STATE OF CALIFORNIA

DEPARTMENT OF MANAGED HEALTH CARE

FINANCIAL SOLVENCY STANDARDS BOARD (FSSB) MEETING

ONLINE/TELECONFERENCE MEETING

HOSTED BY THE

DEPARTMENT OF MANAGED HEALTH CARE

SACRAMENTO, CALIFORNIA

WEDNESDAY, AUGUST 10, 2022

10:00 A.M.

Reported by: Ramona Cota

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APPEARANCES

BOARD MEMBERS

Larry deGhetaldi, MD, Chair

Scott Coffin

Abbi Coursolle

Paul Durr

Theodore Mazer, MD

Jeff Rideout, MD

Mary Watanabe

DMHC STAFF

Pritika Dutt, Deputy Director, Office of Financial Review

Sarah Ream, Chief Counsel

Daniel Rubinstein, Acting Staff Services Manager

Dan Southard, Chief Deputy Director

Jordan Stout, Staff Services Manager I

Michelle Yamanaka, Supervising Examiner, Office of Financial Review

ALSO PRESENTING/COMMENTING

Rafael Davtian, Division Chief
Department of Health Care Services, Capitated Rates Development

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1 PROCEEDINGS

2 10:00 a.m.

3 CHAIR DEGHETALDI: Welcome to the August 10 FSSB meeting;
4 it is Larry deGhetaldi. We typically start with a welcome, which I just did, and
5 introductions. Let me start with myself, Larry deGhetaldi, family physician in
6 Santa Cruz, part of the Palo Alto Medical Foundation.
7 And let's go down to Dr. Mazer.
8 MEMBER MAZER: Ted Mazer, otolaryngology, semi-retired.
9 CHAIR DEGHETALDI: And San Diego, Paul.
10 MEMBER DURR: Paul Durr, CEO for Sharp Community Medical
11 Group, an Independent physician association in San Diego.
12 CHAIR DEGHETALDI: Great. Scott, East Bay.
13 MEMBER COFFIN: Hi, good morning, Scott Coffin, CEO, Alameda
14 Alliance for Health.
15 CHAIR DEGHETALDI: And who is next? Jeff.
16 MEMBER RIDEOUT: Jeff Rideout, the Integrated Healthcare
17 Association.
18 CHAIR DEGHETALDI: And Abbi.
19 MEMBER COURSOLLE: Hi, Abbi Coursolle, senior attorney with
20 the National Health Law Program based in Los Angeles.
21 CHAIR DEGHETALDI: And I think we have -- I think Amy is an
22 excused absence.
23 Mary, do you want to introduce any new members of your staff?
24 MEMBER WATANABE: Sure. So I am Mary Watanabe, I am the
25 Director of the Department of Managed Health Care. I will maybe just quickly

1 introduce the team from DMHC who is not new, you have seen them before, but
2 they will be presenting today. Dan Southard is our Chief Deputy Director; we
3 have Sarah Ream our Chief Counsel; Pritika Dutt, who you know well, the
4 Deputy Director for Office of Financial Review; and of course Michelle
5 Yamanaka, our Supervising Examiner in the Office of Financial Review, who is a
6 regular on these meetings. So I think that is the DMHC team. We have Jordan
7 Stout and I think Daniel Rubenstein providing administrative support.
8 CHAIR DEGHETALDI: Excellent. All right. So let me move to the
9 housekeeping notes that I need to remind folks each meeting. So for our Board
10 Members, please remember to unmute yourselves when making a comment and
11 then mute yourselves when not speaking. For our Board Members and the
12 public, as a reminder, you can join the Zoom meeting on your phone should you
13 experience a connection issue.
14 Questions and comments will be taken after each agenda item. For
15 attendees on the phone, if you would like to ask a question or make a comment
16 please dial *9 and state your name and organization you are representing for the
17 record.
18 For attendees participating online with microphone capabilities, you
19 may use the Raise hand feature and you will be unmuted to ask your question or
20 comment. To raise your hand click on icon labeled Participants on the bottom of
21 your screen then click the button labeled Raise Hand. Once you have asked
22 your question and provided the comment please remember to click Lower Hand.
23 All questions and comments will be taken in order of raised hands as they
24 appear.
25 As a reminder, FSSB is subject to the Bagley-Keene Open Meeting

1 Act. Operating in compliance with the Act can sometimes feel inefficient and
2 frustrating but is essential to preserving the public's right to governmental
3 transparency and accountability.
4 Among other things, the Bagley-Keene Act requires the FSSB
5 meetings to be open to the public and as such it is important that members of the
6 Board refrain from emailing, texting, or otherwise communicating with each other
7 off the record during FSSB meetings because such communications would not
8 be open to the public and would violate the Act.
9 Likewise, the Act prohibits what are sometimes referred to as serial
10 meetings. A serial meeting would occur if a majority of the FSSB Members
11 email, text or spoke with each other outside of a public meeting about matters
12 within the Board's purview. Such communications would be impermissible even
13 if done asynchronously. For example, member one emails member two who
14 emails member three.
15 Accordingly, we ask that all FSSB members refrain from emailing or
16 communicating with each other about FSSB matters outside the confines of a
17 public meeting.
18 Any questions or clarifications there? I think we have heard that
19 before.
20 And then in Item 2, any comments or changes to the May 19th
21 meeting summary and transcript?
22 Hearing none, could I have a motion to approve them?
23 MEMBER MAZER: So moved.
24 CHAIR DEGHETALDI: And a second?
25 MEMBER DURR: Second.

1 MEMBER COFFIN: Second.
2 CHAIR DEGHETALDI: Okay, all those in favor?
3 (Ayes.)
4 CHAIR DEGHETALDI: Aye here. And opposed?
5 So great, we are on to Mary's remarks.
6 MEMBER WATANABE: All right. Good morning and welcome to
7 our almost-fall FSSB meeting. So we have been very, very busy since we last
8 met but I only have a couple of highlights for you.
9 First, I will just note that last month we released our 2021 Annual
10 Report, an infographic that highlights some of our achievements and activities
11 during the year. There is a lot of really good information in there.
12 At the end of 2021 the DMHC continues to regulate the majority of
13 health care coverage in California, including 96% of commercial and public
14 enrollment and state regulated health plans. By the end of 2021 we licensed 140
15 plans and had about 28.4 million consumers in the health plans we regulate. At
16 our FSSB meetings you get more frequent updates and you will see in our later
17 reports I think we are getting close to about 29 million consumers in the plans we
18 regulate. You can read more about our accomplishments by visiting our website
19 at healthhelp.ca.gov. You will see the Annual Report linked under either What's
20 New or on our DMHC Reports webpage.
21 Probably the most interesting news here is on our 2023 rates in the
22 individual market. The DMHC received and is currently reviewing 14 individual
23 rate filings with an effective date of January 1, 2023. This includes 13 on-
24 Exchange filings and there is a new entrant this year; Aetna Health of California
25 will offer individual products on-Exchange. For the 14 individual rate filings that

1 we are reviewing the proposed rate increases range from 1.92% to 13.5%.
2 Health plans projected their proposed rates with the assumption that the
3 additional premium subsidies available through the American Rescue Plan Act
4 would be ending on December 31st of 2022. I think we are all holding our breath
5 and somewhat cautiously optimistic that with the Inflation Relief Act passing in
6 the Senate that that will get passed and we will be able to see continued
7 subsidies in on the Exchange. Covered California also announced last month
8 that their average premium rate increase is 6%. And if those additional subsidies
9 do not pass there is obviously a lot of concern. I think Covered California has
10 estimated about 220,000 Californians and 1.7 million people nationwide could
11 have unaffordable, an unaffordable increase in their premiums and potentially
12 drop coverage. We will have more information on the final, our final review of
13 individual market rates at the next Board meeting so lots more information to
14 come on that but I wanted to give you a preview of what we are seeing.
15 Health plans were also asked to provide the estimated impact of
16 COVID on their proposed rates so we are working closely to see how that is
17 impacting both premiums, medical costs, utilization and medical loss ratio. We
18 publish the rates on our website and accept public comment on the filing so you
19 can see those linked on our website as well.
20 As we have talked about over the last year, I am really excited
21 about the work that we are doing with our Health Equity and Quality Committee
22 meeting. We have held seven meetings so far and we will likely have two more.
23 We were hoping to wrap up in August but I think we are going to need probably
24 one more meeting to finish the conversation around benchmarks and then talk
25 about the final report with the Committee recommendations. Our next meeting is

1 scheduled for next week on August 17 from 12:00 to 5:00. These have been
2 very intense, very technical five hour meetings but I have been really excited
3 about just the level of engagement and participation we have had from the
4 Committee and some public participation as well.
5 The Committee has voted and reached consensus on
6 recommending 13 measures. This includes 12 HEDIS measures and one
7 CAHPS measure, our Consumer Assessment of Healthcare Providers and
8 Systems survey, and it is a composite question related to getting needed care.
9 So the benchmarking and kind of where we set that standard for where we will
10 take enforcement when plans fall below will be part of our robust discussion next
11 week and potentially into September.
12 I will share more information at the next Board meeting because we
13 should have the Committee's recommendations by that time so I will continue to
14 keep you kind of apprised of what we are doing there.
15 If you are interested in looking through any of the PowerPoint
16 presentations or a summary of the meetings you can find that on our Health
17 Equity Committee web page, which is linked on the right of our website.
18 And I just wanted to take a minute to highlight two fairly large
19 enforcement actions that we took since our last meeting. The first is related to
20 Anthem Blue Cross. So we took enforcement actions totaling I think about $1.1
21 million against Anthem Blue Cross for incorrectly applying office visit costs to
22 enrollee deductibles as well as for failing to mail explanation of benefits to
23 enrollees.
24 We also took an enforcement action against Molina Healthcare,
25 including a $1 million fine for failure to timely acknowledge and resolve about

1 29,000 provider disputes between September of 2017 and 2018. The plan paid
2 the fine and implemented a corrective action, including the remediation of about
3 $80 million in payments to providers with an additional nearly $2 million in
4 interest.
5 So those were some of our significant actions that we took since
6 the last Board meeting. And with that I will pause and see if there are any
7 questions from the Board or the public.
8 CHAIR DEGHETALDI: I am looking for hands. Any Board
9 Members' questions? Paul, please go.
10 MEMBER DURR: Mary, just a quick question. I know you
11 commented on the plans showing the impact of COVID-19. Just curious how
12 that will all shape out with regards to the legislation or the lawsuit that is at hand
13 as to where they will factor in their costs versus what has been proposed to be
14 medical group cost and if that will be in appropriately recognized?
15 MEMBER WATANABE: Yes, sure, yes, no. And I will just note that
16 Sarah Ream will be talking more about the SB 510 lawsuit later in the agenda.
17 That is part of what we are reviewing in the filings and asking questions about the
18 assumptions that they are making in light of the lawsuit, so that will be part of our
19 review.
20 MEMBER DURR: Thank you.
21 CHAIR DEGHETALDI: Any other questions?
22 Mary, I do have a question on health equity. Will the initial focus be
23 on identifying race and ethnicity equity variations or benchmarking targets? Is
24 that going to be the initial focus?
25 MEMBER WATANABE: Yes, I think it likely will be. We have had a

1 lot of discussions throughout the Committee meetings and I think it is important
2 to just reiterate that this is not -- it is a quality initiative but the focus really was on
3 equity and on addressing disparities. We really want to make sure that we are
4 not improving quality at the expense of leaving certain communities behind. The
5 Committee Members have definitely reiterated their desire and concern for not
6 going beyond just race and ethnicity so we have had a lot of discussion just
7 about the data that is available. There is certainly interest in collecting very
8 robust data around sexual orientation and gender identity, disability status and
9 other communities that may have just disproportionately been impacted by
10 COVID or other chronic conditions. So that is really what we are looking to the
11 Committee to make recommendations on kind of where do we start.
12 We also have an opportunity to amend to the quality measures and
13 some of the requirements within the next five years. We do have to codify these
14 in regulations. But because of the equity focus I believe at a minimum we will
15 probably at least be looking at race and ethnicity. We have had, thankfully, a
16 participant from NCQA and RAND and others who are really experts in the
17 space; we have got someone from IHA. So we are really kind of looking at what
18 NCQA is doing with their health equity accreditation and trying to align with some
19 of the work that is happening across purchasers and at the national level as well.
20 CHAIR DEGHETALDI: As IHA has pointed out, there is significant
21 geographic variation in quality within California. I am particularly concerned
22 about rural delivery systems being adversely impacted, Mary, just a thought.
23 MEMBER WATANABE: Sure. Yes. No, I appreciate that.
24 CHAIR DEGHETALDI: Great. Any other questions for Mary?
25 Okay, then it is my pleasure to introduce a newcomer here, Rafael,

