And then we also have to
21 issue county guidance for our county partners and then provide technical
22 assistance and support to them in terms of the application of these flexibilities.
23 The other thing that we have done is we had also worked with the
24 United States Digital Services as a way to do an assessment of our renewal
25 processes, specifically looking at ex parte work here in the Department as it

1 relates to the renewals. And again, just as a reminder, when we say ex parte,
2 that means we have an ability to look at information that is already available to
3 the county eligibility worker for that individual. It could be based upon, you know,
4 information that they have because someone is on another coverage program
5 such as CalWORKS or CalFresh. They can look at that information that is
6 already available to them and use that information to then help make a
7 determination of continued eligibility under the Medi-Cal program, to the extent
8 that they have that information available to them.
9 If you recall, I said that the renewal process starts somewhere
10 between 60 to 75 days in advance. Part of that process is looking at what is
11 already in existence and available to that county eligibility worker, as well as also
12 looking at electronic information from state and federal databases that they can
13 use and leverage to then determine if that person is still eligible for the Medi-Cal
14 program. So, that ex parte process then allows us to confer continued eligibility
15 for another 12 months without ever having to reach out and ask for additional
16 information from that Medi-Cal member.
17 So, in working with the United States Digital Services, they had
18 talked with us about different things that we could do to help improve the ex parte
19 rates that we see in our program. And that in turn will, one, help to relieve
20 burden on our members in terms of having to respond to the renewal request;
21 and then it also can help with the reduction of procedural terminations that are
22 experienced by our Medi-Cal members. And procedural terminations are for
23 individuals that do not respond to the renewal request by the county partner.
24 And to the extent that they do not respond, then individuals will receive a Notice
25 of Action indicating that because of their lack of response, they are then

1 discontinued from the Medi-Cal program. And that's part and parcel of what we
2 have historically done in the Medi-Cal program. And typically, the procedural
3 discontinuances have historically been the highest percentage of
4 discontinuances in our program.
5 But this work through USDS has really helped us in terms of
6 helping to increase our ex parte rates, because prior to the public health
7 emergency they hovered around 40 to 50%, meaning about 40 to 50% of our
8 caseload we could renew via this ex parte process without having to reach out to
9 individuals. When we had resumed the renewals, we were somewhere around
10 26, 27%. We are starting to see over time how that percentage is slowly but
11 surely increasing. And we do expect to continue to see it increase with the
12 flexibilities that have been offered to us by CMS. Next slide, please.
13 I did want to call attention to our Continuous Coverage Unwinding
14 Dashboard. So, this is an interactive dashboard that we have now placed on our
15 DHCS website. It can be found on the front page of the DHCS website. We put
16 out a report each month based upon our unwinding efforts and what we are
17 seeing. What you see today in the presentation is based upon Medi-Cal
18 enrollments for the month of August. Just yesterday we released our September
19 report. So, this data is a month in arrears, but you can find all of the reports on
20 our DHCS website. And when I cover some of the stats, I will at least give you
21 what the current stats are today. But because of timing, I did not have the ability
22 to update the presentation.
23 But with the Unwinding Dashboard, individuals have an ability to go
24 in and as the information is presented, both in terms of applications and
25 applications that have been processed, as well as the redeterminations. There's

1 also demographic information for individuals based upon new applicants coming
2 into the program as well as individuals that are being discontinued. This data is
3 presented both on a statewide basis as well as on a county basis. So, you can
4 click to look at the statewide numbers and you can also then click based upon
5 the specific county that you may have an interest in. And so this is just showing
6 you the snapshot of the very first page of the Unwinding Dashboard that gives
7 you information on what our enrollment numbers look like and then what the
8 monthly redetermination processing looks like. And it gives you a snapshot of
9 the number of redeterminations that were due for that particular month, those
10 that were discontinued, those that remained in coverage, and then those where
11 there's -- the cases are still pending the determinations by the county partners.
12 For cases that are pending, meaning that for individuals that did have to respond
13 to a renewal packet, the packet has been received by the county partners, it has
14 just not yet been processed. So, those individuals are remaining in coverage
15 until such time that the county does process that application. Next slide please.
16 In terms of our work with redeterminations, we have leveraged our
17 Health Enrollment Navigator. So, the Health Enrollment Navigators have
18 received funding from the Department to help with outreach and enrollment
19 efforts, in particular with hard-to-reach populations. But we have also through all
20 the work that we have been doing for the unwinding, we have created toolkits
21 and outreach materials and supports that can be used. The Heath Enrollment
22 Navigators have also been doing some outreach and retention activities in terms
23 of looking at and getting information from individuals as to why they are not
24 returning their renewal packets. We are providing these lists of individuals that
25 are subject to renewals, as well as lists of individuals that were procedurally

1 discontinued from the program so that they can also do some additional outreach
2 to them. And we are also doing text messaging and direct phone calls to
3 members through our Health Enrollment Navigators to help support the
4 redetermination efforts.
5 Equally, the same things that we are doing in terms of the support
6 materials, the toolkits, and lists of people that are due for renewals, as well as
7 lists of individuals that were procedurally discontinued from our program
8 because, again, they did not return that information. We are equally providing
9 that information to our county -- to our health plans, so that they can also help to
10 support the outreach efforts to members and reminding them about the
11 importance of responding to the request for the renewal information. As well as
12 also having the ability to provide updated contact information to the Department
13 to the extent that the member has moved between, you know, during the course
14 of the public health emergency -- during the course of the public health
15 emergency and the extent to which they have not yet updated their contact
16 information to the Department.
17 With our Health Enrollment Navigators, they have also been doing
18 some preliminary outreach to better understand why people are not returning
19 their renewal packets. And the one thing that we have done to help focus our
20 members on the renewals is that for the majority of the renewals they are going
21 out in yellow envelopes. So, part of our messaging and outreach strategy is to
22 remind people to look for the yellow envelope. However, people may also
23 receive a white envelope, the typical envelope, from our county partners because
24 then they are doing some additional follow-up to get additional information from
25 people. So, our message is really any type of contact that is coming from the

1 counties as it relates to Medi-Cal, the members should be opening the mail,
2 checking the mail to respond so that they are not, you know, inadvertently losing
3 their coverage because of a lack of response from them. So, the big message is
4 look for the yellow envelopes, but there could be a white envelope. But please
5 review it, open it, respond to it.
6 In terms of the outreach that our Navigators have been doing to
7 people that have been procedurally discontinued. And again, that procedural
8 discontinuance is because we have not heard from that member. In terms of that
9 original outreach for the request for additional information to support their
10 redetermination, individuals have indicated that they have other forms of health
11 insurance, that they did not -- so -- and because of that, they didn't return the
12 renewal packet. Some have indicated they had not received a packet from the
13 county, and then some have indicated that they needed assistance in filling out
14 the packets.
15 One of the things that the Department is also doing is we are
16 working with the California Health Care Foundation to do a more formalized
17 evaluation of doing outreach to individuals that did not respond to the request for
18 renewals to get some more in-depth information from those members to the
19 extent that they respond to that survey, to better understand why they are not
20 returning their renewal packets. So, we are, you know, looking at this on all
21 fronts in terms of helping to support our members and working closely with our
22 Health Enrollment Navigators, working very closely with our Medi-Cal managed
23 care plans. We also have DHCS Ambassadors. We have over 4,000 entities
24 that have signed up to be ambassadors in terms of doing outreach to our Medi-
25 Cal members. And so those collective efforts are helping to support the

1 unwinding, just given the volume of cases that we have to redetermine for the
2 Medi-Cal program. Next slide, please.
3 So, this is just giving you a high-level snapshot of the outcomes of
4 the redeterminations. So, this is covering through August. But like I said,
5 through September we also have that latest information, which is on our DHCS
6 website. And just for context purposes, for December -- I mean for September,
7 month of eligibility. And remember, this is all a snapshot in time. So, for
8 September in terms of monthly enrollment, we are currently at 15.3 million
9 individuals. In terms of the new applications received, a total of approximately
10 160,000 new applications were received. And then for people that are newly
11 enrolled in Medi-Cal for the first time, we have about 60 -- approximately 62,000
12 individuals that have gained coverage from Medi-Cal for the first time. Next slide
13 please.
14 And then in terms of the redetermination outcomes, in terms of
15 what was due. Again, I am going to just give you the snapshot for September
16 because you have June through August here. So, for September, the number of
17 redeterminations that were due was 1.07 million individuals. Of the people that
18 returned their renewal packets or had their renewals completed through the ex
19 parte process, it was 81%. And then the number of individuals that were
20 disenrolled as a result of the renewals, it was 219,000 individuals. And then the
21 percent that was disenrolled as a total of the redeterminations that were due, we
22 are still at 20%. And then our ex parte rate, as you can see here, is 35%. And I
23 believe our ex parte right now is at, I want to say it is at 37%. I don't have that
24 one readily available to me, so my apologies, but I do believe it is at 37%. So, as
25 you can see, over time it is slowly but surely going up and that is truly in part

1 because of the work that we had done with the USDS services in terms of, you
2 know, some changes that we could make in our processes, as well as allowing
3 for some of those waiver flexibilities to be programmed into the eligibility and
4 enrollment systems so that our county partners would not have to be doing that
5 work on a manual basis.
6 So, next I just want to talk about some forthcoming work in the
7 Department as it relates to expansion. So, the first is on asset elimination. So, if
8 you go to the next slide, please.
9 So, as a result of state law changes, and with federal approvals, we
10 did receive in July the final approval for us to completely eliminate the asset test.
11 So, we had two phases of asset elimination. The first phase went
12 in effect in July of 2022 where the asset limit was increased to $130,000 for an
13 individual, and then each subsequent individual in that home could have up to
14 $65,000 in assets. Our historical asset limit was $2,000 for one person, $3,000
15 for a couple; so that is a significant change.
16 But on January 1 of 2024 we will then completely eliminate assets
17 for individuals that are subject to assets, and that's for our non-MAGI programs,
18 including individuals that may be eligible for long-term care services, and the
19 Medicare Savings Programs. And we are on track for implementation of this new
20 change in terms of eligibility. Next slide, please.
21 And then this is just giving some context in terms of the outreach
22 that we have been doing with our Medi-Cal members on this. And we will be
23 sending notifications to our members after January 1 regarding the complete
24 elimination. And so if people were denied in the six months prior for having
25 assets over what our current limits were, which again, were the 130,000, they will

