STATE OF CALIFORNIA

DEPARTMENT OF MANAGED HEALTH CARE

FINANCIAL SOLVENCY STANDARDS BOARD (FSSB) MEETING

THE DEPARTMENT OF MANAGED HEALTH CARE

PARK TOWER, 980 9th STREET

CONFERENCE ROOM, 2nd FLOOR

SACRAMENTO, CALIFORNIA

WEDNESDAY, JULY 17, 2019

10:00 A.M.

Reported by: Ramona Cota

APPEARANCES

BOARD MEMBERS

John Grgurina, Jr., Chair
Jeffrey Conklin
Larry deGhetaldi, MD
Paul Durr
Jen Flory
Jeff Rideout, MD
Shelley Rouillard
Amy Yao

DMHC STAFF

Pritika Dutt, Deputy Director, Office of Financial Review
Deborah Haddad, Acting Deputy Director of Health Policy and Stakeholder Relations
Sara Ortiz, Associate Governmental Program Analyst
Sarah Ream, Acting General Counsel
Jordan Stout, Staff Service Analyst
Mary Watanabe, Acting Chief Deputy Director
Michelle Yamanaka, Supervising Examiner, Office of Financial Review

APPEARANCES

ALSO PRESENTING/COMMENTING

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

William Barcellona, Senior Vice President Government Affairs
America's Physician Groups

Amber Kemp, Vice President, Health Care Coverage
California Hospital Association

Mary June Diaz, Senior Policy & Legislative Advocate
Health Access California

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PROCEEDINGS

10:04 a.m.

CHAIR GRGURINA: Welcome, everyone. A few housekeeping notes before we begin. Be sure to silence your phones, all of us actually, we'll start with me (laughter). I just turned it off.

If you are going to be presenting or speaking at the podium please leave your business card or write your name and title down at the podium or leave it with our transcriber.

For our Board Members, to ensure, to be able to make sure that you are heard on the phone, you press the bottom and it turns green, I just learned that.

And then the restrooms on the floor, for those of us here in person, are locked. The keys are on the table in the back. You head out to the left and then to the right. For the men you have to go across the walkway to the other side.

And with that we can move to Shelley.

MEMBER ROUILLARD: All right. So good morning, everyone. I'm Shelley Rouillard, Director of the Department of Managed Health Care. Before I get started on my remarks I just wanted to mention we are having some issues with the phone so apologies to the people who are on the phone. We do have a court reporter here who is transcribing the meeting and those notes will be available if you can't hear us and you need to know what happened.

I also wanted to mention that you are going to see in the slides and the presentations, they are going to look a little bit different than what you are used to. State law requires all of our websites to be accessible to people with disabilities and

over the last few months the Department has made a very intense and concerted effort to ensure that everything that we post on the website is accessible to people with disabilities and in an accessible format. So that means that some of the charts that you are used to seeing we are not going to be able to use any longer, so I just wanted to kind of point that out. But obviously it is very important that everybody can access the information that we put up there. It was a big push but I am proud of our IT team who made it a priority and got us where we had to be.

Last but not least, I also want to announce that Jeff Conklin has resigned from the Board. This is his last meeting because he is moving to Oregon, he is going to be working at Oregon Health & Science University. So Jeff, I just want to thank you for being a member of the Board and for all your contributions. It has really been great to have your perspective here.

MEMBER CONKLIN: Thank you.

MEMBER ROUILLARD: We have a little certificate of appreciation for you.

MEMBER CONKLIN: Oh wow, thanks, that's nice.

MEMBER ROUILLARD: So best wishes. My mother lives in Portland and I go up there often so it's a beautiful place. Enjoy.

(Certificate presented to Member Conklin followed by applause.)

MEMBER ROUILLARD: Okay. Okay. I'll turn it back to you for the minutes.

CHAIR GRGURINA: Okay. So just as a comment for all of us on the

Board and for those in the public and those on the phones, this means switching the minutes from what we currently see in front of us to an actual transcript. That means that whatever we say will be put on the transcript, including the ums and the changes of thoughts in the middle of sentences, so we will all be on our best behavior.

With that could I have a motion to move -- are there any questions or changes on the minutes?

MEMBER RIDEOUT: John.

CHAIR GRGURINA: Yes.

MEMBER RIDEOUT: I had a question on page 2, the second to the last paragraph, the use of the word "global" ahead of "risk." I am wondering whether -- I don't want to go down a rat hole but is that meant to imply a certain type of risk sharing, financial risk sharing, or is it a general statement about any sort of risk sharing?

MEMBER ROUILLARD: You're talking about the last paragraph here? "The entity accepting global risk will need to request an exemption ..."?

MEMBER RIDEOUT: It said -- yes, that accepts global risk. Because that could be construed as a narrow definition of financial transfer if it meant the entire capitation amount as opposed to a budgeted or shared services or shared savings amount.