1 and will give us our -- hi, Rafael, welcome. You have a full topic here and we will
2 save our questions to the end. So thank you for joining us, it is great.
3 MR. DAVTIAN: Thank you. Thank you very much for inviting me
4 and good morning to you and the other Members of the board and to the public.
5 Yes, you are absolutely right. We do have, we do have a lot to share for DHCS.
6 I will be focusing today on for four key topics really looking,
7 primarily looking ahead but also looking at some of the, some of the work and
8 efforts that have been underway even this year. Focusing on some key items
9 from, some key updates from the latest Medi-Cal budget; talking about work that
10 we have been doing for about a year now building towards the addition of a
11 quality factor in our 2023 rates; and then an update on the, really on the financial
12 perspective or financial update on the status of the long-term care carve-in in
13 Medi-Cal that is, that is occurring next year; and the major organ transplant
14 carve-in that occurred at the beginning of 2022.
15 So, diving right into to our Medi-Cal, Medi-Cal budget items. There
16 are a lot of, there are a lot of changes and a lot of things in the Medi-Cal budget.
17 I will focus on some select highlights, just focusing on some of the major, major
18 overarching changes. And of course no, no discussion of that would be complete
19 without highlighting the continuing efforts related to Medi-Cal for All and the
20 expansion of full scope Medi-Cal coverage to, to all income-eligible individuals
21 regardless of immigration status. The coverage was expanded for, for individuals
22 aged 50 and over earlier this year, and the latest budget also included the
23 expansion for individuals aged 26 through 49, really the last remaining age group
24 that, that needed to be bridged.
25 Another key item in the budget is related to skilled nursing, skilled

1 nursing facility financing reform. There are a number of, a number of changes in
2 the budget, including the establishment of a SNF Workforce and Quality
3 Incentive Program through the Medi-Cal managed care delivery system starting
4 in 2023. The imposition of quality sanctions. And extension of, an extension of
5 rate increases implemented during the pandemic. And then additional rate
6 increases in future years tied to, tied to workforce standards. Next slide. Thank
7 you.
8 Also, a major new initiative within our budget is the Federally
9 Qualified Health Center Alternative Payment Model or APM. Which we will be
10 implementing no sooner than January 2024 essentially to, to create a, to create
11 an alternative model that allows FQHCs to voluntarily choose to participate, to
12 voluntarily choose to join the model and enable FQHCs to undertake practice
13 transformation activities and provide a financial framework for them to do so and
14 to move away from volume-based reimbursement, which is the volume-based
15 reimbursement that occurs today under the prospective payment system
16 payment model.
17 Something else we are very excited about, equity and
18 transformation payments. The budget includes 700 million in total funds over,
19 over a multiyear period to support, to support a range of activities related to
20 equity and practice transformation, including 25 million for a Statewide Learning
21 Collaborative, 25 million to support really essentially initial planning practice level
22 activities, and then $650 million, the bulk of course, to support the actual, the
23 core equity and practice transformation activities that we hope to drive through
24 this program, primarily with smaller independent practices.
25 There are, as expected, also a lot of changes or a lot of updates

1 related to CalAIM. I feel we have been, we have been talking and working,
2 talking about and working on CalAIM for, for the last several years; and it is
3 implemented in full force and still, still being implemented.
4 But some of the key changes in in the budget include the delay of,
5 the delay of the carve-in of ICFs, ICFDDs and subacute care facilities from
6 January to July 2023 based on, based on extensive and continuing
7 conversations with stakeholders in that space.
8 The launch of the Population Health Management Service in July
9 2023.
10 And the expansion of the 90-day prerelease services for our justice-
11 involved population to, to include covered outpatient drugs consistent with, with a
12 state plan. And of course, these are, again, just some of the, some of the key,
13 some of the key changes in the budget but there is, there is a lot of activity going
14 on with CalAIM.
15 The budget also includes some, some updates related to benefits.
16 For example, the doula benefit, the implementation of the doula
17 benefit was, was moved to January 2023 to help support, to be responsive to
18 really the feedback that we have received through the stakeholder process and
19 help, help support a successful launch of that benefit.
20 And the budget also adopted the telehealth policy approaches in
21 preparation for the eventual end of the COVID-19 PHE.
22 More specific to certain financing arrangements, the budget did
23 transition multiple payment programs that are, that were historically funded by
24 proposition 56 taxes to ongoing rate increases that are supported by the General
25 Fund.

1 It also eliminated provider, AB 97 provider payment reductions for
2 quite a long list of provider types.
3 And then something, something that, something that, something
4 more programmatic I guess but still financing related, it did include trailer bill
5 language adopting conforming changes to state law to align with recently
6 imposed federal requirements on medical loss ratio reporting for subcontractors.
7 I am happy to continue but also happy to pause at this point, if you
8 prefer, if you prefer to take questions, to ask questions after each section.
9 CHAIR DEGHETALDI: You know, I would think we should because
10 there is so much. I forget our questions as you go further into your, into your
11 topic. So looking for hands to raise. And Ted.
12 MEMBER MAZER: Yes. Just if you can give us a little bit more
13 detail on the FQHC alternative payment model and how that would play out.
14 MR. DAVTIAN: Certainly. So it is a, it is, it is essentially an
15 alternative model that we would, we would establish and that FQHCs could
16 voluntarily elect to participate in. Whereby, rather than the -- whereby the APM
17 would essentially replace the current, the current per service or per visit
18 reimbursement methodology that applies to FQHCs with a per member/per
19 month methodology where payments, where we, the Department would direct
20 managed care plans to make payments to FQHCs on a monthly basis for each
21 member that is assigned to that, that FQHC as their primary home, if you will.
22 The payment, the payments that the Department would direct plans
23 to make would be projected, would be developed to be, provide equivalent
24 funding to what the FQHCs would otherwise receive under, under the current
25 PPS methodology.

1 And so the intention is really, the intent is really twofold. First, it is
2 to provide revenue to FQHCs on a per member/per month basis kind of on an
3 ongoing basis so that, so that FQHCs don't have to wait for -- well, let me take a
4 step back. Under the current process essentially FQHCs receiving an initial
5 payment and then there is there is a reconciliation later on that brings them up to
6 their, to their federally required rate and so the APM would essentially replace
7 that with a more prospective ongoing payment flow for FQHCs.
8 And secondly, the current methodology, the current methodology
9 allows FQHCs to receive reimbursement for what are defined as, you know,
10 traditional, traditional visits or traditional encounters. The APM would really allow
11 FQs to explore and invest in providing alternative services to their, to their
12 patients, to their members, that aren't necessarily traditional, traditional billable
13 visits but for what -- but which would still be, which benefit the member and
14 provide alternative avenues to deliver care and provide potentially avenues to
15 deliver care in a more holistic fashion without jeopardizing their, without
16 jeopardizing their revenue stream. Essentially by providing that, that monthly
17 payment rather than the per visit payment, we are opening, opening a door for
18 FQs to explore more flexibility in their, in their payment models, more flexibility in
19 their delivery model of how they deliver care to patients. And also, and also we
20 are hoping to explore ways to, to improve not only outcomes for patients, the
21 patient experience, but also the provider experience.
22 MEMBER MAZER: So if I can just follow, it is essentially a cap.
23 Financially how does that impact both the state’s budget and the overall
24 budgeting to the FQHCs? Has that been looked at?
25 MR. DAVTIAN: So in total, in total, we will be developing the cap to

1 be equivalent to, equivalent to the, to the PPS, to the PPS and the utilization of
2 those, of those billable visits that we see in a historical base period. And over
3 time as time passes, because we, we don't want to penalize an FQHC for, for
4 achieving a reduction in billable visits by, you know, by shifting more of their
5 emphasis to these alternative services, we will maintain that historical base
6 period and just account for changes in the program, changes in scope potentially.
7 But essentially look to maintain that equivalence so that the cap is, the cap is
8 providing the FQHC at least what they would have received under PPS. So in
9 total, in total there is that, you know, there is that protective equivalence. There
10 is technically a cash flow, a cash flow impact to the, to the Department and to the
11 state and to the FQHCs in the payments which would flow on that regular
12 monthly cadence rather than being dependent on, on a retroactive reconciliation.
13 CHAIR DEGHETALDI: Ted, are you done?
14 MEMBER MAZER: (Gestured.)
15 CHAIR DEGHETALDI: Yes. Paul, Scott, I am not sure whose
16 hand went up first. Let’s go, Paul.
17 MEMBER DURR: Thank you, Larry; and Rafael, thank you for that
18 presentation. Follow-up on the FQHCs. So going, expected to go live 1/1/24.
19 What has the dialogue been like with the FQHCs overall in the state and do you
20 have early adopters and what are you doing to socialize that amongst the FQs?
21 And then one other question?
22 MR. DAVTIAN: So we started, really started focused conversations
23 around, around this, this iteration of this version of the APM I believe summer of,
24 summer of last year, late summer of last year, to work specifically focusing on the
25 detailed implementation considerations and timelines. We have, we have had a

1 very, very, very successful and very productive dialogue, dialogue and
2 partnership thus far in terms of working through, working through various policy,
3 policy and operational considerations needed to get the, to get the program or
4 get this alternative payment model off the ground through a variety of forums.
5 We have been holding almost monthly formal meetings essentially too with a
6 group of both plan, plan and health center representatives including, including
7 actual plans and health centers but also, of course, their representative
8 associations.

9 We have been, we have dedicated time towards various sub-
10 workgroups to focus on multiple aspects of, you know, narrower aspects of the
11 implementation and the policy, whether it is the rate development, whether it is
12 changes in scope, the quality considerations and so on. And we are continuing,
13 continuing those efforts although over time, of course, our focus continues to shift
14 as we get closer to January 2024. Currently, we are, as I mentioned, still
15 continuing those efforts. We do intend to initiate broader, broader, more
16 expansive engagement and technical assistance with all plans and with all
17 interested health centers so that they are able to hear and ask questions, hear
18 from and ask questions directly to the Department, of course, as part of sharing
19 really the work, the work that, the work that we have done and the information
20 that has been developed, the policies, procedures and guidance that has been
21 developed over the last year.

22 And we are also, I don't want to say -- well it not piloting, really
23 more testing. We have, we do have certain health centers that have volunteered
24 to help test certain, certain parts of the process so that we can really, really make
25 sure before we, before we click Go or before we hit Go, that the process works

1 and we have worked out the bugs.

2 So our most immediate next steps other than initiating, other than

3 initiating the technical assistance are providing information, providing information

4 about a, basically for a way for FQHCs that are interested in participating to

5 express their interest through a letter of interest, providing information about a

6 formal application process and a selection process. And then receiving those

7 applications and going through that selection process really by the end of the first

8 quarter of next year so that well before the program starts we know and health

9 centers know who is participating or who is expecting to participate and who is

10 not.

11 MEMBER DURR: Excellent. I applaud you for the effort that you

12 are going down in that road. My other question, Larry, is, Rafael, is regarding the

13 Medi-Cal expansion. I think it is great that we are expanding and covering more

14 people. The question is the making sure that there is enough funding for the

15 services that will be incurred and providers that are engaged in that. Because I

16 know there are a number of providers that do not take Medi-Cal. But just trying

17 to make sure that as we expand we also need access points with physicians and

18 providers and making sure that we are dialoguing with them about maybe putting

19 more money into the Medi-Cal funding program. And I see you have done that

20 with some of those legislative things that have happened. But that is always on

21 my mind is making sure that there is adequate funding for the providers. Just a

22 comment, thank you.

23 MR. DAVTIAN: Thank you.

24 CHAIR DEGHETALDI: Scott.

25 MEMBER COFFIN: Hi, Rafael. My question is on justice-involved

1 on the 90 day pre-release. Can you outline the steps between now and
2 whenever the state Medicaid plan is going to be updated? Just what that looks
3 like and timing.
4 MR. DAVTIAN: Partially. I think, a lot of -- the policy itself is still,
5 the policy itself is still under, under development, or I should say the operational
6 details of the policy itself are still, still under development and to, to a degree
7 conversations are still ongoing, ongoing with CMS. So I think there is -- I think
8 what I can, what I can share is what I can share is somewhat, somewhat limited.
9 But the -- some of the key areas, some of the key areas of focus, of focus right
10 now other than, other than of course the package of pre-release services, which,
11 which is, you know, which includes, includes, at this point the covered outpatient
12 drugs in addition to clinical consultation, in addition to certain lab/radiology
13 services, care coordination, or care management services and the like.
14 The pre-release, the pre-release services packages is, is what is
15 reflected in the, in the latest budget. But there is still some, still some
16 conversations going on and I think still some work going on regarding the, the
17 details of the implementation, both timeline and, and specific, I guess, nuances of
18 how, how information will be, will be exchanged, will be exchanged with
19 managed care plans and how the transition to, the transition to, to managed care
20 will be managed, for lack of a better, for lack of a better word. Because, of
21 course, that is, that is the, one of the primary, primary goals, one of the primary
22 principles that there be that successful handoff for the individual as they, as they
23 exit incarceration to, to Medi-Cal.
24 So, at this point in time, at this point in time, the key dates that I
25 think have been, have been firmly established is for counties to implement an