1 tell them that the assets have now been eliminated and then encourage them to
2 reapply for Medi-Cal if it's appropriate. And again, this is, you know, for people if
3 they were solely denied eligibility for Medi-Cal because they were over assets.
4 And we do have information on our DHCS website. We have created a webpage
5 specific to this work that we are doing for the asset elimination. Next slide,
6 please. Next slide.
7 So, the last thing I will talk about is our Adult Expansion. So, this is
8 the last of four expansions that we have done as it relates to individuals without
9 satisfactory immigration status. So, come January 1 of 2024, we will now provide
10 full scope Medi-Cal eligibility to California individuals that are between the ages
11 of 26 to 49, regardless of immigration status, to the extent that they otherwise
12 meet Medi-Cal eligibility requirements; and so these individuals will be afforded
13 full scope coverage under the Medi-Cal program. These individuals will also be
14 mandatorily enrolled into our managed care plans.
15 We have been doing outreach to these members. We did have a
16 requirement to develop an enrollment -- I can't remember the term. It is an
17 eligibility and enrollment transition plan for these individuals in terms of the work
18 that we were going to do with outreach, the development of notices, and the
19 development of frequently asked questions for these members.
20 We have estimated that for this expansion it would impact
21 approximately 700,000 individuals. This is our largest expansion by far when we
22 are looking at populations without satisfactory immigration statuses. And we
23 have also issued policy guidance for our county partners.
24 And then we also have, again, information on our website regarding
25 this expansion. We do have dedicated websites for all the expansions that we

1 have done to date. And then next slide, please.

2 This is just to give you an overview of the work that we have been
3 doing for outreach. And we do have a Get Your Community Covered Resource
4 Hub on the DHCS website, that has also been translated into all threshold
5 languages, for individuals to help understand and learn about this coverage
6 option that is going to be made available under the Medi-Cal program. And so
7 we do recommend, you know, for our county partners, our plans, to use the
8 messaging that we have created. We have created social media campaigns to
9 help target this population. We are also doing paid media. And those paid
10 media campaigns, in particular with ethnic media outlets, is running between now
11 and through May. And then we also have a website, our website is also now
12 going to be translated in both English and Spanish, we are looking at other
13 languages. But this was also something that came out when we did our older
14 adult expansion in terms of looking at that information coming out in Spanish.
15 So, with that, I will stop and welcome questions that you all may have. Thank
16 you so much.

17 CHAIR RIDEOUT: So, thank you both René and Bambi for your
18 presentations.

19 So, I will start, any questions from committee members? Jarrod.

20 MEMBER MCNAUGHTON: Yes, thank you so much, Bambi and
21 René, both of you. This is just a comment more than anything. As Bambi was
22 going through all of the changes for the contract in 2024, no question that this is
23 the most significant amount of change in the history of Medi-Cal in really great
24 ways. I mean, I think that what the Department has put together there at DHCS
25 just to make sure that we are all aligned with our mission to serve those that are

1 most vulnerable, we are excited about it. It has been a lot of work from the
2 Department, from the health plans, the provider community and others, and just
3 wanted to say a big thank you to them for that.
4 And René's team on the redetermination piece. Wow, we are
5 learning every day, I know all of us are on this. And just are so grateful that we
6 are doing all of this work together to make sure that those that are in most need
7 don't fall through the cracks. And between the counties and the health plans and
8 the Department's work on this and some really innovative ways to meet those
9 needs, I just wanted to just share my thanks to both of them for taking the time to
10 share. And also their work behind the scenes because it is an incredible, heavy
11 lift on both fronts.
12 MS. MOLLOW: Thank you, Jarrod.
13 CHAIR RIDEOUT: Thank you, Jarrod.
14 Abbi.
15 MEMBER COURSOLLE: Yes, echo the thanks and recognition of
16 all the work that you all are doing, Bambi and René. I appreciate your taking the
17 time to be here when I know you must be incredibly busy.
18 I just had one question for Bambi related to the transition and the
19 Kaiser direct contract. We just heard earlier in Mary's report about some of the
20 actions that the DMHC has taken against Kaiser for failure to provide behavioral
21 health services, and so I am just wondering how DHCS will be continuing to
22 monitor Kaiser as its role in Medi-Cal expands, particularly related to making sure
23 that enrollees have access to necessary behavioral health services.
24 MS. CISNEROS: Yes, thank you so much, Abbi. You know, DHCS
25 is also doing a special focused audit, not just on Kaiser but all of our Medi-Cal

1 managed care plans, in two spaces. So, one is for mental health services and
2 the other is for transportation services. And so we are just going to -- kind of
3 further dive into the plans' provision of these services, including how they are
4 using their subcontractors or delegated entities to provide these services. And
5 so, we are expecting results of that special audit end of Quarter 1 of 2024. And I
6 know we work very closely with DMHC in coordinating any kind of, any
7 coordinated activities when we work with Medi-Cal managed care plans to the
8 extent possible, so we will continue to do that.
9 And then of course, Abbi, I think you are familiar with how we work
10 with our, with our managed care plans with, you know, we have various levers. I
11 think we also -- what I would say is we also strengthened our enforcement ability
12 as well through the work and statute in Welfare and Institutions Code 14197, and
13 so I think that's just one aspect of it, I think. I don't think we want to just say like
14 we have heavy enforcement ability and we are going to continue to do that.
15 I think what I was also hearing Jarrod say is that this is a really
16 heavy lift for the plans too. We really do see them as plan partners and want
17 them to be successful. We are asking a lot of plans to be in this new space. A
18 lot of them have, you know, working in new relationships with CBOs, providing
19 community support, all of these MOUs, all of these different types of third-party
20 entities, just really outside of their wheelhouse. So, I think what I will say is that
21 we will be working very closely with our managed care plans on all of these
22 different transition activities and new policies.
23 I mentioned continuity of care earlier, and how we have those kind
24 of special protections, enhanced protections, going above and beyond our typical
25 continuity of care protections, and even Knox-Keene. But we are also, we also

1 have some reporting to the federal government on this transition and one of them
2 is on retention of primary care providers. So, we are going to be monitoring that
3 closely and also reporting to CMS on kind of what we are seeing in monitoring.
4 And of course, advocates and stakeholders, great inputs, always want to hear
5 feedback and how it is really happening, to make sure our policies are working as
6 intended. So, thanks. I am looking forward to continue to work with you.
7 CHAIR RIDEOUT: Great. Mark. You are on mute, Mark.
8 MEMBER KOGAN: Yes, I am, I was trying to find the mute button.
9 Thank you. I just have a comment. Working in two counties, Alameda and
10 Contra Costa County, that are going to the COHS. I do have a little bit of
11 concern about things like network adequacy and patient access. I know the
12 primary care base here, including community physicians, is, you know, barely
13 adequate, you know, before this transition. I know you are going to be watching
14 this closely. But I do have a lot of concern both for specialty care and primary
15 care, the ability of both systems, and I am sure this is true across the state as
16 well, to be able to serve these patients. So, that is just a comment on that.
17 CHAIR RIDEOUT: Thank you, Mark.
18 David. Paul, I didn't forget you, don't worry, I will get to you. David.
19 MEMBER SEIDENWURM: Yes. First thing is I just want to echo,
20 get on the bandwagon with some of the high praise that has been stated for the
21 work.
22 I do have one question though, perhaps for Bambi. You mentioned
23 a lot of new requirements and a lot of new tasks for the plans to administer as
24 this transition occurs and you also mentioned administrative efficiency as one of
25 the goals. Can you help us to understand how those two goals can be

1 balanced?

2 MS. CISNEROS: Yes, thank you for your question, David. Yes, I
3 think these are a lot of new requirements. That's why I would say we are working
4 really closely with our managed care plans and providing guidance and technical
5 assistance on these requirements. I had mentioned earlier that all plans have
6 undergone an operational readiness process. And so one aspect of that is
7 submitting deliverables, policies and procedures, systems, et cetera, to the
8 department. There were about 236 deliverables per plan that were submitted
9 and reviewed for approval. And so, again, I think this is really delving into the
10 plans' policies and procedures, how they are using the newly kind of appointed
11 staff. So the new Chief Compliance Officer, Health Equity Officer, et cetera, to
12 really make sure that they understand their roles and are working across the
13 organization.

14 And what I would say is that we ourselves here at DHCS is also
15 looking into that kind of organizational assessment. We actually consulted with
16 or contracted with a consultant to look at our processes to make sure that we are
17 aligned and prepared and, you know, to really oversee those requirements as
18 well. So, I would say is, this is the first cut of the requirements of the contract
19 and it means we are going to be working with our plans on how it's really working
20 on the ground. And we will be -- and I had mentioned earlier too, we do still have
21 some guidance that we need to get out for 2025 and beyond as part of this
22 contract that we are working to do. But I would just say, just really keeping a
23 close, close pulse in various reporting requirements with specific elements so
24 they will know exactly what we are what we are looking for in terms of those
25 administrative efficiencies that you had mentioned.