MS. REAM: Would you like me to -- I'm Sarah Ream, the Acting General Counsel for the Department.

MEMBER RIDEOUT: Yes, hi, Sarah.

MS. REAM: So in regard to the general licensure regulation global risk has a specific definition, meaning assumption of any amount of professional risk and

any amount of institutional risk together. So I hear your question as to whether that could be considered confusing. I think, though, that because the comment or the remark was in the context of the general licensure regulation I would hope that that would help define, put parameters on what we meant by global risk.

MEMBER RIDEOUT: Okay. My only concern is the general use of global risk --

MS. REAM: Right.

MEMBER RIDEOUT: -- has a narrower definition or use and that might be just common usage, so I don't want to be confused about sort of what your extended regulations apply to.

MS. REAM: Go ahead.

CHAIR GRGURINA: Other comments?

MEMBER CONKLIN: The regulation is specific on global risk only?

MEMBER ROUILLARD: No.

MS. REAM: No.

MEMBER RIDEOUT: It's broader.

MS. REAM: But it defines the term, global risk.

MEMBER ROUILLARD: And Sarah is actually going to do a presentation about the risk regulation and the responses that we have gotten.

CHAIR GRGURINA: Other comments from Board Members?

(No response.)

CHAIR GRGURINA: Okay, do I have a motion to move the minutes forward?

MEMBER DURR: Motion to approve.

MEMBER CONKLIN: Second.

CHAIR GRGURINA: A second. All those in favor?

(Ayes.)

CHAIR GRGURINA: Opposed?

(No response.)

CHAIR GRGURINA: All right, the minutes pass.

Shelley.

DIRECTOR/MEMBER ROUILLARD: Okay. So just a few comments before we get into the rest of the meeting. So many of you probably already know that on Tuesday, July 9, Covered California announced the weighted average annual rate increase for products offered on the individual market will be 0.8 percent in 2020, so less than a 1 percent rate increase. Obviously this is the lowest change since Covered California was launched.

Covered California projects that lowering health care costs and re-instituting the penalty on individuals who could buy coverage but choose not to will result in 229,000 people becoming newly insured and an estimated 922,000 will be eligible for newly enacted state subsidies.

So approximately 1.4 million people purchased coverage through Covered California and another 800,000 purchased off-exchange directly from health plans and insurers. But the rates negotiated by Covered California affect everyone in the individual market, both on and off-exchange.

We expect Covered California today to announce the plan-specific

premium changes and then we will begin our review of those rates. Our rate review team of actuaries analyzes the assumptions made by the plans regarding their actual expected trends and utilization, medical and prescription drug costs, administration and profit. We also evaluate the plans' assertions that they will meet the medical loss ratio of at least 80 percent in the individual market. Just a reminder that we don't have the authority to approve or disapprove the rates but we can question the plans' assumptions to be sure that they are justified and not unreasonable.

With respect to the small group market, we received those rates yesterday and they will be made public on July 24th.

And then all of the rates must be finalized by October 1 so we typically announce the final rates at the end of September.

Related to this, our risk adjustment transfers that -- these are intended to transfer funds from health plans and insurers that have low actuarial risk to those with high risk.

So for benefit year 2018 there was $1.1 billion transferred between California health plans and insurers. Blue Shield and Anthem Blue Cross received the majority of payments. Blue Shield got about $930 million, Anthem Blue Cross $140.5 million. Thirteen other DMHC-licensed health plans paid into the pool with Kaiser paying over $730 million. Risk adjustment transfers represent an average of about 8 percent of premium.

For 2018 CMS added a high-cost risk pool program to the risk adjustment transfer methodology. The high-cost risk pool helps ensure that risk adjustment transfers reflect the average actuarial risk, while also providing protection to plans and

insurers with exceptionally high-cost enrollees. The high-cost risk pool reimburses plans and insurers for 60 percent of an enrollees aggregated, paid claims costs that exceed $1 million. The high-risk pool charge was 0.2 percent of premium for the individual market and 0.32 percent of premium for the small group market nationally. California health plans and insurers received an additional $115 million through that new program.

I wanted to briefly talk a little bit about our Medicare licensing trends that we have been seeing recently. There has been a steady growth in full-service Medicare Advantage plans over the past six years, plans that directly contract with CMS as well as those that are restricted and get their Medicare enrollment only through subcontracts with other health plans.

As of June 2019 the DMHC has licensed 25 full-service Medicare Advantage plans, 9 of which are restricted licenses. In 2013 there were 19 licensed plans of which 4 were restricted licenses.

We also have three licensed specialized Medicare plans, two for pharmacy and one for vision.

We are currently reviewing two applications for Medicare Advantage licensure, one for full-service and one restricted. And we have had pre-filing meetings with eight additional entities who are interested in obtaining Medicare licensure. Four of these are RBOs seeking a restricted license and the other four are seeking full-service licensure and would directly contract with CMS. All of those plans are projecting very small enrollments in the first two years.