1 inmate pre-release application process for Medi-Cal by January of 2023. And for
2 the, I think some of the further details of the transition, the actual implementation
3 of the pre-release services, either at the state prisons or at the county level, and
4 the transition to managed care are still in the works, so more information to come
5 on that. I do definitely expect that there will be for our plan partners, additional
6 guidance through, through a contract All Plan Letter or other avenues. But I am
7 sure, I am sure it won't be just to the, to the plans that this guidance is issued
8 since we are very closely working with our, we are working with our county and
9 CDCR partners as well.
10 MEMBER COFFIN: Yes, good. Well, thanks. Alameda County,
11 we have been working with Health Care Service Agency and probation and
12 Sheriff Office, et cetera, for the past two years on this. So if there is anything we
13 can do in Alameda County to help inform any of the steps let us know but we are
14 very anxious to move this forward.
15 MR. DAVTIAN: Thanks, Scott. I will be sure to take that back and
16 relay that to our, to the wider program team within the Department.
17 MEMBER COFFIN: Thank you.
18 CHAIR DEGHETALDI: Let me confess that I forgot to ask for
19 public comments after the Director's remarks and we will come back to that.
20 After I ask you a couple of questions, Rafael; Jordan, I would like to offer public
21 questions on this set of topics, Rafael.
22 Rafael, my question, I am very concerned about flipping FQHCs'
23 delivery model, which is so strongly volume-based to an APM model. And so I
24 am just, I just share my concern that if you sub-cap them for a certain set of
25 services, where do their members go after hours and weekends/ They need to

1 be held to -- as those of us that are in full risk delivery models, we own the total
2 patient experience 24/7. And please recognize that it is going to be very hard for
3 an FQHC to get off the PPS model into an APM concept. I worry about member
4 access, you know, as we make that move.
5 One thing that I don't, I am not clear on is the 1.6 million
6 Californians that are duals. What is the timeline that they are going to be moving
7 into managed Medi-Cal by county, so that those of us that care for those patients
8 can prepare to move from a fee-for-service Medicare model to a DSNP model.
9 And maybe this would be a question for the Office of Medicare Innovation for a
10 future Board meeting but I really think that California's physician groups,
11 physicians, need to know when their patients are going to move from fee-for-
12 service Medicare into a DSNP model. So that is just a question. I think better
13 clarity there would help us prepare for that movement. I don't know if you have
14 any comments on that? Is it clear in the minds of DHCS when all these members
15 will move by county by county?
16 MR. DAVTIAN: I can provide a, I can provide a kind of, I think, a
17 high level, a high level response. I think it, I think it may be -- it is, it is a complex
18 topic, though and so I think it may be better to, to dive into the details separately
19 with, with OMII.
20 But the plan, the DSNP implementation plan is essentially for our,
21 you know, for our counties, is aligned to the transition of or the sunset of the
22 Coordinated Care Initiative and the transition of that, of that model, really, into the
23 broader, broader managed care delivery system. So 2023 for the CCI counties
24 and then no later -- all managed care plans are required to implement a DSNP by
25 2026. There are some caveats to that and an exception process to that but I

1 think really those are the, those are the two key dates, 2023 and then by 2026 for
2 everyone else.
3 CHAIR DEGHETALDI: Great. Any questions? Jordan, any
4 questions on these topics from members of the public?
5 MR. STOUT: There are none at this time.
6 CHAIR DEGHETALDI: Great, Rafael, then head on to your next
7 set. Great.
8 MR. DAVTIAN: All right, thank you. So this next topic is something
9 we are actually, something we are very excited to be, to be implementing. We
10 have really consistent with CalAIM, consistent with a lot of things that the
11 Department is doing we have been, we have been exploring, exploring, and for
12 multiple years taking, taking different steps to, to link payments to quality in
13 managed care. Historically, those, historically those linkages have existed within
14 the context of really discrete, separate, isolated, isolated individual programs that
15 are Proposition 56 funded or otherwise.
16 We are very excited that for the first, for the first time in 2023 we
17 will be incorporating a quality component or a quality factor directly into the, into
18 the base rate, base rate development for our managed care plans through,
19 through a mechanism that we have we have identified and really developed and
20 embedded with conversations with our, with a plan work group.
21 So currently and since for the last several years the rates paid to
22 managed care plans reflect a blend of a 75% county-average risk-adjusted rate
23 and a 25% plan-specific rate. I say plan where the slide says “plan-specific” in
24 quotation marks because there are elements of rate setting that are still county-
25 wide or, or statewide in most cases, in all cases. But the 25% plan-specific rate

1 and 75% county average risk-adjusted rate is established practice and has been
2 at least for since, since state fiscal year ’18-19.
3 And so it is within this county-wide averaging framework that we
4 are looking to incorporate consideration of quality. Essentially, what we are
5 looking to do is to establish, establish a mechanism that will shift dollars from the
6 lower quality MCO to the higher quality MCO within the same county or within the
7 same rating region.
8 For 2023 we are going to be looking, looking primarily at quality
9 data for measurement year 2021. So this is a prospective change that we are
10 making based on, based on historical data, based on historical performance.
11 We will be considering both raw achievement against an
12 established benchmark as well as year-over-year self -improvement.
13 And we will be looking really for material quality differences. We
14 were not looking to try to, try to move dollars if plans are essentially equivalent in
15 terms of their quality scores but we are looking to recognize and reward large,
16 large or significant differences in quality.
17 And lastly, we are, we will be, we will be imposing, especially for
18 this, for the first year, we will be imposing a cap on the total dollars shifted so that
19 we can really ensure, ensure that we are we are not creating unintended
20 consequences as a, unintended negative consequences as a result of this
21 mechanism and controlling the impact that this has within a particular county.
22 We have identified a list of ten measures that will be used to, on
23 which quality will be will be evaluated and that will be used to calculate a score. I
24 won't go into the measures in detail other than to say that the measures by and
25 large are aligned with DHCS priorities under our comprehensive quality strategy.

1 Some considerations or limitations of this, of this, the approach that
2 we are taking is, first of all, it is a budget-neutral approach. We are looking, we
3 are implementing a mechanism that shifts dollars between from one plan to
4 another plan.
5 Second, we can only really, for the first year we can only really
6 implement this in plans where there -- in counties where there are two plans. So
7 we are unable to implement this in County Organized Health Systems, we are
8 unable to implement this in Sacramento and San Diego with the GMC counties,
9 and we are also unable to do this in San Benito for the time.
10 This is also only being applied to our, what we think of our, what we
11 call our mainstream rate model or mainstream programs, so specialty, specialty
12 plans and specialty programs are currently not impacted.
13 And then finally, the basis of the mechanism means that the reward
14 is varied. So, you know, if we look at two counties with, with an equivalent
15 difference in quality scores between the two plans, the amount of the -- the
16 impact of this adjustment in one county may be different from the impact of the
17 adjustment in another county, really depending, on really depending on the
18 underlying county-wide averaging component, how that how that actually plays
19 out today.
20 We recognize these limitations. We are, I think, deliberately taking
21 a more cautious approach in 2023, first to ensure that this novel methodology
22 can be federally approvable; and secondly to really be able to consider and
23 prepare for the continuation and growth of this programming in 2024.
24 We will, we do plan to start hosting plan work groups in the fall to
25 have conversations about 2024. We have already been, we have already been

1 hosting plan workgroups since winter or spring of this of this year on the ‘23
2 portion. But we intend to start 2024 conversations in the fall of this year.
3 We will be considering the changing managed care landscape as a
4 result of county model changes as well as, as well as potential plan exits or plan
5 entrances related to the managed care plan re-procurement.
6 And then we will, and this will be more of an annual, an annual
7 practice, we will revisit the quality metrics and the measurement period. We will
8 revisit the scoring methodology and how we account for achievement or
9 improvement.
10 And of course, revisit the percent-of-revenue cap on essentially on
11 an annual basis for, for the duration of, of this program, which we, which we hope
12 to, as I said, hope to continue and hope to build on not just from ‘23 to ‘24 but
13 also going forward.
14 So again I will pause there for questions.
15 CHAIR DEGHETALDI: Yes, I think we should go into this one
16 because it is so important. Jeff.
17 MEMBER RIDEOUT: Yes. Hey, Rafael, thank you for a very clear
18 presentation and thank you for this direction. I guess the general theme is
19 alignment so to what extent are the measures of the program designed, aligned
20 with say DMHC’s focus on health equity, with IHA’s program for commercial
21 provider performance, which would obviously be the next step in translation.
22 Why aren't COHS or GMC counties included? Are you benchmarking against
23 non-Medi-Cal performance? It just goes on and on and on in terms of creating a
24 great program that might be very isolated from what especially the provider
25 community is managing on the ground. And maybe those things have all been

1 considered but I would say that is a pretty big thing to discuss and figure out.

2 MR. DAVTIAN: Sure, happy, happy to address those. I am not
3 the, I am not the, I am not the best person to speak about the quality metrics
4 themselves, that would be, that would be our quality partners within, within the
5 Department. But I do know the quality metrics were selected specifically to be in
6 alignment with at least DHCS's Comprehensive Quality Strategy. There is a
7 particular focus, I think if you look at the measures there is, you know, there is a
8 particular focus on, you know, prenatal and postpartum care. There is a focus on
9 childhood preventive care, childhood wellness, and even patient experience or
10 member experience. And so all of those, all of those are intended to be, to be
11 aligned.

12 MEMBER RIDEOUT: Yes, the only thing I would say, Rafael, I
13 have been through numerous rounds of Medi-Cal and non-Medi-Cal related
14 measures and alignments and I totally get populations are different, we have got
15 to account for that. The fact that this is all happening, I really worry that we are
16 going to have yet another example where DHCS is doing something really
17 important and really good and completely isolated from the rest of the provider
18 and health plan community. It just feels like it is so far along already that the
19 ability to kind of pull it back into something, even if you have your constituents
20 defined, it is really challenging. And I don't mean to be in debate mode but, you
21 know, in the end, it comes back to the provider groups implementing this on the
22 ground to the extent these are clinical and it just, it creates a cacophony of
23 challenges for the provider and the plan community for that matter.

24 MEMBER WATANABE: Maybe if I can jump in really quickly, Jeff,
25 as it relates to the work we are doing on DMHC's Health Equity and Quality

1 Initiative. I really appreciate DHCS has been very actively involved in this
2 initiative. Because we have been very mindful from the beginning about the
3 alignment and not, not wanting to create yet another round of measures and
4 silos. I will say I did a quick check. So at this point the Committee has
5 recommended 13 measures. The Department will need to make some decisions
6 about which ones we actually adopt. But 7, 7 of the measures that are in
7 DHCS's quality metrics are included in the Committee's recommendations
8 currently.
9 I will just note, the Health Equity and Quality Initiative work that we
10 are doing will be applied to Medi-Cal managed care plans and DHCS will be
11 implementing those for the COHS plans. So I just want to make sure we are
12 thinking big picture. The work we are doing here with the Health Equity and
13 Quality Initiative will touch on some of these areas that may not be included here
14 too. But understand the challenges of really getting providers to focus on
15 addressing disparities and improving quality.
16 CHAIR DEGHETALDI: Abbi.
17 MEMBER COURSOLLE: Thank you. I wanted to first just make a
18 comment sort of picking up on one of the points that Jeff raised and just note the
19 importance of DHCS continuing to think about how to apply these types of quality
20 measures to plans, especially COHS plans, where there is not competition within
21 the county but to ensure that we are raising all boats, so to speak.
22 And then my question was somewhat answered by your last slide in
23 terms of looking at how the model will have to adapt with the model changes
24 coming in 2024. But I was wondering also if you could speak to how the quality
25 measures will apply to the Kaiser direct contract, assuming that goes forward.

1 MR. DAVTIAN: It is it is something, it is something that we, it is a
2 question that we know we need to answer but one which I don't have an answer
3 right, right now. Part of, I think part of the, you know, part of the change in 2024,
4 in addition to the actual change in programmatic landscape associated with the
5 re-procurement, Kaiser has a direct contract and then the county model changes.
6 We are also, we are also working on the implementation of regional rates no
7 sooner than January 2024 and so that is that is something we also still have to,
8 have to work through, work through quite a bit. And so we recognize it is a
9 question we will have to answer. We are definitely, definitely very, very
10 motivated to expand, expand this factor, this adjustment statewide so that it is not
11 only being applied in a subset of counties, but have further work to do to, to
12 figure out how we can do so. How we can do so in a way that still supports the
13 quality goals that we have but also is federally approvable within, within the rate-
14 setting context.
15 MEMBER COURSOLLE: Thank you.
16 CHAIR DEGHETALDI: Rafael, it is Larry. I just want to stress a
17 little what Jeff said. From the perspective of the primary care physicians caring
18 for 40 million Californians, having different quality measures based on who pays
19 for the patient is care is absolutely infuriating. So I would just encourage
20 alignment. And particularly the omission of cancer screening measures on your
21 list is very, very concerning. So again, if we are asking our providers to focus on
22 different quality measures based on who pays for the patient’s care, we have
23 failed Californians. So I just, I can't. That has been my theme for 40 years.
24 I am also concerned about whether we will be risk-adjusting across
25 a two-plan county. I’ll look at Alameda County. Scott’s Alameda Alliance may