1 CHAIR RIDEOUT: Paul.
2 MEMBER DURR: Yes, thank you. Great overview, Bambi and,
3 and René, I think it's very comprehensive. As everyone has said, I applaud the
4 effort for DHCS in moving that direction.
5 My question, a couple of questions that I had. One is kind of
6 touching on what David was just talking about, is the readiness of the plans as
7 well as the readiness of DHCS, both to administer and to monitor all of the work
8 that is being required. Because there's a lot more that the plans have to do and
9 there's a lot more that DHCS is going to have to monitor. That's one question, if
10 you could address that.
11 My other question has to do with the Kaiser. You know, I do see
12 that they kind of have a favorable piece, and just not completely understanding
13 the open enrollment type of thing that when you do open assignment, as to how
14 that will be delegated to Kaiser for those members. And thinking that if I saw
15 Bambi correct, that there was the -- if they had a historical relationship with
16 Kaiser in 2023, that they would be eligible to get that member. But my question
17 then on that is, well, what if they become eligible in '24, you know, through a
18 commercial plan, and then in '25 they are now eligible for Medi-Cal. Would that
19 look-back also apply to the fact that they had eligibility with Kaiser in '24, not 23,
20 because it was specific to '23.
21 So my last question is maybe more for René, is that you mentioned
22 that 20% of the people are disenrolling from Medi-Cal. Do we have any insight
23 into where they are going? Are they, are they getting insured insurance through
24 another product or are they just leaving the state or things like that? So, that's a
25 lot, but thank you all for your responses.

1 MS. CISNEROS: Okay, great. Thank you, Paul, for your
2 questions. I am going to hope that I remember them all, okay. For operational
3 readiness, I did mention about kind of different aspects that we looked at
4 including those 200-plus deliverables. We also contracted with a consultant to
5 do deep dives and so these are really kind of interviews with key personnel at the
6 staff level to really truly understand their processes and their systems to make
7 sure they are ready. So, for example, a big component of that is their call center
8 staff. Are they prepared? Are they trained? Can they handle the influx of all of
9 the calls, particularly someone calling in about continuity of care. Do they
10 understand those policies? And we actually had the plans, show on their screen
11 like step by step, like we had scenarios. Like, say I'm this number and I am
12 calling for this. And so we wanted to make sure that it's not just like the top line
13 staff that really understood these policies but their actual staff that's going to be
14 working with members. And so that was a really big aspect that went into
15 operational readiness and played a big role in our decision in going live with all of
16 these plans.
17 And then for DHCS, there's still a lot of planning and preparation for
18 the transition because it's going to be pretty massive and so wanted to just say
19 out loud there that this is a really big priority for the Department. So, we are
20 setting up some data reporting requirements for plans to collect at the plan
21 county level on certain kind of domains, if you will. So, some of the things that
22 we are going to be asking about are continuity of care, the kind of requests that
23 they are receiving, you know, what the disposition of that is. Continuity when it
24 comes to ECM and community supports. You know, member issues, provider
25 issues. And so, so that's like one aspect of that piece.

1 I did also mention that we are going to be reporting to CMS,
2 reporting on how we are assessing the continuity of primary care providers. And
3 so we are going to be monitoring that very closely and reporting that as well.
4 And then there's some -- in order for all of this to happen really is
5 like the data has to be there, right. So, we at the Department as well as the
6 plans that, you know, that are here today, that are existing plans. We are
7 requiring them to share data with the new plan so that the new plan can already
8 start to prepare and, you know, find out who the members are working with, what
9 kind of services are they getting, what providers are they using, to really start
10 those continuity of care arrangements. So, that plan-to-plan data sharing and
11 monitoring is in process, and we are actually doing like sampling and spot-
12 checks to make sure that data transfer is happening.
13 And of course, as I kind of mentioned to Abbi, just that stakeholder
14 feedback. We are kind of thinking through all of our different venues and thinking
15 through even like maybe like new webinars. But we are trying to figure out how
16 best to get that rapid cycle kind of stakeholder feedback because that's really
17 important. I think, you know, a lot of our stakeholders and advocates work more
18 closely with the members than I even see and so I think I would be -- I really
19 appreciate that information when that's shared with the Department.
20 And then just quickly on the Kaiser piece, because I know René
21 has a part as well. Is that what I kind of shared was really about like the
22 transition going into 2024. And so that's why we are saying, like, as of 2023,
23 these are the members that are going to be eligible. And so the important theme,
24 I would say, with the whole Kaiser direct contract is that the Department really
25 engaged in this contract for continuity. So, the 22 counties where we already

1 have Medi-Cal members in Kaiser, either directly or through that subcontract is
2 already kind of existing. But then there's those 10 additional counties where
3 Kaiser already exists with a Medicare or Commercial footprint. And the idea is if
4 they were to lose their coverage, or you know, whatever circumstance that could
5 be, like Medi-Cal would be available for them. And so there's that whole --
6 there's that network and kind of framework there.
7 And so Kaiser today, they are, you know, there's certain eligibility
8 criteria that you need to get into Kaiser and that's still kind of the same, right. So
9 we have the duals, for example. Those populations that are listed in AB 2724,
10 like the dual members, Medicare, Medi-Cal, you know, foster, foster kids and
11 youth, and those that have been with Kaiser or have that family linkage with
12 Kaiser, there's like a whole kind of list. So, those that's separate and apart from
13 the actual growth. So, in addition to those members that will be -- that have
14 Kaiser as an option and they can actively choose, Kaiser has also committed to
15 doing a 25% growth over time. And so they have to be part of the auto-
16 assignment/default enrollment, however, it's, you know, the term that is used.
17 That applies to all other plans. And so that means for members that don't
18 actively choose a plan, they kind of go into this algorithm, and it's really attributed
19 to quality. So, the idea is the higher quality you have as a plan, higher quality
20 scores, you will get more members because you have the ability to provide high
21 quality care for members, and so Kaiser would be part of that mix as well. So, in
22 addition to those populations called out in the statute, they will also be part of this
23 kind of auto-assignment process, same as other plans.
24 And the only thing I would say that's a little bit different because,
25 you know, like, this is new for Kaiser just because they are -- they have that -- it's

1 their integrated model, they can't just like build new Kaiser buildings. And so we
2 have to be kind of thoughtful and careful with the way that we do their growth.
3 Because it wouldn't really be fair if we set a really high standard and you know.
4 As I believe, Paul or Mark, you had mentioned earlier, like network adequacy is a
5 concern. So, we want to make sure that there's actually providers there, facilities
6 there to provide the care. So, we just want to be careful with the way that we did
7 that. So, that's the way it was, that's why it was structured, so there's different
8 buckets. So the AB 2724 populations, and then for those who don't make a
9 choice, they will be part of that auto-algorithm process, same as all the other
10 plans. So, hopefully, that --
11 CHAIR RIDEOUT: Could I --
12 MEMBER DURR: Just comment, I'm sorry.
13 CHAIR RIDEOUT: Paul. Paul.
14 MEMBER DURR: Yes?
15 CHAIR RIDEOUT: If you really want to ask it, please do. But we
16 are about 45 minutes behind already and I want to get to the public.
17 MEMBER DURR: Okay.
18 CHAIR RIDEOUT: Is that okay? Sorry, I am trying to be a good
19 chair but, you know, there is only so much time. So, let me open it up for public
20 questions. And please, if you have a question, identify yourself and your
21 organization. Any on the phone?
22 MR. STOUT: Seeing none at this time.
23 CHAIR RIDEOUT: Okay. I would like to thank our friends from
24 Medi-Cal. Thank you for being here, DHCS, and we will continue the dialogue
25 next quarter. So, thank you.

1 MS. MOLLOW: Thank you.

2 MS. CISNEROS: Yes, thank you.

3 CHAIR RIDEOUT: So, just an agenda note. We have six
4 substantive sections left. We are about 45 minutes behind. So, Mary, if you can,
5 as we are going through this section, tell me which sections we may need to
6 defer, if any, if we can. For the presenters, since they are all from DMHC, please
7 try to shave at least five minutes off of your section; but that doesn't mean talk
8 faster or skip things that are important. So, I think, at least for the committee, we
9 have read the material ahead of time. Please bring out those things that we
10 need to understand that aren't obvious from the information, so you don't have to
11 read every slide. And I tell that to my own staff too. So, anyway, please go
12 ahead, Pritika.

13 MEMBER WATANABE: I will just note, I think our provider
14 solvency and our health plan quarterly updates are our standing reports.
15 Historically, when we have got to make up some time we will keep those short
16 and maybe just hit the high points. But I think some of these presentations will
17 be fairly short so we will try to make up some time.

18 CHAIR RIDEOUT: Thank you.

19 MEMBER WATANABE: Go ahead, Pritkia.

20 MS. DUTT: Hi, good morning. I am Pritika Dutt, Deputy Director
21 for the Office of Financial Review. I will provide you a quick update on the
22 Financial Summary of the Medi-Cal Managed Care Report for the second
23 quarter, which is June 30, 2023. A copy of the report is available on our public
24 website under the Financial Solvency Standards Board section. Next slide.

25 There are 9 Local Initiative plans that serve over 6.9 million Medi-

1 Cal beneficiaries in 13 counties.

2 Overall, the LI plans' Medi-Cal enrollment increased by 117,000 or

3 1.7% from the previous quarter.

4 For the second quarter of 2023, all LIs reported profit totaling up to

5 $462 million.

6 All LIs met the DMHC's reserve requirement or TNE, tangible net

7 equity requirement. So, TNE to required TNE ranged from 617% to 1,447%, so

8 they maintained healthy reserves at June 30 quarter end.

9 There are 6 County Organized Health System plans that serve 22

10 counties. We receive financial reports from 5 County Organized Health Systems.

11 Gold Coast does not currently report to the DMHC.

12 The 5 COHS that report to the DMHC, they serve 2.5 million Medi-

13 Cal beneficiaries.

14 And compared to prior quarter, COHS plans' Medi-Cal enrollment

15 increased by 34,000 lives.

16 For the second quarter of 2023, the COHS plans reported total net

17 income of $324 million.