1 care for more complex patients than the other plan in that county. And I am
2 concerned also in 2024 in the COHS counties when a Kaiser comes into a Marin
3 or a Sonoma County, whether we will risk-adjust across the two-plan models so
4 that we don't encourage cherry picking of more compliant, less complex, more
5 English-speaking patients. I am very concerned about that.
6 MR. DAVTIAN: Thank you for, thank you for sharing your
7 concerns. With regard to the quality, the concern about quality and alignment. I
8 will say alignment is definitely one of the, one of the key goals of as we, you
9 know, of the Department as we have had these, as we have had these
10 conversations. But I am happy to take that back and share your concern with,
11 with my quality, quality colleagues. And make sure, you know, continue to make
12 sure that we think about that more holistically.
13 In terms of, in terms of risk-adjustment within 2024. That I can
14 confirm with a yes, we will, we will be risk-adjusting for the, for relative
15 differences in the, in the risk or acuity of the members if there, if there is more
16 than one plan either in the county or in the region; and we may be speaking more
17 about regions going forward as we move towards regional rates.
18 CHAIR DEGHETALDI: Back to Scott.
19 MEMBER COFFIN: Larry, just to support the discussion and your
20 question. DHCS has been very responsive to concerns raised about the risk-
21 adjustment in 2024 so, Rafael, thanks to you and your team for jumping on that.
22 MR. DAVTIAN: Thank you, Scott.
23 CHAIR DEGHETALDI: Ted.
24 MEMBER MAZER: Yes, trailing also on something Larry just said.
25 As you shift in these multi-plan counties I worry about the iterative effects of

1 taking money away from some group that may not be performing as well, putting
2 the pressure on them rightly to perform better, but taking away the resources that
3 might help them do so. We saw the same thing at the beginning of even the IHA
4 incentives about bonusing improvement within a group over time. So rather than
5 shifting monies bonusing so that nobody gets hurt, might prevent what is a
6 downslide in the opposing group that is being shifted away from. Have you
7 considered what that might do over the course of a couple of years of hurting the
8 organization that you are trying to seek improvement from?
9 MR. DAVTIAN: We have, we have. It is something that we, it is
10 something that we intend to closely, to closely monitor to, to avoid, avoid that sort
11 of unintended, negative, self-fulfilling prophecy, if you will. We have taken steps
12 in in our current implementation approach to, a few steps in our current
13 implementation approach to try to mitigate that however. First, in terms of
14 casting, casting a somewhat wide net in terms of, in terms of the metrics that we
15 are, we are considering so that, you know, a plan's results are not hinging just on
16 one or two, one or two, one or two measures. But also really in terms of looking
17 at imposing that hard cap on the percent of, percent impact to any particular plan,
18 within, within a rating period so that we can, we can limit, we can limit both the
19 negative and positive impacts and ensure, and ensure that we are, you know, we
20 are able to keep our finger on the pulse as this program continues to evolve.
21 Because we do expect 2024 really to be a significant evolution in terms of both
22 expanded in terms of all the changes we have discussed as well as the
23 expanded scope, scope statewide. But to your, to your fundamental concern.
24 Yes, it is something we are, it is something we have considered that we will
25 continue to monitor and we will continue to take steps to mitigate.

1 CHAIR DEGHETALDI: Jeff, then.

2 MEMBER RIDEOUT: I'm sorry, Larry, are you calling me?

3 CHAIR DEGHETALDI: Yes, your hand is up.

4 MEMBER RIDEOUT: Yes, just, Rafael, just an open offer. Twenty
5 years of materials on incentive design measures, quarterly approval by providers
6 and plans in the industry at your disposal. And would also, if you haven't
7 reviewed it, I participated in a CHCF-funded exercise about a year and a half ago
8 that was heavily dominated by those that are more directly involved in Medi-Cal
9 that defined set of measures and incentive design. The maintenance insurance
10 so that people have the funding to maintain high performance, upside incentives
11 so that people have the funding to improve as opposed to just be penalized. So I
12 am assuming that the workgroups have looked at all of that, or I'd like to assume
13 that, but if you haven't I think it is not about IHA or CHCF, it is about what the
14 industry has already plowed through at great length and great time commitment
15 that may be informative about what people think will work if it is not included
16 already.

17 MR. DAVTIAN: Thank you, Jeff. And I will be sure to convey your
18 offer to our quality officer.

19 CHAIR DEGHETALDI: And Paul.

20 MEMBER DURR: Yes. So Rafael, just following up on the risk-
21 adjustment and I think that is definitely very important as we move forward. I
22 think we also need to consider the ability of some of these smaller groups to be
23 able to capture that risk-adjustment data and appropriately account for that,
24 something that we really need to consider.

25 I would also echo Larry's point about ensuring the alignment of

1 those quality metrics with other programs that are out there, commercial plans.
2 Because to Larry's point, the bane of our physicians is the fact that we are
3 answering to different metrics for different; even if the metric is the same it could
4 be the thresholds are different and all of that. So really alignment with IHA would
5 be helpful. As well as really making sure that we have the ability and we are
6 educating the providers on what risk-adjustment data needs to be captured.
7 Because if this is going to go live in '24 I would imagine you are going to be
8 looking at that data capture and how that information is coming across to you.
9 Well thought out but just making sure that we have the tools in place and the
10 providers have the tools in place to get that information to you.
11 CHAIR DEGHETALDI: Thank you, Paul. And just to, I am going to
12 highlight what Jeff said. Rafael, we will improve the quality scores for the 14
13 million Californians on Medi-Cal if all plans reported into IHA. If all providers that
14 are already working with IHA could use the same methodology the scores will go
15 up because we will have better data. So again, to the extent that we can
16 encourage our Medi-Cal plans to piggyback onto IHA's, what Jeff, 25 years of
17 success, I think that would improve the quality scores for all Californians. Jeff,
18 that was sort of if you want to follow up on that.
19 MEMBER RIDEOUT: Look, it is again, I'd say it is not about IHA, it
20 is about the experience. And it is not even about getting the data; we have been
21 through that, you know, for five years now. It is really about the design features
22 so that the people that are delivering care and the people that are paying for care
23 understand what they are incented to do and that they are not trying to figure that
24 out as they go. So it really, we don't even have to be in the equation as an
25 organization, it is just about the alignment more than anything else.

1 CHAIR DEGHETALDI: And Rafael, one last point. Two of our
2 COHS span urban and rural areas and I know for a fact that the urban counties
3 within those COHS, the quality scores are vastly superior to in the rural areas.
4 And it is not that the rural providers are lower quality, it is just access in our rural
5 communities is so much worse. I just hope that we don't penalize the parts of
6 partnership or CCH that are focusing on rural communities.
7 MR. DAVTIAN: It is some, I think it is something we will, we will
8 make sure to consider as we, as we look to expand for 2024. We have --
9 effectively, but we haven't had to cross that bridge yet because we are currently
10 only implementing in the counties with two plans. But it is something I will make,
11 it is something we will be sure to consider, that urban/rural distinction as we, as
12 we look at the statewide expansion.
13 And then with regard to the to the alignment of quality measures. I
14 mean, I will note that the quality measures that were selected are measures to
15 which are -- on which our plans are currently being measured and to which they
16 are currently being held. But again, will definitely take back the, take back your
17 feedback and concerns related to a broader alignment to our, to my quality
18 colleagues.
19 CHAIR DEGHETALDI: Back to Jeff.
20 MEMBER RIDEOUT: One very last comment. The measures are
21 critical and alignment on the measures is critical. But I think what you are
22 hearing from a number of us is the alignment on design, on incentive, on
23 benchmarking, all of that is just as critical. And in the work that we did several
24 years ago, when we did have some Medi-Cal results it is clear there is lots of
25 variation within different types of Medi-Cal models. So inclusion of COHS,

1 inclusions of GM, inclusion of rural/non-rural, as well as two-county, or in LA
2 County where you have multiple plans participating as subcontractors, all that
3 becomes sort of the soup that determines whether people know what they need
4 to be improving on and whether they feel comfortable doing that. So I would just
5 encourage you to think less about measure alignment and more about sort of
6 program design alignment, because those are the features that people respond
7 to as well.
8 CHAIR DEGHETALDI: Thank you. And I will go, Jordan, we will
9 open it up with just one last comment, Rafael. The nirvana for the 40 million
10 Californians is that we would have the same benchmarks, the same targets
11 irrespective of who pays for your care, where you live, and your disability, race,
12 SOGI status. So someday we will have the same benchmarks irrespective of
13 who you are and where you live.
14 Jordan, any comments from the public, questions?
15 MR. STOUT: Hearing none at this time.
16 CHAIR DEGHETALDI: Okay, Long-term care.
17 MR. DAVTIAN: All right, long-term care. So currently our Medi-Cal
18 managed care plans cover long-term care in 27 counties, the 22 COHS counties
19 and the 7 CCI counties; and there is an overlap, of course, between, between --
20 in that two of the COHS counties are also CCI counties.
21 Outside of the COHS and CCI models, managed care plans cover
22 long-term care only for the month of admission and the subsequent month, after
23 which the, after which the member is dis-enrolled to the fee-for-service delivery
24 system.
25 So as a part of, as a part of CalAIM, of course, the long-term care

1 benefit is being carved in and standardized, carved into managed care and
2 standardized statewide. Starting January 2023 plans will cover skilled nursing
3 facility services across all, across all counties.
4 And as of July 1, 2023, all other institutional long-term care will be,
5 will be carved into managed care.
6 The state law, the state law that implements or requires the carving,
7 authorizes the carving, also establishes specific reimbursement requirements for
8 plans and providers. In particular, requiring plans to pay network providers of
9 long-term care services and for those providers to accept the payment amount
10 they would have received under the fee-for-service delivery system from the date
11 of the carve-in to or through December 31, 2025, so really a three year, a three
12 year transitional period. It serves as a protection for both, for both long-term care
13 facilities as well as for managed care plans and more broadly for the state to --
14 more broadly for the state and for our members to ensure first that there is a,
15 there is a preservation of payments, payment levels and payments through the
16 transition. And second, really to try to ensure, try to ensure -- try to avoid access
17 disruptions for our members as part of the transition. So, if we could go to the
18 next slide.
19 After the carve-in or post the carve-in the payments that plans will
20 be required to make are really twofold. So for the applicable services in the
21 transitioning counties, plans will be required to pay the fee-for-service per diem
22 rate and an additional supplemental, supplemental payment rate for Distinct part
23 Nursing Facilities in order to reflect or in order to equal what those facilities would
24 have received under the fee-for-service delivery system.
25 In addition, under the nursing facility financing reform initiatives,

1 there will be a new performance-based directed payment for network providers
2 for SNFs, for skilled nursing facilities specifically, who contract with, who contract
3 with managed care plans to provide additional, additional supplemental
4 reimbursement tied to, tied to performance. Details of that program are still, still
5 being, still being worked through but we do, we do intend to have or continue,
6 continue stakeholder engagement. I should say, dive deeper into engagement
7 with affected stakeholders both plans and, plans and providers, as well as, as
8 well as publish guidance for both plans and providers related to these programs.
9 From a, from a plan perspective specifically we will be establishing
10 new rating categories for long-term care members. Or more specifically, for
11 members in long-term care aid codes so that we can, we can pay a long-term
12 care rate to our managed care plans. this exists today in the COHS and CCI
13 counties, we are just expanding the principle statewide.
14 And then for individuals who are residents of long-term care but not
15 necessarily in a long-term care aid code, we will, we will ensure that we are
16 accounting for those costs and including that funding through within whatever
17 rating category the member does fall into. Typically it will be our seniors and
18 persons with disabilities or SPD, SPD category.
19 We will be ensuring that our payments to the plans reflect, reflect
20 the appropriate funding levels corresponding to the state-directed payments
21 corresponding to all of the required direct payments, to all of the required
22 payment levels.
23 And then just as a point of, and as a point of note really separate
24 from the directed payment conversation but tied to our efforts around long-term
25 care more generally, we will be implementing for our COHS counties a blended

1 payment rate for the long-term care and seniors and persons with disabilities
2 rating categories starting in 2023. Essentially with the intention of enabling,
3 enabling and incentivizing our managed care plans in the COHS counties to
4 explore or explore or pursue avenues to support transitions to community-based
5 care when, when appropriate and when in the member's best interest.
6 CHAIR DEGHETALDI: Any questions? Rafael, that last point is
7 heroic. That is, let's not incentivize patients to be institutionalized if we can
8 spend additional dollars supporting them to be at home. That is super, super
9 important so thank you for that. Any other questions there or questions from the
10 public, Jordan?
11 Then let's go. I think this is your last topic. I hope you are still, you
12 are still hanging on.
13 MR. DAVTIAN: Still going. All right. And then finally, our major
14 organ transplant carve-in. Somewhat of a similar situation to long-term care in
15 that we, the Department identified us as part of CalAIM that there was a lack of
16 consistency, a lack of alignment across our delivery system in that in the benefit
17 structures within certain counties compared to other counties. So as part of
18 CalAIM MOT was carved into the managed care delivery system statewide,
19 whereas previously it had only been -- it had been covered fully in COHS
20 counties and elsewhere only kidney and corneal transplants were covered by our
21 plans. Starting January of this year that coverage has been expanded statewide.
22 Again, the authorizing state statute does impose a payment
23 obligation associated with, with the carve-in and the transition from fee-for-
24 service to manage care. Obligating plans to pay providers and for providers to
25 accept what the provider would have otherwise received in the fee-for-service

1 delivery system.

2 We have implemented this requirement as a, as a state directed

3 payment in the, in in those transitioning counties covering the costs of the

4 transplant event. What we have defined as the organ acquisition, the transplant

5 surgery and the associated, the associated post-surgery and patient stay.

6 The reimbursement rates that apply, the fee-for-service equivalent

7 reimbursement rates that apply essentially follow a dichotomy. For private

8 hospitals plans have to follow the instructions within the Provider Manual,

9 essentially they are reimbursing APR DRG.

10 For public hospitals, plans are required to reimburse a case rate

11 that has been, has been developed by DHCS using public hospital data that,

12 essentially that pays, that pays the public hospitals what they would have

13 otherwise received under the historical fee-for-service certified public

14 expenditures methodology. That fee schedule is specific to each UC facility and

15 it is specific to and it is broken out by adult and pediatric transplants and also

16 broken out by transplant type, recognizing the wide ranging costs or the wide

17 differences in costs, sometimes between facilities but especially between

18 different transplant types. Obviously, a kidney transplant, the cost of a heart

19 transplant is very different from the cost of say, a kidney transplant or a bone

20 marrow transplant.

21 For the fee schedule, for the case rates that we have developed we

22 have broken it out into three components. There is a case rate for the organ

23 acquisition, there is a case rate for the transplant surgery and the inpatient stay

24 up to up to an average or specified duration, and then recognizing that there are

25 sometimes outliers. Major organ transplants in general are pretty, pretty volatile

1 as a service in terms of, in terms of cost and utilization patterns. We have also
2 implemented a per diem rate for outlier inpatient stays beyond a particular
3 duration.
4 We had shared the draft fee schedule early, early last month and
5 we will be sharing a final fee schedule this month to -- this month with all of our
6 plan and hospital partners to make that known.
7 We are also continuing to pursue federal approval of this
8 arrangement but have been, have been engaging our partners at CMS closely
9 since before, before the start of the, start of the year.
10 Finally, recognizing the volatile nature of the major organ transplant
11 benefit we did implement a two-sided, symmetrical risk corridor for, for this
12 benefit for the calendar year ‘22 rating period. We are currently having
13 conversations about, about ’23 but it is in place for ‘22.
14 This risk corridor applies to the costs and revenue subject to the
15 directed payment requirement and is centered on, centered on 100% of the gross
16 medical expense component of the plan rates. So essentially we are looking at
17 the medical expense component of the rates, what the plans are funded for, for
18 MOT, for the MOT carve-in, and then building a risk band of ±5% in both
19 directions. Anything below that risk band, anything below that 5% or anything
20 above that 5% is, is not at risk effectively.
21 And we have shared details of the, of the risk corridor with our, with
22 our managed care plan partners in December of last year but will be, will be
23 having further conversations really starting early, early next year after, after we
24 expect to have federal approval of the, of the directed payment arrangement.
25 And that is it.

1 CHAIR DEGHETALDI: Any questions on transplants from the
2 Board?
3 MEMBER RIDEOUT: I had a general question unrelated to that.
4 CHAIR DEGHETALDI: Yes.
5 MEMBER RIDEOUT: Rafael, does the Inflation Reduction Act
6 CMS negotiation with pharmaceutical manufacturers, does that in any way affect
7 the state's carve-out pharmacy provision by Magellan? I don't know that it would
8 but I am just wondering if the feds are doing anything on the Medicaid side.
9 MR. DAVTIAN: I am not, I am not, I am not aware of an impact but
10 it is it is kind of, as it is kind of ongoing or ongoing or new legislation it is
11 something that we are, that the Department is looking at so I wouldn't be able to
12 comment until after we had.
13 CHAIR DEGHETALDI: Any other questions?
14 Rafael, I was a little confused on where we are going to end up with
15 the UC fee schedule for transplants? If I am a member in LA, Cedars and UCLA
16 may offer the kidney transplant. Will there be different rates of pay for two
17 institutions that are that close?
18 MR. DAVTIAN: There will, there will. The state statute requires,
19 requires that the payment to the, to the hospital be what they would have
20 otherwise received in fee-for-service and the fee-for-service methodologies for
21 private and public hospitals are different. So the payment, the payment level
22 really is linked to the facility providing the transplant.
23 CHAIR DEGHETALDI: Okay. And Jordan, any questions from the
24 public on this topic or on all of Rafael's presentation?
25 MR. STOUT: There are none at this time.

1 CHAIR DEGHETALDI: Okay, wow. That was heroic. Again I will
2 use that word again for you so thank you.
3 And let me go back and, Jordan, ask if any members of the public
4 have questions on Mary's Director's comments from the topic before Rafael?
5 MR. STOUT: Seeing no hands.
6 CHAIR DEGHETALDI: Great. Then now we are going to go to
7 Dan and so thank you, Rafael.
8 MR. SOUTHARD: Thank you, Larry. Good morning. My name is
9 Dan Southard and I am the Chief Deputy Director at the DMHC. Today I will
10 provide you with a brief overview of the DMHC's fiscal year 2022-2023 budget.
11 In 2021-2022 the DMHC's budget was a little over $103 million,
12 with 516 authorized positions.
13 From fiscal year 2021-2022 to the current fiscal year of 2022-23 the
14 DMHC's budget increased by $22 million, to a total of $125 million dollars and
15 the authorized positions increased by 94 positions to a total of 610.
16 This chart shows the DMHC's continued growth in funding and
17 position authority over the last five fiscal years. Since fiscal year 2018-19 the
18 DMHC's funding has increased by 51% and the position authority has increased
19 by 35%. Next slide, please. Thank you.
20 The DMHC received approval for six legislative BCPs in the current
21 budget.
22 The first BCP was to address workload associated with AB 347,
23 which requires health plans to expeditiously grant requests for step therapy
24 exceptions if the requests meet certain criteria. To address this workload we
25 were provided with 12 full time positions and, excuse me, $3,020,000 on an

1 ongoing basis.

2 For AB 457, which requires health plans to file reports with the

3 DMHC regarding the utilization of corporate telehealth services and requires

4 health plans to ensure that corporate telehealth providers send patient records to

5 the enrollees' primary care providers. And it also added Section 1374.141 to the

6 Health and Safety Code that requires players to provide disclosures to enrollees

7 on the availability of receiving services, and also their right to access their

8 records. to address this workload we are approved for three additional positions

9 and $614,000 ongoing.

10 The next BCP was related to SB 221 which placed some of the

11 previous DMHC timely access standards adopted in the regulation into the

12 Health and Safety Code. The main addition in SB 221 requires health plans as

13 of July 1, 2022 to ensure that its contracted provider network can offer non-

14 urgent follow up appointments with a non-physician mental health care or

15 substance use disorder provider within 10 business days of the prior

16 appointment, or longer if the treating provider determines a longer wait time will

17 not have a detrimental impact on the health of the enrollee. To address that

18 workload we were given 19 positions and $4,241,000 ongoing.

19 The next BCP was related to SB 255, which allows an association

20 of employers, also known as Association Health Plans, or Multiple employer

21 Welfare Arrangements or MEWAs, to offer a large group health plan contract if

22 certain conditions are met. And we receive one position and a total of $229,000

23 to address that workload.

24 The next one is SB 368, which requires health plans to provide

25 enrollees with an accrual balance toward their annual deductible and their out-of-

1 pocket maximum for every month in which benefits were used, until the accrual
2 balance equals the full deductible or out-of-pocket maximum amount. It also
3 requires them to establish and maintain a system capable of allowing an enrollee
4 to request their most up to date accrual balance and require accrual balances to
5 be mailed to the enrollee unless the enrollee elects to opt out of a mail notice and
6 elects to receive the accrual update electronically. To address this workload we
7 received two full time positions and $456,000.
8 And the last legislative BCP was related to SB 718, which is similar
9 to SB 255. SB 718 allows them association or employers, also known as
10 Association Health Plans or MEWAs, to offer a large group health plan contract
11 to employer members in the biomedical industry if certain conditions are met.
12 We received $301,000 for '26-27 fiscal years to address that workload.
13 In addition to the legislative BCPs we put forth five workload BCPs
14 and this is to address the increased workload that we have seen as a result of an
15 increase in the growth in the number of licensed health plans enrollees under the
16 DMHC's jurisdiction. The DMHC received approval for these five workload
17 BCPs.
18 The first being the Office of Plan Monitoring. So we needed
19 additional positions to perform our medical surveys and review health plan
20 networks at the time of the filing by a health plan or through our annual network
21 review or timely access processes. We received 11 positions and $3,165,000 to
22 address that work.
23 The next is workload related to the Help Center. We have seen a
24 moderate increase in the number of complaints and IMR requests from
25 consumers and to address that workload we received 21 positions and

1 $3,412,000.

2 The third workload BCP was related to our Office of Plan Licensing

3 workload and that is to address changing control or merger filings. And we

4 received three positions and $834,000 to address that workload.

5 And the final internal workload BCP was related to our

6 administrative support services. This was gaining positions, 12 total, and

7 $2,224,000 to support from an administrative perspective and our IT perspective

8 all the positions throughout the Department.

9 And the final workload BCP was related to AB 290, which was

10 signed into law in 2019 and requires health plans to accept premium payments

11 from a limited number of third party entities. In addition, AB 290 requires the plan

12 to establish an independent dispute resolution process. The DMHC has not yet

13 implemented the requirements of AB 290 as the bill is currently in litigation. The

14 DMHC requested resources for fiscal year ‘22-23 and ‘23-24. In the event the

15 litigation is resolved the DMHC will have the resources to implement the bill’s

16 requirements. And the resources we received there were $782,000 for fiscal

17 year ‘22-23 and $750,000 for fiscal year ’23-24.

18 And that concludes my overview of the DMHC’s fiscal year ‘22-23

19 budget. More than happy to address any questions.

20 CHAIR DEGHETALDI: Any hands? Paul.

21 MEMBER DURR: Yes. Dan, nice overview. My question is, I

22 know there is a lot of budgeted positions there. How is the Department doing

23 from a staffing perspective to be able to recruit for those people and retain

24 people?

25 MR. SOUTHARD: Yes, I think that is a challenge throughout all of

1 our departments. I think just in the economic situation we are in we have seen a
2 decrease in the number of applications to our vacant positions. I think it is more
3 impactful in some classifications than others but it is a challenge and we are
4 working with HR to be innovative in the way that we advertise, recruit staff and
5 then retain staff as well.
6 CHAIR DEGHETALDI: Jeff.
7 MEMBER RIDEOUT: Dan, good to see you. Much of what you are
8 now charged to do requires pretty major IT or operational shifts within the
9 organizations you regulate. How do those positions that you are filling ensure
10 that that actually is happening as opposed to kind of seeing if it does or doesn't
11 happen, if you know what I mean?
12 MR. SOUTHARD: Can you repeat that, Jeff, because I am a little
13 confused with your saying we have to oversee the plans' IT systems.
14 MEMBER RIDEOUT: Well, a lot of what is required, like just take
15 the deductible accounting, for instance. That could require a whole new system,
16 a change in an existing system to produce it. It is long overdue and it is
17 absolutely necessary but that is not something that DMHC itself will control. So
18 are the kinds of people that you are hiring for that kind of oversight skilled in that
19 or is that an expectation you have when you hire them? I am just trying to get
20 some sense of how you change operations within those that you regulate.
21 MR. SOUTHARD: Sure. Yes, if we don't have the classifications
22 and expertise within the Department as part of these BCPs we request consulting
23 funding. And so we use consultants regularly in our medical survey work and so
24 that is how we would address any lack of internal staff abilities.
25 MEMBER WATANABE: And maybe I will just jump in and say, Jeff,

1 part of how we monitor health plan compliance is through our Help Center and
2 consumer complaints. So on the out-of-pocket requirements, if we were to get a
3 help Center complaint that a plan wasn't appropriately applying that or reporting
4 where the consumers had met their deductible; that could lead to us investigating
5 and looking into how the plan is complying. A lot of our role as a regulator is the
6 plans file their policies and procedures and tell us how they are complying. We
7 don't necessarily get into the details and the documentation around their
8 systems.
9 But when we go out on our medical surveys every three years part
10 of what we look at is, okay, you told us you were doing this, but how did you
11 actually operationalize that. And so through our medical surveys we can look in
12 more detail about how they have actually implemented it. But those consumer
13 Help Center complaints really kind of tell us where there may have may be a
14 problem for us to look into further. We can do non-routine surveys when we see
15 that there is a trend or a pattern in noncompliance as well. So we don't
16 necessarily, those classifications that are tied to this are not IT positions to go
17 look at systems, it is really more compliance in the operationalization of the
18 requirements.
19 MEMBER RIDEOUT: Thank you.
20 CHAIR DEGHETALDI: Excellent. Any other questions or
21 questions from the public?
22 And now then we turn to Sarah.
23 MS. REAM: Good morning. I am going to be giving an update on
24 Senate Bill 510, the lawsuit that was filed by the California Association of Health
25 Plans. Next slide, please.

1 Before I get into the lawsuit itself, though, let me just refresh your
2 recollection about what SB 510 does. So it was enacted last year by Senator
3 Pan and it requires health plans to cover COVID-19 testing and vaccination
4 administration, I am going to refer to those collectively as COVID-19 services,
5 retroactively to the beginning of the pandemic. It is important to note that even
6 without SB 510 plans under federal law and existing state law have to cover
7 COVID-19 testing and vaccine administration. But SB 510 clarifies that plans
8 must do so without cost-sharing or utilization management. Federal Law, the
9 CARES Act, also to a large extent requires that as well. And plans cannot
10 require enrollees to go in-network to receive those services; enrollees can go to
11 any willing provider where they can get the services.
12 Importantly for the lawsuit, the purposes of my discussion of the
13 lawsuit, SB 510 also states that the financial risk for COVID-19 services remains
14 with the plans unless the plan and the provider have agreed that those services
15 will be the financial responsibility of the provider. So if the plan and provider
16 have a DOFR, a previously existing DOFR that delegates financial risk for
17 diagnostic testing generally, vaccine administration generally, that DOFR does
18 not capture COVID-19 services unless the plan and the provider, again, have
19 specifically negotiated and agreed that that risk will shift to the provider.
20 So that brings me to the pending lawsuit. Next. Thank you. So
21 this was filed by CAHP in 2021, last fall. And it challenged, it is actually a very
22 narrow challenge. It challenges the retroactive or the pre-2022 application of that
23 financial delegation piece. It does not challenge, so CAHP is not challenging the
24 health plans' obligations to cover COVID-19 services for enrollees. There is no,
25 there is no argument there that those services need to be covered for enrollees.