18 All COHS plans reported over 700% of required TNE for June

19 2023. TNE to required TNE for the 5 COHS plans ranged from 771% to 1,556%.

20 And then next we have the NGM plans. These are the plans that

21 are not an LI or COHS but they have more than 50% of their enrollment in Medi-

22 Cal. So, there are 7 NGM plans that serve 4.3 million Medi-Cal beneficiaries in

23 37 counties. And they get their lives through directly contracting with DHCS or

24 they act as a sub-delegate to plans that contract with DHCS.

25 All NGM plans reported an increase in Medi-Cal enrollment in June

1 of 2023.

2 For the second quarter, NGM plans reported total net income of

3 $450 million.

4 TNE to required TNE ranged from 268% to 1,108%. Next slide.

5 Okay. So, some of the takeaways from this report:

6 All Medi-Cal plans reported increases in enrollment for the majority

7 of 2020 and the trend continued for 2021, 2022 and the first half of 2023.

8 The majority of the Medi-Cal plans reported net income at June 30,

9 2023.

10 And as René mentioned, the Medi-Cal redetermination or renewal

11 process resumed in April of 2023, with the first disenrollments from coverage

12 occurring in the June, July timeframe. So we will be seeing some changes in

13 enrollment for the Medi-Cal plans resulting from the re-procurement, which may

14 result in decreases in enrollment/revenues for the Medi-Cal plans, starting with

15 the second half of 2023. Additionally, we will see some changes in enrollment

16 for Medi-Cal plans, resulting from the re-procurement, which goes into effect

17 January 1 of 2024.

18 A few of the NGM plans will no longer have Medi-Cal enrollment so

19 they will drop off the report, which is Aetna Better Health, and California Health

20 and Wellness.

21 Imperial County will add a new Medi-Cal plan, so we are currently

22 working on reviewing their license application. So Imperial County Local Health

23 Authority, they plan on going operational on January 1, 2024.

24 We will also see some movement in enrollment between plans,

25 counties. Again, we will be tracking that.

1 We will continue to monitor the enrollment trends and financial
2 solvency of all LIs, COHS and NGM plans that report to the DMHC. So, with the
3 upcoming changes that go into effect 1/1/2024, we are going to be make
4 changes to the format of the Financial Summary of Medi-Cal Managed Care
5 report. So, we will be looking at making changes and making sure that we are
6 incorporating these changes in the report.
7 That brings me to the end. Any questions?
8 CHAIR RIDEOUT: Questions from committee members? Jarrod.
9 MEMBER MCNAUGHTON: Just a brief question, Jeff, I will make it
10 very brief. Pritika, I am just curious. How does the TNE requirement for DMHC
11 compare to the 2024 contract requirements for reserves with DHCS? Have you
12 folks done a cross-comparison there?
13 MS. DUTT: Jarrod, we have not, but we will work with DHCS on
14 that.
15 CHAIR RIDEOUT: And I want to make sure the committee knows,
16 I am not trying to cut people off, other than what I just did to Paul. I am sorry,
17 Paul. I do think, you know, we do want to make sure we leave the time that we
18 can. So, Jarrod, if you have another question you are certainly welcome to ask
19 it.
20 MEMBER MCNAUGHTON: (Smiled and shook head.)
21 CHAIR RIDEOUT: Okay, any other questions from committee
22 members?
23 Seeing none, questions from the public on Zoom?
24 MR. STOUT: There are none at this time.
25 CHAIR RIDEOUT: Okay, questions on the phone?

1 MR. STOUT: None as well.
2 CHAIR RIDEOUT: All right. Thank you, Pritika, and you did get us
3 a little bit back on track so we appreciate that. So, next up, Amanda.
4 MS. LEVY: Good morning, Amanda Levy, Deputy Director, Health
5 Policy and Stakeholder Relations for DMHC. I am happy to be here today to give
6 a brief legislative update. we can go to the next slide.
7 This year in 2023, 18 bills were signed into law that DMHC was
8 monitoring. It is equivalent or it is just about where we were last year, it was
9 about 21 bills were signed into law, so pretty much on pace. Several of the bills
10 that DMHC analyzed didn't apply directly to health plans or insurers, so we won't
11 be presenting on them today. But we have 12 bills total to present; and in the
12 interest of time I won't go into detail on this first page. But just want to note in the
13 next six weeks there will be a lot of activity for the end of the year for the DMHC
14 to issue guidance, so we look forward to working with stakeholders as we move
15 towards implementation. Many of the bills, as you will see, have a January 1,
16 2024 implementation date so it will be coming up here very soon. So, again, I
17 won't go into detail on any of these bills on this slide. Happy to take questions at
18 the end if something sparks interest. But as you can see, the topics were wide
19 ranging, including coverage for doulas, dental coverage, dental services, for
20 Pharmacy Benefit Manager PBM Discrimination, and our Digital Application
21 Medical Privacy. So, wide ranging topics. But the next six bills I will go over
22 have a deep impact to the Department.
23 The first, I believe, three bills we will talk about are kind of in the
24 category of cost sharing. AB 659 by Assemblymember Aguiar-Curry relates to
25 the HPV vaccine. And this requires a health plan to provide coverage without

1 cost sharing for the human papilloma virus, or known as HPV, vaccine, as
2 approved by the US Food and Drug Administration. Currently, the Center for
3 Disease Control's Advisory Committee on Immunization Practices recommends
4 administration of the HPV vaccines to individuals up to age 26. And the FDA
5 limits approved usage of the HPV vaccination at 45 years old. This bill will go
6 into effect January 1, 2024. Next slide.
7 Our second of our cost sharing related bills relates to limits on
8 prescription drug cost share. Current law states that cost sharing for prescription
9 drugs shall not exceed $250 for up to a 30-day supply unless the health plan is
10 equivalent to a bronze health plan. In that case the maximum is $500 for the 30-
11 day supply. This bill eliminates what was a January 1, 2024 sunset date for the
12 cost sharing limit for prescription drugs and extends that indefinitely. And it
13 further defines health plan drug formulary tiers. So, since this is eliminating a
14 sunset, this will effectively be in effect January 1, 2024. Next slide.
15 Our second of our cost sharing related bills, Senate Bill 421 by
16 Senator Limon, is a $250 oral anti-cancer prescription drug cost share limit.
17 Again, current law similar to the last bill states that cost sharing for prescription
18 drugs shall not exceed $250 for up to a 30-day supply of an orally administered
19 anti-cancer medication. This bill, similar to the last bill, eliminates the January 1,
20 2024 sunset day for a cost sharing limit on the prescription of this 30-day supply
21 of the oral anti-cancer medication. So it again becomes effective January 1,
22 2024. Next slide.
23 AB 317 by Assemblymember Weber relates to pharmacist
24 reimbursement. This bill requires a health plan that offers coverage for a service
25 that is within the scope of practice of a licensed pharmacist to pay or reimburse

1 the cost of services performed at an in-network pharmacy, or by a pharmacist at
2 an out-of-network pharmacy if the health plan has an out-of-network pharmacy
3 benefit. And this will also go into effect January 1, 2024. Next slide.
4 The next two slides concern AB 716 by Assemblymember Boerner
5 relating to ground ambulance balanced billing prohibition. The bill first requires
6 the Emergency Medical Services Authority to develop and publish on its website
7 an annual report showing the allowable maximum rates for ground ambulance
8 services in each county. I think most importantly, limits an enrollee’s financial
9 responsibility to the in-network cost sharing amount for ground ambulance
10 services and eliminating large balance bills and large surprise bills for consumers
11 for ground ambulance services. Next slide.
12 Lastly, the bill requires health plans to reimburse noncontracted
13 ground ambulance providers the difference between the in-network cost sharing
14 amount and the established or approved rate by the relevant local government
15 entity. That bill has a January 1, 2024 implementation date as well.
16 And I believe this is my last slide, Senate Bill 621 by Senator
17 Caballero, relating to biosimilar drug coverage. This bill authorizes a health plan
18 or a utilization review organization to require an enrollee to try a biosimilar drug
19 before providing for the equivalent branded prescription drug if it does not
20 prohibit or supersede a step therapy exception request. It clarifies that the
21 requirement to try the biosimilar generic and interchangeable drugs does not
22 prohibit or supersede that step therapy exception request. That bill also goes
23 into effect January 1, 2024. Next slide.
24 I believe that leads me to questions on any of these bills or any of
25 the bills that we didn't have enough time to go over in detail. But as you can see,

1 another busy year here DMHC with the implementation.

2 CHAIR RIDEOUT: Thank you, Amanda, and thank you for helping

3 us get back on time a little bit.

4 David, you have a question?

5 MEMBER SEIDENWURM: Yes. Hopefully this will be quick.

6 Regarding AB -- sorry, pardon me. SB 496 biosimilar -- biomarker testing,

7 pardon me. Are we in line with the new FDA rulemaking on this topic? And have

8 we developed or have we developed any standards internally for the accuracy or

9 validity requirements for these tests?

10 MS. LEVY: I believe -- so the bill, just to kind of level set, it requires

11 health plans after July 1, 2024 to cover the medically necessary biomarker

12 testing for diagnosis, treatment, appropriate management, ongoing monitoring of

13 an enrollee's disease or condition to guide treatment decisions. And I will

14 probably have to get back to you on in-line with federal guidance.

15 MEMBER SEIDENWURM: Great. At your leisure, of course.

16 CHAIR RIDEOUT: Other questions from committee members?

17 Hearing none, questions from the public?

18 MR. STOUT: There are none at this time. Oh, actually one just

19 came through. When prompted, please state your name and organization.

20 MS. MILLERS: Hi, can you hear me?

21 MEMBER WATANABE: Yes.

22 CHAIR RIDEOUT: Yes, we can.

23 MS. MILLERS: Thank you. This is Anete at CAHP. Sorry, more of

24 a logistical question for Amanda. Going back to that first slide. I missed that last

25 bill under SB 496. What was that?