1 Really what this comes down to is CAHP arguing that the SB 510 improperly
2 stepped into the role between or the relationship between the providers and the
3 plans. Next slide please.
4 So status of the lawsuit. In June of this year, so just a couple of
5 months ago, Americans Physician Groups intervened, APG intervened in the
6 action, which makes sense because their members are directly impacted by the
7 outcome of this case.
8 The court -- so CAHP asked for, initially asked for a temporary
9 restraining order to prevent the DMHC from enforcing that portion of SB 510 that
10 CAHP is challenging. The court denied the temporary restraining order but
11 actually did grant a preliminary injunction in this last June. So what the injunction
12 does is it prohibits, at least for now, the DMHC from enforcing that portion of SB
13 510 that would require plans to go back and reimburse or make providers whole
14 for COVID-19 testing that was done prior to January 1st of 2022. January 1st of
15 2022 is the date that the bill took effect so in essence CAHP is saying you cannot
16 retroactively enforce that portion of the bill. We are currently in discovery in this
17 action and there is a trial scheduled for January to start in January of 2023. And
18 we will certainly keep you posted as this case evolves. And with that, happy to
19 take questions.
20 CHAIR DEGHETALDI: Any questions from the Board?
21 Has anybody quantified, Sarah, the dollars spent prior to January 1,
22 2022?
23 MS. REAM: I am sure they have. I don't have those numbers at
24 my fingertips right now.
25 CHAIR DEGHETALDI: Okay, great. Jordan, any questions from

1 the public?

2 MR. STOUT: There are none at this time.

3 CHAIR DEGHETALDI: Paul.

4 MEMBER DURR: Yes, sorry, Larry, for the late question. Sarah, I

5 think this is a lesson and I would encourage the department to think about what

6 has transpired with regards to COVID-19 in light of other viruses that are coming

7 up, monkey pox and other things. That we can learn on being real clear about

8 the delegation of risk and what that entails and making sure the regulations kind

9 of follow suit in an orderly fashion and maybe can be more broadly interpreted as

10 much as possible.

11 MS. REAM: Great, thank you for that.

12 CHAIR DEGHETALDI: Jeff.

13 MEMBER RIDEOUT: Picking up on what Paul noted. I think the

14 devil is in the DOFR details, having lived in that world for a little while. And to the

15 extent that vaccinations are named but not specified to the type of vaccination,

16 there is still going to be a debate. You can go down the road with drugs, you

17 know, Hep C treatments. While pharmaceuticals may be delegated or even

18 certain types or categories, but is a whole new class of drug included or not? I

19 sympathize with both the plan and the provider community and DMHC on this but

20 I think it is really, really hard to anticipate this kind of thing and I think people will

21 still dispute it. And then you have got the element of time here where yes, you

22 can't do this retroactively but there was a huge expense that fell on both the plan

23 and the provider community that nobody anticipated so what is fair in terms of

24 dealing with that year before it became regulated? So yes, anticipate away but I

25 think it is always going to be a sort of dispute. And that is one reason why I kind

1 of got out of the DOFR business because you can get theoretical, but once it
2 gets down to what is specified and what is the actual money being transferred
3 between different organizations it gets very, very testy sometimes, I would say.
4 MS. REAM: Agreed.
5 CHAIR DEGHETALDI: Sarah, I would just observe, I think that
6 RBOs are probably more concerned about the impact on testing, and many of
7 those tests came in at very high gross charging, rather than the vaccination.
8 That is an area that I think a lot of the medical groups are still smarting from.
9 MS. REAM: Thank you for that.
10 CHAIR DEGHETALDI: Okay. Then we have -- there are some big
11 numbers in the MLR. Suddenly the MLR is back in the news.
12 MS. DUTT: Good morning. I will provide you an overview of the
13 2021 annual federal medical loss ratio, or as we call it, MLR reports that was due
14 from health plans on July 31, 2022. So on July 31 we received the 2021 Federal
15 MLR results. For the details related to this presentation please refer to the
16 Federal Medical Loss Ratio Summary for Reporting Year 2021 report that was
17 included with the meeting handouts.
18 Federal laws require health plans that sell health care products
19 directly to enrollees and employer groups to spend a certain percentage of their
20 premium dollars on health care or medical expenses. The medical loss ratio
21 requirement went into effect for reporting year 2011 so we have been receiving
22 reports since 2011. Health plans in the small group market and individual market
23 have to spend 80% of their premium on medical services; and for plans in the
24 large group market the requirement is 85%. If the plans fail to meet this
25 requirement they have to pay a rebate to their enrollees or employer groups. For

1 rebate purposes, MLR is based on a three year average. For the reporting 2021
2 the MLR and rebate calculation was based on the average health plan premiums
3 and medical expenses for 2019, 2020 and 2021.
4 Page 2 of the detailed report shows the MLR for the plans in the
5 individual market. As I mentioned earlier, the Federal MLR reporting requirement
6 for the individual market is 80%. The MLR for the 12 plans in the individual
7 market range from 81.7% to 99.9%. So all plans met the 80% requirement and
8 no rebates were paid.
9 For the 2020 Federal MLR reporting year we had the same 12
10 plans in the individual market and the MLR ranged from 77.8% to 95.6%. In last
11 year's presentation we saw that two health plans had paid MLR for the 2020
12 reporting year. It was LA Care paid $9.7 million and Molina paid $3.4 million.
13 Page 3 of the report shows the MLR for health plans in the small
14 group market. For the small group market the MLR requirement is 80%. We
15 have 13 plans in the small group market and the MLR ranged from 77.3% to
16 96.6%. Three plans, Anthem Blue Cross, Health Net and united Healthcare
17 Benefits plan paid rebates for 2021 reporting year. Anthem paid $75.9 million,
18 Health Net paid $9.1 million and United Healthcare Benefits Plan paid $10.4
19 million.
20 For reporting year 2020 there were 13 plans in the small group
21 market, and MLR ranged from 77% to 102.4%. Only two plans reported MLR
22 below 80% and paid rebates totaling $80.2 million. Anthem paid rebate of $66.7
23 million and Health Net paid rebate of $13.5 million.
24 The table on the next page, or page 4, shows the MLR for full
25 service plans in the large group market. There were 22 health plans that offered

1 products in the large group market. All of them met the MLR requirement of
2 85%, which means they spent 85% of their premiums on providing health care to
3 enrollees. The MLR ranged from 86% to 111.8%. All plans met the MLR
4 requirement and no rebate was required.
5 In 2020, the MLR in the large group market for full service plans
6 ranged from 85.4% to 115.2% and again no rebate was paid for the 2020
7 reporting year.
8 Table 4 for on page 5 shows the MLR for the four specialized plan
9 subject to federal MLR reporting requirement for their large group products. Two
10 plans reported MLR below 85% and paid rebates totaling $1.9 million.
11 OptumHealth Behavioral Solutions of California reported an MLR of 70.4% and
12 paid rebates of $1.8 million. OptumHealth Physical Health of California, which is
13 a chiropractic plan, reported an MLR of 81.1% and paid rebate of $101,000.
14 For the 2020 Federal MLR reporting year we had the same four
15 specialized plans and the MLR ranged from 65.8% to 89.8% so we saw an
16 increase in MLR for the current report that we are looking at for 2021. The two
17 health plans for 2021 that reported MLR below 85% were Holman and they paid
18 rebates of $20,000 and OptumHealth Behavioral that paid rebate of $2.4 million.
19 This chart here shows the total rebates paid by year since 2011.
20 Health plans have paid $656 million in rebates over the last 11 years. For
21 reporting 2021 the health plans paid total rebates of $97.4 million.
22 The health plans have to issue the rebate checks by September 30,
23 2022 and the rebates may be issued in a number of ways. Enrollees may
24 receive a rebate check in the mail, a deposit paid into the account used to pay
25 their premium, or a direct reduction in future premiums.

1 Currently the DMHC is reviewing the 2023 individual and small
2 group rates, as Mary had mentioned earlier. The MLR information will be
3 reviewed closely as we review the health plans' proposed rate increases and the
4 justifications for those increases. So we are looking at the rates, we are looking
5 at comparing the MLR results that we just received from the plans. At the next
6 meeting we will present the 2023 individual rates as well as the risk adjustment
7 transfer for benefit year 2021.
8 With that I will take any questions.
9 CHAIR DEGHETALDI: Any questions from the Board?
10 Pritika, both Health Net and Anthem two years in a row have had
11 fairly substantial rebates. Will that impact the rates that they are approved going
12 forward for the, I think it is in the small group market?
13 MS. DUTT: Larry, that is a good question. So we are -- like I said,
14 we received the MLR reports last week so the actuaries are currently reviewing
15 the information. We are sending additional questions to both Blue Cross and
16 Health Net on their rebates and their MLR projections for 2023.
17 CHAIR DEGHETALDI: Do the rebates get back to the consumer or
18 does it go to the employer? I don't quite understand what happens with those
19 rebates, whether those that were essentially overcharged or made whole. I don't
20 understand.
21 MS. DUTT: That is a good question. It goes to whoever paid the
22 premium.
23 CHAIR DEGHETALDI: But there is out-of-pocket that an employee
24 might have not enjoyed but been overcharged, the opposite of enjoyed. I don't
25 know how it flows.

1 MS. DUTT: Right. So if the enrollee is paying a certain percentage
2 of the premium then it will go down to the enrollee from the employer group. So
3 the employer will receive the premium and then they will pass down a certain
4 amount to the enrollee.
5 CHAIR DEGHETALDI: Jeff.
6 MEMBER RIDEOUT: I think given what we talked about in terms of
7 whether plans can keep track of deductibles it is highly unlikely that anything that
8 was applied to a deductible would get rebated, that is just my guess. And
9 percent of premium options are not that common so my guess is a lot of these
10 rebates stay with the plan, not the consumer. But that is just a guess, from what
11 I am hearing.
12 CHAIR DEGHETALDI: Paul.
13 MEMBER DURR: Yes, my question was following along Jeff's line
14 of thought. Is any audit done to the plans to show that the rebates are passed
15 down appropriately to the consumer?
16 MS. DUTT: We do audits on the MLR reporting itself so we do a
17 few exams every year on the health plan reporting but we do not do audits on the
18 rebate payment itself. We have had meetings with CMS to make sure that the
19 rebates are passed down to enrollees. There are times that those checks are
20 escheated so we have had some conversations with CMS to make sure that the
21 rebates do go down to the enrollees and the employer groups.
22 CHAIR DEGHETALDI: And Ted.
23 MEMBER MAZER: Yes, I guess just to pile-on on the deductible
24 question. I don't think there is anything in statute that requires it to go to anybody
25 but the payer of the premium and perhaps that is something that should be

1 looked at if there is a way of tracking it. The other side of that coin is, deductibles
2 are recorded but they are not always paid by the individual so in some cases it
3 might not be correct to send the portion of rebate back down to the individual. I
4 am not sure there is a clear way of doing that but without statutory requirement I
5 think it is a moot question.
6 MS. DUTT: The rebate is not for deductibles. It will be for the
7 premium payment itself, not for the deductible and copays. Those out-of-pockets
8 do not get counted for rebate payment purposes.
9 CHAIR DEGHETALDI: Any other questions from the Board?
10 Or Jordan, from the public?
11 MR. STOUT: There is none at this time.
12 CHAIR DEGHETALDI: Excellent. Then we go to Michelle.
13 MS. YAMANAKA: Hi; thank you, Larry. Today I am going to give
14 an update on the risk-bearing organization or RBO reporting for the quarter
15 ended March 31, 2022.
16 We have 207 RBOs that reported for this quarter. This is a net
17 decrease of one RBO from the previous reporting period. There was one new
18 RBO that began reporting and 2 RBOs that went inactive for that net decrease.
19 We received 191 annual survey reports for the fiscal year ended
20 2021. There are 10 RBOs that are on our non-filer list and we have escalated
21 the non-filer list to our Office of Enforcement for administrative action.
22 We also receive monthly financial statements from RBOs as
23 required of their CAP. As of March 31 there were 8 RBOs on that monthly filing
24 requirement. And we also have 18 RBOs on Corrective Action Plans, or CAPs,
25 which I will present the additional details in an upcoming slide.

1 There are 123 RBO accounts that have been inactivated for various
2 reasons and these reasons are captured through either Financial Concerns, No
3 Financial Concerns or an Other reason. For the quarter ended March 31 I
4 mentioned that there were two RBOs that went inactive and those two RBOs
5 were captured in our No Financial Concerns category, which reflects they were
6 compliant at all times with the grading criteria previous to March 31.
7 We also look at the enrollment assigned to those RBOs. For the
8 two RBOs that went inactive, one was captured in our 0-5,000 category, one was
9 captured in our 30-70,000 category.
10 Moving on to the status of RBOs. There we go, thank you. For the
11 quarter ended March 31, 2022, the last column on this table reflects that there
12 are 189 RBOs or 91% of the RBOs that were compliant with all grading criteria;
13 18 RBOs were non-compliant or were on a corrective action plan.
14 In the Compliant category, within that 189 there were 16 RBOs on
15 our monitor closely list, which we are watching and will be reviewing those as our
16 next filings come in. There are 18 RBOs on CAPs and 4 of these RBOs have 2
17 corrective action plans; so a total of 22 CAPs that we are monitoring.
18 Of those 22 CAPs, 15 are continuing from the previous quarter and
19 7 are new as of the March 31 filing.
20 Of the 15 continuing CAPs, 12 RBOs or 13 CAPs are improving
21 from the previous quarter and 2 RBOs did not meet their approved projections.
22 For those 2 RBOs we have been monitoring them and reviewed their April and
23 May financial statements and as of May they are meeting all of the grading
24 criteria.
25 For the 7 new CAPs, 3 of the 7 CAPs were non-compliant with

1 claims timeliness and 4 RBOs were had corrective action plans due to not
2 meeting the financial metrics TNE, working capital and/or cash to claims. For
3 those three claims timeliness CAPs, they were due to staffing issues or one RBO
4 had a new claims system implementation. For the 4 CAPs for financial metrics,
5 they were due to year-end audit adjustments or financial transactions.
6 After our initial review of the new CAPs, a majority of these RBOs
7 will be compliant by quarter-ended September 30 and we are currently working
8 with those RBOs to obtain an approvable CAP.
9 For the 22 CAPs, approved or in review, after review of the March
10 31 financial filings as well as the annual 2021 Survey Report, 6 of those CAPs
11 were completed and 2 of those CAPs were closed.
12 For additional information on the corrective action plans there is an
13 attachment of the 22 CAPs that are sorted by management services organization
14 or MSO and it includes information on the contracting health plans or RBOs,
15 enrollment, a visual for the duration of the CAP and the grading criteria
16 deficiencies.
17 Moving on to enrollment. The RBOs are required to submit
18 enrollment information with their survey reports. As of quarter ended March 31
19 there are approximately 8.9 million enrollees assigned to the RBOs. This is an
20 increase of approximately 149,000 enrollees from the previous reporting period
21 and a majority of this increase is in the Medi-Cal enrollment.
22 We also conduct an analysis on the Medi-Cal lives assigned to the
23 RBOs, which is on the next slide. And there is approximately 5.1 million lives
24 assigned to 89 RBOs. This is approximately 57% of the total lives assigned to all
25 of the RBOs. And within those 89 RBOs, 71 had no financial concerns, eight

1 were on our monitor closely list and 10 RBOs were on CAPs.

2 Looking at the top 20 RBOs that had a majority of the Medi-Cal

3 lives assigned to them, this represents approximately 3.9 million lives or

4 approximately 44% of the total enrollment. Thirteen RBOs had no financial

5 concerns, 4 were on our monitor closely list and 3 were on corrective action

6 plans.

7 That concludes my presentation and happy to take any questions.

8 CHAIR DEGHETALDI: Right to Paul.

9 MEMBER DURR: Okay, Michelle, thank you, always a great

10 report. Two questions I have. One is on the 10 that are non-filers and I know

11 you have escalated it to the Office of Enforcement. How quickly do they take

12 action? Because my concern would be is for the providers who are in those

13 groups and the in the enrollees, what exposure they might have?

14 My other question has to do with the adjustments that were made

15 for those 4 RBOs that didn't meet the metrics for financial because of audit

16 adjustments or things like that. Do they incorporate the audit adjustments into

17 their quarterly financial reports instead of waiting to the end of the year?

18 MS. YAMANAKA: Sure. Okay, so let me take your first question.

19 So prior to us recommending enforcement action and sending a referral to our

20 Office of Enforcement we send letters to the contracting health plans or to the

21 contracting RBOs informing them of their contracted RBOs that they have not

22 submitted their survey reports. Within that notification there is a 30 day notice

23 that is provided to all of the contracting entities, the health plans and the RBOs,

24 that if the survey reports are not received within the 30 days then enforcement

25 action may be taken. So after that 30 days is up we send the enforcement

1 referral. So the enforcement referral can take effect immediately once those
2 orders are sent to the health plans and/or the RBOs. So does that answer your
3 first question?
4 MEMBER DURR: Yes. So my concern is how quick, I guess, does
5 the enforcement group sort of take any additional action? So great on the
6 process of the notice but, you know, just if they are still non-compliant I am
7 concerned that we have got to do something about those RBOs and does
8 enforcement action, get on it right away?
9 MS. YAMANAKA: Sure. That would be a question for the Office of
10 Enforcement because they have their own workload but we can follow up. They
11 keep us informed of where things are within the process.
12 MEMBER DURR: Okay, thank you.
13 MS. YAMANAKA: Okay. And so the second question is regarding
14 those year-end audit adjustments. In the financial filings, the March 31 filings are
15 due prior to the annual reports. The March 31 filings are due May 15, the annual
16 reports are due May 31 if the RBO is on a fiscal year of 12/31. So in the event
17 that the RBO doesn't capture the year-end audit adjustments in their March 31
18 filings we will have them go back and amend their March filing to take into
19 consideration those audit adjustments. And then it will flow going forward.
20 MEMBER DURR: Great. Thank you.
21 MS. YAMANAKA: Okay.
22 CHAIR DEGHETALDI: Jeff, Ted, then Abbi.
23 MEMBER RIDEOUT: Yes. Just maybe a general question for
24 DMHC staff but, Michelle, you might know. Is there any relationship between the
25 mandatory submitters to HCAI and the HPD and the RBOs status? I am trying to

1 understand how the physician organizations that are now mandatory submitters
2 are defined. Is there an easy answer to that?
3 MEMBER WATANABE: Michelle, I don't know if you know; I don't
4 know. I will just say that that is an item for a future FSSB meeting is to have
5 HCAI come and talk about the HPD and probably the Office of Health Care
6 Affordability. But we could flag that as an item to maybe be able to respond to at
7 a future meeting. Actually, it hadn't occurred to me to do that crosswalk but we
8 can take that back, Jeff.
9 MEMBER RIDEOUT: Thanks, Mary. And I am thinking like in
10 some cases the RBOs that are on watch, you know, is there a correlation with
11 their performance? I know we didn't see that before but hopefully these things
12 would tie together you know, so you are looking at the same type of organization.
13 CHAIR DEGHETALDI: Ted.
14 MEMBER MAZER: Yes, my usual comment looking at the CAP
15 Review Summary. We have one outstanding MSO that continues to have a lot of
16 Xes. I am encouraged to see that all but one category they are compliant with
17 the final CAP but they are still under CAP.
18 I do have a question regarding the RBOs with Medi-Cal lives 50%
19 or more. You are looking at 20 to 25% of covered lives in those RBOs being in
20 groups that are monitored closely or under a CAP. I think that is significantly
21 more than the non-Medi-Cal lives RBOs. And given the growth still of Medi-Cal
22 lives are we concerned about that? is there a rationale for why they are doing
23 that much more, or having that much more difficulty complying with financial
24 concerns?
25 MS. YAMANAKA: There were two comments, I am going to

1 comment on the first one first. So when you -- this was as of March 31. Once
2 we review those financial filings as well as because it is the year-end audit we
3 want to make sure, as Paul asked the question about the year-end audit
4 adjustments, if there were any year-end audit adjustments. We want to make
5 sure that they are reflected in the March 31 filings to ensure that the RBO was
6 compliant overall. So when we looked at those two filings after, as well as
7 reviewed the corrective action plan, once we determined that the RBO is
8 compliant with all grading criteria as well as worked with the health plans to
9 ensure they didn't have any additional concerns, we are able to complete the
10 corrective action plans. So for some of our oldest corrective action plans on the
11 list, mentioned that we have -- we closed or completed 6 of those corrective
12 action plans and those would be reflected in those 6. So as of -- as long as the
13 RBOs remain compliant they will not be reflected on the next upcoming financial
14 survey reports for the corrective action plans, okay.
15 Regarding the RBOs with Medi-Cal lives, we definitely take a look
16 at them. In addition, because we also look at providing this additional information
17 with those RBOs that have Medi-Cal lives to them. And it all really depends on
18 the issue of non-compliance. So some of these RBOs, they may have fallen out
19 of compliance at December 31 with their annual filing, but by the time that they
20 submit the corrective action plan they are either close to compliant or are
21 compliant and have remedied the deficiencies. So it is really on a case-by-case
22 basis with the RBOs with the Medi-Cal lives. But yes, we do keep track of them
23 to ensure that all of them are meeting their metrics and are on to the road to
24 compliance.
25 MEMBER MAZER: Thank you.

1 CHAIR DEGHETALDI: Abbi. Abbi, your hand is up.
2 MEMBER COURSOLLE: Yes. I just had a quick follow-up
3 question I don't know if you will be able to answer, Michelle, on sort of the
4 enforcement question that Paul raised. I am just wondering sort of what the role
5 of any plans that contract with the RBOs that are referred to enforcement action
6 is and how DMHC is communicating with the plans when the RBOs have been
7 referred for enforcement?
8 MS. YAMANAKA: Sure. So if the Department needs to take
9 administrative action we go through the health plans. The Order is issued to the
10 health plan because they have the contract with the RBO. So the two types of
11 action that we can take is to freeze the enrollment or to require the health plan to
12 de-delegate. And so in either one of those situations it all starts with the health
13 plan, because they need to work with the RBO to take that action.
14 MEMBER WATANABE: And I will just add maybe, Abbi, I think we
15 have, we refer things to our Office of Enforcement when there is a violation of the
16 law so it could be that they end up filing. A lot of times just these notices and the
17 pressure that comes from the plan down gets them into compliance but they still
18 did not file timely and so when there is a violation we refer to enforcement. So
19 there could be a delay in the actual enforcement action but there is not
20 necessarily harm, as Paul noted, either to the providers or to enrollees. So just
21 to clarify on the enforcement process.
22 And Michelle, I don't know if you have a sense of once we do all of
23 these notices that this is going to enforcement if things tend to get resolved
24 quickly. I know we have had some issues that we have noted at prior Board
25 meetings where that doesn't happen but is that your experience generally? You

1 are nodding your head, yes.

2 MS. YAMANAKA: Yes, yes.

3 MEMBER WATANABE: Okay.

4 MS. YAMANAKA: I was on mute. Yes, they tend to get resolved

5 fairly quickly, yes.

6 MEMBER COURSOLLE: That is really helpful. Thank you both.

7 CHAIR DEGHETALDI: Jordan, could you go back to Slide 52 and I

8 want to share my concern. You know, the top line, Michelle, whether you are a

9 solo physician, an RBO, a hospital, a health system, the top line subsidizes your

10 care to Medicare and Medi-Cal patients. And this is just a one year trend but it is

11 ominous. And coupled with the fact that the payments from Medi-Cal and

12 Medicare are essentially zero year-over-year, cost inflation is 5 to 10% for our

13 providers, I am just worried about sort of the homeostasis of this world and the

14 pressure on any RBO or provider that continues to care for Medicare and Medi-

15 Cal patients. This trend in terms of people is going to continue. I am highlighting

16 Ted's point that those RBOs that are caring for disproportionately government

17 patients, in this economic time, it is going to get worse for them. And access will

18 get worse, quality scores will decline. I am just worried about the pressure on

19 those RBOs that are in the second and third rows. Ted.