1 MS. LEVY: Oh, that relates to biomarker testing.
2 MS. MILLERS: Oh, the one underneath it, the last one on that first
3 slide.
4 MEMBER WATANABE: PBMs. It was the PBM.
5 MS. LEVY: PBM discrimination relating to the 340B program.
6 MS. MILLERS: Got it. Thanks so much. That's all I had.
7 CHAIR RIDEOUT: Are there other questions from the public?
8 Okay, hearing none, we will move forward. Pritika is back up with a
9 risk adjustment discussion. And I am happy to say we have made up about half
10 the time so I think we can ease back a little bit and ask those probing,
11 challenging questions that we all love. And Paul, you can have as many as you
12 want.
13 MS. DUTT: And Jeff, I would like to point out Amy Yao is not here
14 to help me with those answers so I will get started here. So, I will provide you an
15 update on the 2022 risk adjustment transfers. CMS released the 2022 Risk
16 Adjustment Transfer Summary at the end of June of 2023, so this information is
17 covering the California portion of that. The ACA included three premium
18 stabilization programs: risk corridors, reinsurance, and risk adjustment. The risk
19 corridor and reinsurance lasted from 2014 to 2016 and the risk adjustment
20 program continues to date.
21 The risk adjustment program transfers funds from lower-risk, non-
22 grandfathered plans in the individual and small group markets to higher-risk, non-
23 grandfathered plans, both in and out of the Exchange.
24 The purpose of the program is to discourage cherry-picking. The
25 plans that end up with healthier populations must compensate plans that have

1 more costly enrollees.

2 For Benefit Year 2022, $1.32 billion was transferred between

3 California health plans and insurers.

4 Four DMHC health plans were on the receiving end. Blue Shield

5 received $1.14 billion, Anthem received $88 million, Sharp received $63,000, and

6 Ventura County received $59,000. Thirteen DMHC health plans, which includes

7 Aetna, Chinese Community Health Plan, Health Net, Kaiser, LA Care, Molina,

8 Oscar, Sutter, United Healthcare, United Healthcare Benefits Plan, Valley Health

9 Plan, and Western Health Advantage had to pay into the risk adjustment pool,

10 with Kaiser paying the most, which was $750 million.

11 Overall, the PPO plans ended up on the receiving end while HMO

12 plans ended up paying.

13 The results have been consistent compared to previous years. So,

14 the same plans have been receiving risk adjustment dollars and the same plans

15 are ending up paying. Next slide.

16 In 2018, CMS added a high-cost risk pool program to the risk

17 adjustment transfer methodology. The high-cost risk pool helped ensure that the

18 risk adjustment transfers better reflect the average actuarial risk, while also

19 providing protection to issuers with exceptionally high-cost enrollees.

20 To fund these payments, the high-cost risk pool collects a small

21 percentage of an issuer’s or a health plan’s total premiums. The high-cost risk

22 pool charge for 2022 was 0.36% of premium for the individual market, and 0.49%

23 of premium for the small group market, nationally. The high-cost risk pool

24 reimburses issuers for 60 percent of an enrollee’s aggregated paid claims costs

25 exceeding $1million. So, this program assists plans that end up with a very high-

1 cost claim.

2 The DMHC-regulated plans received $211 million towards this
3 program, with Blue Shield receiving $84million, Kaiser received $87 million, and
4 Anthem received $23 million.

5 How does the risk adjustment program impact premium rates and
6 medical loss ratio?

7 So first of all, on the medical loss ratio side. If the plan received a
8 risk adjustment payment from CMS, the plan would reduce the amount from its
9 current claims, hence reducing their MLR. And the plans that pay into risk
10 adjustment, or the ones that have to pay more money into it, that ends up
11 increasing their claims, hence, increasing their MLR.

12 The risk adjustment transfers represent an average of 10% of
13 premium, or about $50 per member per month, assuming a statewide average
14 premium of $500 per member per month.

15 The amount of risk adjustment assumed in setting rates varies by
16 plan depending partly on the relative risk score, which is the health status of
17 members, to the statewide average risk score.

18 The 2022 risk adjustment transfer from CMS may be used by
19 health plans to estimate their 2024 risk adjustment amount that the plans used in
20 their 2024 rate setting.

21 Similar to other assumptions used in rate setting, an over- or under-
22 estimate in risk adjustment payment or receivable may impact rates, profits, as
23 well as the plan's medical loss ratio.

24 Then the last slide. Okay, I think I covered it already, thank you.

25 CHAIR RIDEOUT: Great.

1 MS. DUTT: Any questions?
2 CHAIR RIDEOUT: Thank you, Pritika.
3 Paul, do you have a question? (Laughter.) All right.
4 MEMBER DURR: Jeff, it's all okay, I'm all good with it. You know,
5 my only question, since you called me out, I appreciate that, is really the
6 perspective that 10% I think is overall what the impact is to premiums nationally.
7 I wonder, I mean this is just more food for thought, as to whether that is a
8 targeted rate overall or not? And just a general question, I don't know that you
9 would know, Pritika, but maybe Jeff in your work or Mary, in your understanding
10 is that -- you know, 10% of premium seems like a lot, but I don't know if it's
11 enough.
12 CHAIR RIDEOUT: Yes, we don't look so much at that specifically.
13 I think what I am personally concerned about and what we see in our data is the
14 expectations about affordability are vastly small in terms of percent increase and
15 built on a very expensive base relative to the cost of delivering care. So, I see
16 those things kind of diverging. And, you know, OHCA is pushing a 3%
17 affordability increase on whatever base you are starting on. And, you know, I
18 know they'll work through that, and they have got plenty of people giving them
19 input, but that seems out of step with even some current laws about health care
20 workers. But I think that's kind of off your topic a little bit, Paul.
21 MS. DUTT: So, Paul, the health plans use their actuaries to
22 analyze that information and determine whether those -- you know, the average
23 is 10%, but when we look at the health plans that report to us, the percentage
24 may be like higher or lower depending on what, you know, their studies, their
25 analysis shows for the actuaries. But we ask detailed questions when we review

1 the health plan rates around the estimates use in risk adjustment. Because
2 again, our goal is to make sure that the rates that consumers get are reasonable
3 and not unjustified, so the rates are supported by the backup documentation.
4 So, those are some of the things that our actuaries ask questions on.
5 CHAIR RIDEOUT: Are there other questions from committee
6 members for Pritika?
7 Okay, hearing none we will move to the public.
8 Oh, Paul, one other comment, maybe for the benefit of that
9 discussion is, again, OHCA will find its way. But my understanding at this point is
10 their risk adjustment is limited to age and sex. So, I would encourage people to
11 think about how to change that so that clinical status, disability and other things
12 are more prominent in their approach. They are talking about all of that, but I
13 think, again, we are going to get a little bit skewed if we have got age/sex as
14 clinical risk adjustment coming from the plans or from third parties but they don't
15 line up with other discussions about affordability.
16 Questions from the public?
17 MR. STOUT: Seeing none at this time.
18 CHAIR RIDEOUT: Okay. Thank you, Pritika.
19 We stay with you and we now are going to look at 2024 premium
20 rates. And once again we have made up some time so I think we can all pause
21 and relax.
22 MS. DUTT: Thank you, Jeff. Okay, so now we will talk about the
23 2024 premium rates. And the purpose of this presentation is to provide you with
24 an update on the 2024 premium rates in the individual, small group, large group
25 market. Historically, we have only talked about individual markets, but this time

1 we have added small group and large group market to the discussion. We have
2 also included a handout *2024 Premium Rates* that was included with the meeting
3 materials.
4 Okay, so for the 2024 individual market rates: On September 29,
5 2023, the DMHC finalized the 2024 individual rate filings. The DMHC actuaries
6 reviewed the 2024 individual rate filings and supporting documentation from
7 health plans and determined the rate increases were not unreasonable or
8 unjustified.
9 Twelve health plans will offer products on-exchange and one plan
10 will offer products off-exchange only in 2024. There is a new plan entering the
11 individual market for 2024, Inland Empire Health Plan. And then Oscar Health
12 Plan is exiting the individual market in 2024. Sutter Health only offers non-
13 exchange individual products, so they only offer off-exchange products; and the
14 projected enrollment was 32,000 lives and an average annual increase of 8.7%.
15 The final average rate increase for the 13 plans in the individual
16 market ranged from a decrease of 0.9% to an increase of 15%.
17 Overall, the average rate increase was 10.4% across all plans; and
18 the projected enrollment for the non-grandfathered individual market was 1.8
19 million lives.
20 The average premium ranged from $448 to $908 per member per
21 month. Kaiser has the most projected lives in the individual market and the
22 average rate of change for Kaiser is 7.4%. Blue Shield is the second-largest plan
23 in the individual market, and their average rate increase is 15% for 2024.
24 The averages you see here may differ slightly from what Covered
25 California posted because the rate filings submitted to the DMHC include both

1 the on-exchange, which are products offered on Covered California's exchange
2 program, and also the off-exchange rates, those that are not sold on Covered
3 California, for all the health plans that we regulate.
4 The primary drivers for rate increase, the premium rate increases
5 for 2024 include, and this also includes for the small group and large group. So,
6 the primary reasons include rise in healthcare utilization following the pandemic.
7 So, the health plans saw an increase in utilization. The increases in pharmacy
8 costs, and inflationary pressures in the health care industry, such as the rising
9 cost of care, labor shortages, and salary and wage increases.
10 We received small group rate filings from 12 health plans.
11 The rate change ranged from a decrease of 6.5% to an increase of
12 13.4%, with an average rate change of 8.4%.
13 The average premium ranges from $459 to $765, with projected
14 enrollment of 1.9 million lives.
15 So, the small group includes those employer groups with less than
16 100 lives. Next slide.
17 Health plans with large group products must file specified
18 information at least annually, and 120 days before any change in methodology,
19 factors or assumptions that would affect the rates paid by a large group employer
20 or contract holder. The DMHC reviews the methodology, assumptions and
21 factors used by health plans to develop their large group premium rates to
22 determine whether the methodology is not unreasonable or not justified. So, we
23 are not looking at every single contract in the large group market. Rather, we are
24 looking at the methodology the health plans use to develop rates. We look at
25 their rating manual, do detailed reviews of those.