20 MEMBER MAZER: Larry, if I can pile on a little bit; we didn't really

21 bring it up before but it is appropriate now. Yes, there is the subsidization from

22 commercial payers, which is fading and the commercial payers are kind of

23 tightening down as well. But it is far overdue for the state to look at the overall

24 reimbursement rates of the Medi-Cal program. The Medicare program is frozen

25 at this point. California has taken a beating even with, even beyond that. But

1 Medi-Cal has not kept up at all. It has fallen further and further behind whether it
2 is fee-for-service or managed care. I had a curious question that I was afraid to
3 ask and I am sure the data is not readily available and that is, is there a
4 comparison of managed care Medi-Cal to the Medicare Advantage programs
5 which are being looked at as costing more money than the fee-for-service
6 Medicare program? I suspect that would probably be true in a comparison of
7 fee-for-service Medi-Cal because of the extremely low rates and managed care
8 Medi-Cal getting -- for some reason able to pay far better than the state.
9 But I do think that year over year over year, decade over decade,
10 frankly, the state has failed to do anything to increase the Medi-Cal
11 reimbursement rates to encourage participation by providers. And given the
12 current inflationary rates of providing care, it is going to knock more people off
13 the edges and cause increased access problems for Medi-Cal enrollees. It
14 should be a priority of the Department.
15 CHAIR DEGHETALDI: And Scott.
16 MEMBER COFFIN: Yes. To Ted's question, which I think it is a
17 good question; Mary, this may be a topic that we ask DHCS to address maybe in
18 a future FSSB meeting. Yes, no, I appreciate that, Scott. We have only so much
19 authority at the Department and certainly appreciate the impact on financials, but
20 the rate-setting and the rate comparisons within Medi-Cal would be, we would
21 need to work with DHCS on that. But I will make a note of it for our future
22 agenda items.
23 MEMBER COFFIN: Okay. Thank you.
24 CHAIR DEGHETALDI: And, Mary, we know the limits of the
25 Department. But I do think we are seeing an expansion in Medi-Cal lives, yet

1 another group which is so wonderful but, you know, half of Californians are
2 covered by Medicare and Medi-Cal. And we don't want to see access and health
3 disparities worsen based on who pays for your care, you know.
4 MEMBER WATANABE: Agree.
5 CHAIR DEGHETALDI: Yes. Any other Board comments?
6 Michelle, thank you.
7 Any public comments here?
8 MR. STOUT: There are none at this time.
9 CHAIR DEGHETALDI: We go Pritika, Michelle, Pritika every
10 quarter.
11 MS. DUTT: Okay. I will provide you an update on the financial
12 status of health plans at quarter ended March 31, 2022. We have been tracking
13 the health plans' financials and enrollment trends very closely and working with
14 health plans if we see any unusual trends that would raise concerns.
15 We also included a handout that shows the enrollment at March 31,
16 2022 and tangible net equity for five consecutive quarters starting from March 31,
17 2021 to March 31, 2022 for all licensed health plans. The information is broken
18 into three categories. We are looking at full service plans, restricted full service
19 and specialized health plans.
20 As of August 1, 2022 we had 143 licensed health plans. Golden
21 State Medicare Health Plan surrendered its license and it went into effect August
22 1, 2022. We licensed 3 health plans, one Medicare Advantage plan which was
23 Evergreen Health Plan, and 2 Restricted Medicare Advantage plans Golden Bay
24 Health and Star Life Holdings.
25 We are currently reviewing 8 applications for licensure, 5 full

1 service and 3 specialized. Of the 5 full service, one is looking to get licensed for
2 Medicare Advantage, one for Restricted Medicare Advantage, one is looking to
3 get licensed as a Medi-Cal plan and 2 for restricted Medi-Cal. For the 3
4 specialized plan applicants, 2 are looking to get licensed as employee assistance
5 programs or EAP and one for dental, to offer dental benefits.
6 So we experienced an uptick in the number of entities interested in
7 obtaining a license to operate as a Medicare Advantage plan in the last few
8 years. In 2021 alone, out of the 7 health plans that the Department licensed, 6 of
9 those were Medicare Advantage health plans.
10 March 31, 2022 there were 28.9 million enrollees in full service
11 plans licensed by the DMHC. Total commercial enrollment includes HMO,
12 PPO/EPO and Medicare Supplement. As you can see on the table, compared to
13 the previous quarter, total full service enrollment increased by approximately
14 444,000 enrollees, and most of the increase was driven by government
15 enrollment.
16 And this chart shows the enrollment trends since 2018 for
17 commercial and government enrollment for the DMHC-licensed health plans.
18 The gap between commercial and government enrollment widened until 2019.
19 The commercial was higher until 2019 and in 2020 government enrollment
20 surpassed commercial enrollment and the trend has continued in 2022.
21 This slide shows the makeup of HMO enrollment by market type.
22 HMO enrollment in all markets remained relatively stable compared to previous
23 quarters.
24 This slide shows the makeup of the PPO/EPO enrollment. As you
25 can see in the table, there was a slight increase of about 30,000 enrollees in

1 PPO/EPO compared to the previous quarter. And we don't currently get the
2 breakout of PPO and EPO; that is why we report combined reporting on that.
3 This table here shows the government enrollment, which is Medi-
4 Cal and Medicare. Overall, the government enrollment increased, as I
5 mentioned earlier. The majority is due to Medi-Cal enrollment, which increased
6 by 355,000 lives just in that one quarter. Next slide.
7 There were about 4 million enrollees in the closely monitored full
8 service plans. So we had 27 closely monitored full service plans and 14 out of
9 those plans were Restricted licensees with 462,000 lives. These are small
10 restricted plans with low enrollment. For the 4 specialized plans, they had
11 220,000 lives. That included one vision plan, two dental and one behavioral.
12 We have three health plans that did not meet the Department's
13 minimum financial reserve for tangible net equity or TNE requirement.
14 Brandman Health Plan was TNE deficient at month ended April 30,
15 2022 and from month ended May 31, 2022 as well as their quarterly reporting at
16 May 31, 2022. So if we have, if a plan is newly-licensed or if we have financial
17 concerns where the plan's TNE dropped below 150%, those plans are placed on
18 monthly reporting. The plan has not cured their TNE deficiency as of the date of
19 this presentation so we are still working with the plan and our Office of
20 Enforcement on the next steps.
21 Brown & Toland Health Services reported TNE deficiency as of
22 December 31, 2021, due to their year-end audit adjustments. The plan received
23 capital contributions from its ultimate parent entity which is Blue Shield of
24 California and they were able to cure the TNE deficiency so currently Brown &
25 Toland is compliant with the TNE requirement.

1 And the next is Golden State. As I mentioned earlier, Golden State
2 surrendered its license effective August 1, but we did receive their quarter end
3 March 31 financial statement and they were TNE deficient. As you may recall
4 from previous meetings we did a lot of work with CMS, the Department. Our
5 Office of Financial Review team as well as our Office of Enforcement coordinated
6 with CMS, had several meetings with CMS and the health plan. So the plan
7 ended up entering into a mutual termination with CMS and that went into effect
8 August 1. And then simultaneously the plan filed its application to surrender its
9 license with the DMHC and then we processed that so Golden State is no longer
10 a licensed health plan.
11 This chart shows the TNE of health plans by line of business. A
12 majority of health plans with over 500% of required TNE are specialized health
13 plans.
14 This chart shows the TNE of full service plans by enrollment
15 category. Of 59 health plans, over half of the total licensed full service plans
16 reported TNE of over 250% of required TNE. One thing you may have noticed in
17 the previous slide and this one here, we made a change to the ranges on this
18 slide because effective July 1, 2022 if a health plan's TNE falls below 150% of
19 required TNE the plan will be required to a submit monthly financial statement
20 with the DMHC. The previous requirement for monthly reporting was 130% of
21 required TNE for monthly reporting or if the plan is newly licensed. The change
22 is as a result of updated health plan financial reporting regulations that went into
23 effect July 1 of 2022.
24 This chart shows the breakdown of the 24 full service plans in the
25 150% to 250% range. Like we have mentioned previously, we also monitor

1 health plans closely if we observe a declining trend in their financial performance
2 which is TNE, net income and enrollment.
3 This chart shows the TNE of full service plans by quarter. For
4 detailed information on health plan TNE levels and enrollment please refer to the
5 handout that was provided with the meeting materials and you can see which
6 health plans fall into each category of TNE and enrollment.
7 And that brings me to the end of the presentation. I will take any
8 questions.
9 CHAIR DEGHETALDI: Abbi is first.
10 MEMBER COURSOLLE: Just going back to the slide on, I think it
11 was two or three slides back on the plans that are I think under CAPs right now.
12 It showed that Brandman Health Plan currently has-yes, this is the slide-has zero
13 covered lives. I was just curious about that, if you could provide a little more
14 information.
15 MS. DUTT: Sure. So the plan was newly licensed. They had
16 enrollment for 2021 so they got their first enrollment with CMS for Medicare
17 enrollment effective January 1 of 2020. And then in early 2021 they contacted --
18 let me back up here. So they first reported enrollment for 2021 so their effective
19 date for a CMS contract was January 1, 2021. Early this year they contacted,
20 Brandman contacted CMS and asked for mutual termination. They had not
21 reached their enrolled, you know, their projected lives so the enrollment was very
22 small. And they were experiencing a lot of net losses and they ended up
23 entering into a mutual termination and transitioned the lives out of the plan. So
24 those lives moved into other plans or our direct for traditional Medicare. But the
25 plan is still has a DMHC license so one of the requirements is that they maintain

1 compliance with all the financial and compliance requirements of the Knox-Keene
2 Act. So they still have to meet the TNE requirement which for a plan with zero
3 lives for a full service plan is a million dollars. So since Brandman's TNE fell
4 below the million dollar requirement we are working with the plan. We have them
5 on a CAP and we have continued discussions with the health plan.
6 MEMBER COURSOLLE: Thank you, that is helpful.
7 CHAIR DEGHETALDI: Any other Board questions, comments?
8 And, Jordan, from the public?
9 MR. STOUT: There are none at this time.
10 CHAIR DEGHETALDI: I just have to tease, Bill Barcellona is not
11 attending today so maybe that is part of the silence that we are hearing.
12 (Laughter.) We can tease him. Okay.
13 And I think that brings us, we are about almost 20 minutes ahead. I
14 know Mary has to leave a little early but maybe we can jump in to your topic of
15 meeting dates.
16 MEMBER WATANABE: Yes, just really quickly. Jordan, I think we
17 have a slide with our proposed meeting dates for 2023. It is all on Wednesdays
18 right now, February 22, May 17, August 16 and November 15. I know it is a little
19 bit early to be thinking about 2023 but we'd like to preview this both for the Board
20 and the public and then we will kind of finalize and confirm those that our
21 November meeting. I think the Board has said they are okay for now but if there
22 is any conflicts that come up please let us know. We will continue to meet
23 virtually through the first half of 2023 so our November meeting as well as the
24 February and May meeting will be virtually. And then we will just need to see if
25 there is additional action taken to allow us to continue to meet virtually after that.

1 But potentially August and November we will be back in-person.

2 CHAIR DEGHETALDI: Dr. Rideout.

3 MEMBER RIDEOUT: Quick question, Mary or Jordan. Did these

4 dates go out already? I think they did but I don't know.

5 MEMBER WATANABE: I think they, I think we shared them in

6 advance and I think we have cleared them with IHA's board meetings.

7 MEMBER RIDEOUT: Okay, well, that's (overlapping).

8 MEMBER WATANABE: I don't think there is a conflict.

9 MEMBER RIDEOUT: I was going to say I'd have to move a board

10 meeting maybe but I will check with my folks. Okay, thank you.

11 MEMBER WATANABE: Yes, please confirm. There are a couple

12 of significant public meetings that many of our stakeholders attend so we tried to

13 do a crosswalk but, you know, it is a little early in the year.

14 MEMBER RIDEOUT: Yes.

15 MEMBER WATANABE: So just let us know in advance of

16 November if you can.

17 MEMBER RIDEOUT: Yes, thank you.

18 CHAIR DEGHETALDI: You anticipated Jeff's concern, Mary.

19 MEMBER RIDEOUT: We do the same thing and it is like who is

20 going to commit first and who is going to change and we try to be good about all

21 that.

22 CHAIR DEGHETALDI: Any other questions?

23 Okay, then we open it up to the public for comment on matters not

24 on the agenda. Jordan, I am waiting on you to say yea or nay.

25 MR. STOUT: There are no hands at this time.

1 CHAIR DEGHETALDI: Okay. And then we can jump to -- there
2 are some things that we have talked about, agenda items for future meetings. I
3 jotted down inviting HCAI. I mentioned the DHCS Medicare Innovation Team, a
4 very interesting body of work. We asked for a side-by-side comparison of Medi-
5 Cal expenditures. Ted asked on the fee-for-service versus HMO side. Anything
6 else? Any other topics or concerns? Paul.
7 MEMBER DURR: Mary and team, I wonder, could we get an
8 overview of the Office of Enforcement and not just put it on Michelle to bring that
9 information back. But just understanding how they approach things might be
10 helpful.
11 MEMBER WATANABE: Yes, sure. Our Office of Enforcement is
12 getting a lot of attention these days so be happy to have them kind of talk about
13 our authority, the tools we have in our toolkit and the process, so we will add that.
14 MEMBER DURR: Thank you.
15 MEMBER WATANABE: Larry, I will just note that we have planned
16 already I think is risk adjustment transfers and the final individual market rates.
17 We will have the final report from the Health Equity Committee as well so we will
18 share that information as well. So it is going to be, it is going to be a packed
19 agenda but we will try to accommodate some of these other requests as well.
20 CHAIR DEGHETALDI: Just big numbers in those risk adjustment
21 transfers, folks haven't seen. Anything else?
22 Okay, well, I don't have any closing remarks. This was -- we got
23 through this with a half hour to spare, a little more. I just thank everybody. The
24 conversations are just stimulating and you people are great. And, Mary,
25 compliments to your department. And with an expanded budget you have got to

1 hire those people though, yes.

2 MEMBER WATANABE: We are trying. We have to get creative. It

3 is a tough market out there, I think everybody is feeling it.

4 CHAIR DEGHETALDI: Yes.

5 MEMBER WATANABE: But it is a great place to work. A lot of

6 smart, passionate people.

7 CHAIR DEGHETALDI: Okay, well, thanks everyone. Thank you.

8 Have a great day.

9 (The meeting was adjourned at 12:27 p.m.)

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24 CERTIFICATE OF REPORTER

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1

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

3 hereby certify:

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

5 Department of Managed Health Care, Financial Solvency Standards Board

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

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

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

9 IN WITNESS WHEREOF, I have hereunto set my hand this 23rd

10 day of August, 2022.

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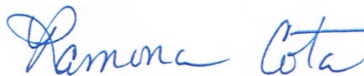
14 

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