1 So, 23 large group health plans submitted 37 rate methodology
2 filings, which included their rates for their community rated products and their
3 experience rating products. The rate change in the last week market ranged
4 from 0% to 15.7%, with a weighted average rate increase of 11.5%, with
5 projected enrollment of approximately 8.1 million lives. Most of the commercial
6 market receives their coverage through the large market.
7 Additionally, a large group contract holder that meets certain criteria
8 can request the DMHC to review their group rates. So, we can get contract
9 holders to request us to do their rate reviews for their specific contract. So, once
10 they receive their renewal notice they have 60 days to submit a request to the
11 DMHC. So, currently, we are reviewing three rate review requests from three
12 large contract holders. This is the first time we have received this request, and
13 the reviews are still in progress. Next slide.
14 We are seeing some large increases in the three markets. We will
15 continue to collaborate with Covered California, the Office of Health Care
16 Affordability and other stakeholders to address the increase in health care
17 premiums.
18 So, with that, I will take any questions.
19 CHAIR RIDEOUT: Okay, thank you, Pritika.
20 Paul.
21 MEMBER DURR: Yes, so thank you, Pritika. My question is kind
22 of tying back to our last conversation to some degree is that the impact of these
23 rate increases certainly will be an impact for OHCA to be aware of.
24 And then my other comment is with regards to SB 525 and certainly
25 the minimum wage going up. That will also further exacerbate the cost increases

1 that plans will need, providers need, in order to cover labor costs, and you have
2 mentioned that as an issue. Those are more comments.
3 My real question, one question is, you mentioned the three large
4 group rate reviews that you are doing. What is your time period in order to get
5 those done? Do you have a specified time that you need to get those done by?
6 MS. DUTT: The Department has 60 days from when we receive all
7 the information to complete our review. So, which would include getting all the
8 information from the plan. So, we try our reasonable efforts to get that review
9 done within 60 days after we receive all the information from the health plan. So,
10 we receive the request from the contract holder, then we go back and forth with
11 the plan, we ask them questions, collect more information. So, again, so it's 60
12 days from when we receive complete information from the plan.
13 CHAIR RIDEOUT: Other questions from committee members?
14 My comments in passing, in our IHA data we looked at, did a five
15 year look back, and specialty pharmacy costs have increased 284% in five years,
16 so that's not good.
17 And also, I would suggest that we all promote good segmentation
18 of results. This is segmentation by line of business. But there are significant
19 differences if you look at integrated versus nonintegrated care, if you look at
20 different geographies. And that also will, I think, give everybody a better sense of
21 where the root cause problems are and where to go first, so that would be my
22 comment in passing.
23 All right, questions from the public?
24 MR. STOUT: There are none at this time.
25 CHAIR RIDEOUT: All right. And gold star, Pritika, you got us back

1 perfectly on time with the original agenda, so thank you.

2 Next, we have got Michelle Yamanaka who is going to give us an

3 update on provider solvency. Thanks.

4 MS. YAMANAKA: Hi, Michelle Yamanaka, Supervising Examiner

5 in the Office of Financial Review. Today I am going to give you an update on

6 Risk Bearing Organization or RBO Financial Reporting for the quarter ended

7 June 30, 2023. Next slide, please.

8 We have 212 RBOs reporting to the Department as of this quarter.

9 That's an increase of one from the previous; and that one RBO has less than

10 10,000 lives assigned to them.

11 We also received two annual survey reports for the fiscal year

12 ended March 31, 2023. A majority of the -- the annuals are due 150 days after

13 the fiscal year end, that's the RBO's fiscal year end, and a majority have a fiscal

14 year end of December 31.

15 We also receive monthly financial statements from 8 RBOs as a

16 requirement of their corrective action plan or CAP. At June 30 we had 11 RBOs

17 on CAPS, and more to come on those 11 CAPS.

18 Next we are going to look at the financial reports received. Next

19 slide, please. 95% or 201 RBOs are reporting compliance with all grading

20 criteria. Again, 11 RBOs on CAPS. And we also have 6 RBOs on our monitor

21 closely list. Next slide, please.

22 Moving on to the corrective action plans. Again 11 CAPS. Three

23 new CAPS as of quarter ended June 30, and we have 8 RBOs continuing from

24 the previous quarter. Of those 8, 7 are improving, meeting their approved CAP

25 projections; 1 RBO is not meeting. We worked with that RBO. They need a little

1 bit of additional time to obtain compliance and that was approved by the
2 Department and their contracting health plans. Of the 11 CAPS, 9 are approved,
3 2 are in review. For additional information on the corrective action plans there's a
4 handout that lists all 11 RBOs and it is sorted by the MSO or Management
5 Services Organization. And it includes the RBOs contracted health plans,
6 enrollments and ranges, the quarter the CAP was initiated, the noncompliant
7 grading criteria, as well as if the RBOs is meeting their approved CAP.
8 After our June 30 review of the financial survey reports and CAPS,
9 4 of those 11 CAPS were completed. We start our review of September 30 with
10 7 continuing CAPS, and those financial filings for September 30 are due today.
11 Moving on to the grading criteria. Next slide please. Let's look at
12 the TNE requirement. We compared TNE to required TNE. RBOs reporting less
13 than 100% are noncompliant with this category. We have one RBO that has less
14 than 10,000 lives, and another RBOs that has more than 10,000 lives that are
15 reporting noncompliance. And 75% of the RBOs are reporting more than 500%
16 of TNE.
17 Moving on to relative working capital. This is the comparison of
18 current assets to current liabilities. Again, one RBO has less, anything less than
19 one is noncompliant. There is one RBOs in this category that has over 100,000
20 lives assigned to them. And a majority of these RBOs have a ratio of over one,
21 which states that they have -- their current assets exceed their current liabilities.
22 Moving on to the cash-to-claims ratio, anything less than .75 is
23 noncompliant. This takes the RBO's cash and health plan capitation receivables
24 collectable within 30 days, over their total claims liability. All RBOs are reporting
25 compliance with this category. We have 4 RBOs that have less than one but are

1 still meeting the required calculation.

2 And last is the claims timeliness requirement. There are 2 RBOs --

3 next slide, please. Two RBOs that are noncompliant or put in noncompliance at

4 June 30. One is in our 10,000 to 25,000 category, and the other is in our over

5 100,000 category. The majority and the remainder are reporting compliance with

6 this category.

7 Moving on to enrollment. We have approximately 9.5 million

8 enrollees assigned to the 212 RBOs. The increase from the previous reporting

9 period was in the Medi-Cal enrollment only. The decreases were in Commercial

10 and Medicare. Next slide please.

11 And then looking at the RBOs that have Medi-Cal lives assigned to

12 them. There's approximately 5.6 million Medi-Cal lives assigned to the 81 RBOs.

13 This represents 60% of the total enrollment assigned to all RBOs. Of those 81

14 RBOs, 71 have no financial concerns, 4 are on our monitor closely list, and 6 are

15 on corrective action plans.

16 Moving to the top 20 RBOs that have more than 50% Medi-Cal

17 lives assigned to them. There's approximately 4.3 million lives assigned to these

18 20 RBOs, which represent approximately 45% of the total enrollment. Of those

19 top 20, 16 have no financial concerns, 1 is on our monitor closely list, and 3 are

20 on corrective action plans.

21 With that, that completes my presentation, so happy to answer any

22 questions.

23 CHAIR RIDEOUT: Paul.

24 MEMBER DURR: Yes, just a comment, Michelle, nice job. One

25 comment and one question.

1 The comment is, fabulous improvement from where we have been
2 on the RBOs' compliance. I think it's a testament that what we are doing or
3 what's happening is working and so many are improving and that's great to see.
4 My question is, the one RBOs that is over 100,000, deficient in TNE
5 and working capital. I notice, I think it's the first time they have been there.
6 Concerns that you might have with regard to the trajectory.
7 MS. YAMANAKA: So, we are reviewing that CAP right now and
8 working with the contracted health plans. It's a little bit early to say. We need an
9 approved corrective action plan and continue to monitor so we really need to look
10 at the financial assumptions on how the RBO will obtain compliance. So, right
11 now we are just pretty much in review. It's a little bit hard to say right now, but
12 we are watching it very closely.
13 CHAIR RIDEOUT: Abbi.
14 MEMBER COURSOLLE: Thank you. Yes, Michelle, totally agree.
15 These numbers look great so that's really exciting to see how many fewer
16 plans -- or RBOs, I should say, are on CAPS right now.
17 I am wondering if you can speak to, specifically looking at the
18 RBOs with Medi-Cal lives, if you all are anticipating any impact of all the
19 transitions that are coming next year, or if it's a little too soon to say what that
20 impact might be? It's a little hard for me to tell from the summary which ones of
21 those RBOs that are in CAP right now might be impacted by the transition one
22 way or the other. So, I am not sure if that's something you all have been looking
23 at or if you have any insight on that.
24 MS. YAMANAKA: It is something that we are looking at, however,
25 it's a little bit hard to say how, you know, all of the changes in Medi-Cal are going

1 to affect the RBOs at this point. But the RBOs that have Medi-Cal enrollment
2 assigned to them. Any time an RBOs is on a CAP we monitor them on a monthly
3 basis. So, any changes that occur -- we are in frequent contact with them as well
4 as we are monitoring them on a monthly basis to ensure that if there's any
5 changes, we jump on it ahead as early as possible. The impact -- to ensure -- if
6 there's a negative -- if there's something negative that is going to affect them
7 meeting their final CAP, again, we jump on it as soon as we can to get the
8 outlook going forward in order to see how that RBOs is going to get back on track
9 with their corrective action plan.
10 MEMBER WATANABE: Jeff, maybe if I can just jump in here, too.
11 CHAIR RIDEOUT: Great.
12 MEMBER WATANABE: It struck me yet again when DHCS was
13 making their presentations, just the significant changes we are going to see in
14 the landscape next year. We are already thinking on the financial summary of
15 Medi-Cal managed care plans how we present that information. I think we will try
16 to take a fresh eye to all of our reports to see where we can highlight potential
17 impacts across the board of the changes happening in Medi-Cal. Obviously, the
18 significant increases in the commercial market are obviously of a concern, too.
19 So, I just would put a call out there maybe when we get to future agenda items, if
20 there's things that you want to flag for us that we should be looking at or
21 considering in terms of how we display data, definitely let us know. I know we
22 have had some offline conversations with some groups too about different ways
23 we might use the data we get, but appreciate that note, Abbi.
24 CHAIR RIDEOUT: Great. David, did I see your hand up or not?
25 MEMBER SEIDENWURM: My question was addressed, thank

1 you.

2 CHAIR RIDEOUT: Thank you. I have got a question. It's probably

3 for Mary or Amanda or Sarah. Could one of you describe the extent that the

4 RBO regulations would allow for monitoring of something like quality of care, in

5 light of the health equity and quality measure set. It is not to be punitive, but,

6 Mary, you have seen this data, but there is so much dependency, good

7 dependency on EMR data and clinical data to actually properly represent

8 performance. And it's a combination of plan and provider data together, that

9 really gives everybody the best starting point. And I just, you know, with DMHC

10 regulating, you know, obviously, all the Medi-Cal plans and most of the

11 commercial plans, it would seem to be a logical kind of goal to try to use the

12 regulations for RBOs to encourage the best performance possible. And it's not a

13 IHA commercial, necessarily, but I do think that's something that we are going to

14 have to come to grips with sooner rather than later.

15 MEMBER WATANABE: No, it's a good question. We obviously

16 have pretty broad authority in a lot of areas. I guess the question, Jeff, is like,

17 what would that look like? Is it a metric around encounter data, the quality of

18 data? I am trying to think where we would collect that or what that would look

19 like for us. I think, obviously, we are going to get, dip our toes a little bit more

20 into this as we start to look at the health equity and quality metrics. One of the

21 pieces there is a process measure that we will be developing around just the

22 completeness of demographic data, but I don't know that that's quite getting to

23 what you are asking. But maybe let me just ask you. In an ideal world, what

24 would that look like that we would collect and monitor?

25 CHAIR RIDEOUT: Well, I think the simplest thing would be what is

1 the view of an enrollee from their medical group versus their plan? And, you
2 know, we do that, we have done that for 20 years to try to true up the results or
3 give everybody the benefit of the doubt. So, I think Paul, or David or Mark might
4 have some ideas. But I think when there's that kind of discrepancy and it goes
5 both directions, plans have better pharmacy data then provide groups do. You
6 know, actually just knowing the difference, especially if it's a regulated entity by
7 DMHC, might be helpful in sort of, is this a data problem or is this a real gap?
8 And we have done some of this with health equity data, and some of it is so bad
9 that there's no way you can assume that that's the right answer, you assume that
10 there's a data problem.

11 MEMBER WATANABE: Right.

12 CHAIR RIDEOUT: So, that would be my first comment. But Paul
13 or David or Mark, you might have other -- well, or Abbi or anybody.

14 MEMBER SEIDENWURM: Well, since I have been invited to
15 comment. The first thing we need to do is to see what the differences are among
16 the different methods for measuring any particular item. And I think that that's
17 where we should start, with some sample of quality, some sample of utilization,
18 some sample of member engagement, or member experience, and so forth. It
19 almost doesn't matter what the specific metric is because first we need to find out
20 how good we are at measuring anything. Then I think we can go and decide
21 which of those domains would be the most fruitful and which of those domains
22 are the most germane to our task.

23 CHAIR RIDEOUT: Thank you, David. Other comments from
24 committee members or questions?

25 Seeing none, let's move on to the public for questions.

1 MR. STOUT: Seeing no questions.
2 CHAIR RIDEOUT: Okay. All right. So, I think we now move on to,
3 back to Pritika for the health plan quarterly update.
4 MS. DUTT: Thank you. The purpose of this presentation is to
5 provide you an update of the financial status of health plans at quarter ended
6 June 30, 2023. All the licensed health plans are required to submit quarterly and
7 annual financial statements to the DMHC. Additionally, we get monthly financial
8 statements from health plans who are newly licensed, or if their TNE, tangible net
9 equity, falls below 150% of what is required. We also place plan on monthly
10 reporting if we have financial concerns with their performance. We also included
11 a handout that shows the enrollment at June 30, 2023 and the TNE for 5
12 consecutive quarters from 6/30/2022 to 6/30/2023 for all licensed health plans
13 and is broken by full service, restricted full service and specialized.
14 As of November 10, 2023, we had 142 licensed health plans.
15 We are currently reviewing 10 applications for licensure, which
16 includes 5 full service and 5 specialized. Of the 5 full service, 3 are looking to get
17 a license for restricted Medicare Advantage, one for Medicare Advantage where
18 it plans to contract directly with CMS, and one is looking to get into Medi-Cal
19 managed care. For the 5 specialized plans, 3 are looking to get licensed for
20 employee assistance program or EAP, and 2 for dental.
21 Since the last meeting we licensed Champion Health Plan of
22 California as a Medicare Advantage health plan. They plan on offering benefits
23 to ESRD or end-stage renal disease enrollees. Their first financials will be due
24 for the third quarter.
25 Two plans, Evergreen Health Plan and Americas health Plan,

1 surrendered their license. Additionally, Managed Health Network is in the
2 process of surrendering their license. We have received the application for
3 surrender. That application is in review and we will probably finalize their
4 surrender by next week. Next slide.
5 At June 30, 2023, there were 30.66 million enrollees in full service
6 plans licensed with the DMHC. Total commercial enrollment includes HMO,
7 PPO/EPO and Medicare supplement. As you can see on the table, compared to
8 the previous quarter, total full service enrollment increased. And the increase
9 was driven by the government enrollment, which comprises of Medi-Cal and
10 Medicare Advantage. Next slide.
11 This slide shows the makeup of HMO enrollment by market type.
12 HMO enrollment in all markets remained relatively stable compared to previous
13 quarters. Large group HMO and individual HMO products experienced a slight
14 decrease in enrollment. It was a very minimal decrease. Next slide.
15 This slide shows the makeup of PPO/EPO enrollment. Similar to
16 HMO, PPO large group and individual markets experienced slight decreases in
17 enrollment.
18 This table shows the government enrollment, like I mentioned, it
19 includes Medi-Cal and Medicare. Enrollment for both Medi-Cal and MA plans
20 have experienced significant growth. At June 30, Medi-Cal enrollment increased
21 by 234,000 lives and Medicare Advantage increased by 27,000 lives. Next slide.
22 We have 34 plans that we are monitoring closely, which includes 28
23 full service plans and 6 specialized plans. There are various reasons why we
24 monitor health plans closely, which may include but are not limited to the plan
25 may be newly licensed, a low enrollment, financial solvency concerns, concerns

1 with parent entity, claims processing issues that have been identified during our
2 exams or if we receive complaints from providers about claims processing issues
3 at the plans, an ongoing enforcement action, and staff turnover to name a few. A
4 majority of the plans that are monitored closely are not very large in terms of
5 enrollment. Next slide.
6 Two health plans did not meet the Department's minimum financial
7 reserve or tangible net equity requirement.
8 Brandman Health Plan, they have been reporting noncompliance
9 with the TNE requirement since April of 2022 and their noncompliance went
10 through July 31, 2023. The plan cured its TNE deficiency as of October. So, we
11 received their monthly financial statements for September, which demonstrated
12 that they are compliant with the TNE requirement.
13 The other plan is Holman Professional Counseling Centers. The
14 plan reported TNE deficiency for quarters ending March 31, 2023 and June 30,
15 2023. The plan remains TNE deficient and we are currently working with the
16 plan.
17 Both plans have been reported to Enforcement for their TNE
18 violation. Next slide.
19 This chart shows the TNE of health plans by line of business. A
20 majority of the plans with over 500% of required TNE are specialized health
21 plans. Next slide.
22 This chart shows the TNE of full service plans by enrollment.
23 Sixty-eight health plans, or over half of the total licensed full service health plans,
24 reported TNE of over 250% of required TNE. The plans below 150% of TNE are
25 required to file monthly financial statements with the Department. We had 11

1 plans that are below 150% of required TNE so they are on monthly reporting.
2 Next slide.
3 This chart shows a breakdown of the 20 full service plans in the
4 150% to 250% of TNE range. If a health plan's TNE falls below 150% of the
5 required TNE, those plans are placed on monthly reporting. We also monitor the
6 health plan's closely if we observe a declining trend in their financial
7 performance, their TNE, if they are reporting net losses, their enrollment is
8 declining, or if they are increasing as well. We place those plans on monthly
9 reporting, as mentioned earlier. Next slide.
10 This chart pretty much summarizes the handout that was provided
11 with the presentation, and it shows the TNE of full service plans by quarter. Next
12 slide.
13 This slide shows the working capital for full service health plans by
14 enrollment as of June 30, 2023. The working capital is the excess of the plan's
15 Current Assets over Current Liabilities. How much assets/cash they have readily
16 available to cover their costs for a period of a year. Next slide.
17 This slide shows the cash-to-claims ratio for full service health
18 plans by enrollment. About 26 plans have a cash-to-claims ratio of 2.5 or above.
19 These 26 plans are also less than 1.0 of our cash-to-claims ratio. Next slide.
20 This brings me to the end of the presentation. Any questions?
21 CHAIR RIDEOUT: Thank you, Pritika.
22 Questions from committee members? I will start with Abbi this
23 time.
24 MEMBER COURSOLLE: All right. Well, this is sort of similar to the
25 question I asked Michelle, but, Pritika, I am just wondering, and I think Mary

1 spoke to this a little bit, but if there's more that you can tell us about sort of how
2 you are monitoring is looking at the plans that will be impacted by the Medi-Cal
3 transitions and if there's anything we should be looking out for as that transition
4 rolls forward in January.
5 MS. DUTT: Sure, Abbi. The plans that are adding additional
6 counties or are going to get additional lives from, through DHCS. We have --
7 they have had to file notices of material modification with the DMHC, so we have
8 reviewed those. We have asked them to submit their financial enrollment
9 projections, so those reviews have happened. Like I had mentioned during the
10 Medi-Cal managed care report presentation, we have Imperial County is adding
11 a plan, Imperial County Health Plan. So, they are -- they were required to get a
12 license from the DMHC. So, again, there's a lot of work happening with the
13 health plans. Also, we have periodic meetings with DHCS, so we have frequent
14 meetings with DHCS where these discussions are ongoing. So, our team is
15 tracking on, you know, we are looking at projections, et cetera, from plans and
16 getting ready for the transition.
17 CHAIR RIDEOUT: Paul, I think you had a question.
18 MEMBER DURR: I did, but Pritika just answered it so I'm good.
19 CHAIR RIDEOUT: Okay. Any other questions from the committee
20 members?
21 Seeing none, any questions from the public, either on Zoom or by
22 phone?
23 MR. STOUT: There are none at this time.
24 CHAIR RIDEOUT: Okay. That brings us to the next section, which
25 is meeting dates for next year. Mary?

1 MEMBER WATANABE: Yes, sure. I think we shared these
2 meeting dates last time, but nobody objected so we are going to move forward
3 with February 28, May 8, August 14, and November 6 of 2024. You all are
4 probably aware there was some recent legislation that allows -- one, it allowed us
5 to extend virtual meetings to the end of this year, but into next year it allows us to
6 also hold virtual meetings. There are some nuances to that including that we will
7 have to have an in-person option that at least one person from our office will be
8 there in the event that the public wants to participate in person. So, plan on
9 these being virtual with an in-person option next year. We will provide more
10 information as we get some clarity on some of these requirements, but will likely
11 have an option if anybody would want to come in person, you would be welcome
12 to do that. And we would do that similar to what we have done with our laptops
13 in front of us from a conference room. So, more to come on that. But look
14 forward to being with all of you next year and hope you all have happy holidays.
15 CHAIR RIDEOUT: Any questions from the committee members
16 about the dates, or any questions from the public?
17 Okay, I think we are moving on now to matters not on the agenda.
18 From the public, any comments?
19 MR. STOUT: No comments at this time.
20 CHAIR RIDEOUT: Okay. Any agenda items for future meetings?
21 I'll start with committee members. Any suggestions, anything that came out
22 today or anything that people would like to see considered? Paul.
23 MEMBER DURR: Yes, one thing to consider is I know we were
24 starting to get into it on the discussion with the Medi-Cal and Kaiser, but with
25 regards to network adequacy, and the idea that we want to not push a lot to

1 Kaiser because they have to build capacity. There does need to be
2 consideration that, you know, with 700,000, immigration type of people that will
3 be expanded into this, that that will create capacity issues for non-Kaiser
4 providers as well and there needs to be some consideration for that. You know,
5 it's something for consideration, Mary and team. Nothing we can do about it. But
6 I think if we are going to hold Kaiser to certain standards, you know, we have to
7 be somewhat mindful of the impact that that will have to the rest of the provider
8 community who will be asked to take probably more of those patients.
9 CHAIR RIDEOUT: Jarrod.
10 MEMBER MCNAUGHTON: Yes, thanks, Jeff. Great, great
11 comment, Paul. It is going to be interesting to see how all that comes together
12 for sure.
13 I just wanted to briefly share, Jeff, my personal thanks to the team
14 there at DMHC, Mary and her whole team. As Pritika shared during her report,
15 we are one of the new entrants or the new entrant for Covered California; and we
16 are learning things every single day, Jeff and team, about what we should be
17 doing, what we didn't do and should do and all kinds of stuff. And just really
18 wanted to say a big thank you to the team for their guidance and navigation into
19 some uncharted territories for us as a as a local Medi-Cal plan. We have
20 stepped over ourselves a couple of times and probably banged ourselves up a bit
21 but Mary and her team have been incredibly gracious with us and helping us on
22 that journey. I know that in January I will be sharing some thoughts with my local
23 health plan partner CEOs, the 17 of us are getting together, and I will be just
24 sharing about some ideas on Covered California for the other local plans to
25 potentially look at. And just really wanted to say a big thank you to the team on

1 the call today for just helping us navigate some very unique things that are the
2 right thing to do; we are just trying our best to learn as we go. And so just a huge
3 thanks to the Department for that.
4 MEMBER WATANABE: And welcome, Jarrod. Thanks for
5 acknowledging the team. And always good to work with your team.
6 CHAIR RIDEOUT: David.
7 MEMBER SEIDENWURM: Yes, well, the first thing I want to say is
8 that as a new member to this group I am really super impressed by the level of
9 knowledge and the quality of the presentations and the quality of course of the
10 work that that reflects. So, the first thing I want to do is say thank you and yay for
11 you guys.
12 Second is, there's a couple things that have struck my attention
13 over the, you know, only two meetings that I have been able to attend, you know,
14 since I was appointed. But one is the impact of some of the new mandates and
15 some of the new program changes on the financial viability of the plans with
16 respect both to their solvency and to what might be happening in the rate
17 increase domain, and how that, of course interacts with the affordability goals.
18 And so it seems like we have got a lot of things that are pushing us in different
19 directions and it might be interesting to see what the relative magnitude of some
20 of those shifts might be. Anyway, that's one thing that kind of intrigues me.
21 The other is the definition of health care performance that we use is
22 financial, right, because we are the Financial Solvency Standards Board. But as
23 Jeff and others have pointed out, there are other domains of performance that we
24 ought to take into account. And I think that as mentioned earlier, the first thing
25 we need to know is how can we measure, how good are we at measuring those

1 things? So, I am quite intrigued, and it seems like this this impressive team could
2 help us to, to learn about that. And then once we learned about that, then
3 perhaps domains of quality or other areas might be added to our definition of
4 performance. So, anyway, thank you very much.
5 MEMBER WATANABE: And I appreciate those comments. We
6 will take that back and do some thinking. I will say, you know, we will start to
7 collect the health equity and quality data next year with a report and 2025. So,
8 there are some things that are just in the general, you know, quality space that
9 we will be looking at. But I think you had some good points about the disconnect
10 between what the health plans have versus what the RBOs and providers have
11 too and what that quality looks like.
12 I will just say, Jeff, I think we are planning to have DHCS come I
13 think twice a year, we are going to ask HCAI and OHCA to come do an update
14 as well as Covered California. I think we tentatively have Covered California
15 planned for the next meeting. I know there's some shift in enrollment from Medi-
16 Cal to Covered California too so wanted to -- we will be tracking very close to
17 kind of where the movement in enrollment is happening next year, too. So, lots
18 of exciting things. But yes, let us know other areas that we should continue to
19 look into.
20 CHAIR RIDEOUT: Mary, one thought or question. How realistic is
21 it to have either Michelle Baass or the new COO at DHCS do at least one
22 presentation for this group?
23 MEMBER WATANABE: We could certainly ask.
24 CHAIR RIDEOUT: I think, you know, leveling it up would be, would
25 be an interesting discussion and dialogue.

1 MEMBER WATANABE: Sure. No. We could certainly ask. I know
2 Michelle is very busy. I will say one of the things that we will -- we may have an
3 opportunity as Jacey Cooper has left DHCS, I think most of you know, and so
4 they are recruiting for a new Medicaid Director too. So, maybe between Michelle
5 and the new Medicaid Director we can have them, them pop in as well. And
6 appreciate -- hopefully, Jessica will continue to be able to come from Covered
7 California too, so we will take that back.
8 And then, Jeff, I do, we would love to have an Atlas update at the
9 February meeting, hopefully.
10 CHAIR RIDEOUT: Yes. I will try to turn that on some of the data
11 gaps that came up. I mean, I brought them up so that's -- but I do think it's pretty
12 interesting to look at blinded information that cuts across health plans in terms of,
13 you know, what they have, what they don't have, where they can go get it, that
14 kind of thing. So, I will make that a point of emphasis.
15 Are there other suggestions for future meetings?
16 Anything from the public on this? Get out of our own echo chamber
17 here.
18 MR. STOUT: None at this time.
19 CHAIR RIDEOUT: Okay. All right. I think that concludes that item.
20 And closing remarks.
21 MEMBER WATANABE: I don't have any. I will just say I
22 appreciate the robust discussion as always and everybody's participation. Thank
23 you to my team for all the work that goes into pulling these meetings together
24 too. And just wish you all happy holidays and we will see you in the new year.
25 CHAIR RIDEOUT: Thank you all.

1 Any final comments from anybody?

2 MEMBER WATANABE: Okay.

3 CHAIR RIDEOUT: All right, we will call it a wrap. Thank you, we

4 are adjourned.

5 MEMBER WATANABE: Thank you. Bye.

6 (The meeting was adjourned at 12:46 p.m.)

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1 CERTIFICATE OF REPORTER

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

5 hereby certify:

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

7 Department of Managed Health Care, Financial Solvency Standards Board

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

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

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

11 IN WITNESS WHEREOF, I have hereunto set my hand this 7th day

12 of December, 2023.

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17 RAMONA COTA, CERT*478

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