And I bring this up because we currently have seven Medicare Advantage

plans on our Closely Monitor list and their combined enrollment is only 150,000 enrollees, that is an average of 21,000 per plan. We also have five Medicare Advantage plans with less than 130 percent of required TNE and one of which has less than zero percent of required TNE.

Small plans obviously are less financially stable and raise concerns about their ability to adequately serve their enrollees and pay providers. These plans require additional scrutiny and actually take up a lot of DMHC resources and it is not proportional to their size or market impact. So this is something we are taking a look at and ensuring -- OFR is working hard to ensure that the plans that are in this space really have the financial wherewithal to provide the services; and we have been in touch with CMS about the one that is, you know, has no reserves to speak of. So I will be interested in any thoughts that the Board may have about how we might address that problem.

Okay. Merger Mania 3.0 is currently upon us. I want to give you a brief update on two of the mergers that we are currently reviewing and analyzing in the context of AB 595, which expanded our authority regarding mergers. So the DMHC is evaluating whether each of these mergers is a major transaction or agreement under AB 595. And if we find that either one to be a major transaction we must hold a public meeting and seek independent analysis of the market impact of the transaction.

So the first one is Centene and WellCare. Centene is a St. Louis-based parent corporation of six Knox-Keene licensed plans. They propose purchasing WellCare, which is a Florida-based health plan which owns two Knox-Keene plans, for approximately $17.3 billion. Nationally this is a very large transaction. Just so you

know, Centene is the parent company for Health Net of California, Health Net Community Solutions, California Health & Wellness, Managed Health Network, Health Net Health Plan of Oregon and Envolve Vision. WellCare is the parent of Easy Choice Health Plan, which is a Medicare Advantage plan, and WellCare Prescription Insurance, which is a Medicare Part D plan.

The combined company would have a large footprint in the Medicare and Medicaid space with combined revenue approaching $100 billion in 2019 and 22 million lives in all 50 states. So we are looking at the California impact of this merger. WellCare is very small in California compared to what it has nationally but we will be reviewing all aspects of the transaction to make a determination whether or not we consider it to be a major transaction.

The other one is Anthem and Beacon. On June 6, 2019 Anthem announced it entered into an agreement to acquire Beacon Health Options, Incorporated, which is the largest privately-held behavioral health organization in the US. Beacon Health Options owns Beacon Health Options of California, which was formerly known as Value Options, which is a Knox-Keene licensee. Beacon is a specialized health care service plan and offers mental health, substance abuse disorder and EAP services. Beacon's total enrollment is 617,500, which is mainly large group EAP enrollment. We do not yet know the value of this transaction.

If the transaction is completed then Anthem will be the ultimate controlling parent of five Knox-Keene licensees including Blue Cross of California, Blue Cross of California Partnership Plan, CareMore Health Plan, which is a Medicare Advantage plan, Golden West Health Plan, which offers dental and vision services, and then

Beacon Health Options of California. Our review of that has just gotten underway so more to come on that one.

The last thing, I want to update a little bit on a couple of the undertakings, particularly Symphony Provider Directory and Health Net's Encounter Data Project. So we talked about the Symphony Provider Directory before but I just want to mention that currently there are over 65 provider groups actively participating in Symphony and new provider groups are joining every month. IHA's goal is to finish 2019 with at least 85 provider groups using Symphony. On the plan side, besides Anthem, Blue Shield and Health Net, United and Aetna are actively on-boarding Symphony and IHA is in active contact with 6 other health plans. So good job.

And with respect to Health Net, Health Net has contracted with Manatt to facilitate an industry-wide stakeholder process to address issues on how to achieve better and more timely and complete encounter data. The summit is planned for August 29, 2019, here in Sacramento, it will be at the Hyatt. The summit is to kick off the stakeholder engagement process to develop this industry approach to problems with encounter data, and so I want to encourage all of the industry stakeholders to participate in the summit and then in the ongoing work groups and committee meetings that we happen to have.

And that is it for my comments. Do you have any questions? Happy to answer them.

CHAIR GRGURINA: Questions or comments from the Board Members? Larry.

MEMBER DEGHETALDI: Shelley, the $115 million for high-cost

enrollees. Is that budget neutral or is that additional dollars? I understand risk adjustment transfers tend to be budget neutral, but is that an additional set of funds?

MEMBER ROUILLARD: So I am going to defer, I am going to let -- Pritika, correct me if I'm wrong, but there was a percent of premium that goes into that pool. So in the individual market it's .2 percent and .32 percent for the small group market. So that's how that fund got created, correct?

MS. DUTT: Yes. Yes.

MEMBER ROUILLARD: Thank you.

MEMBER RIDEOUT: Shelley, could you repeat the risk-transfer payment numbers for the plans that you mentioned?

MEMBER ROUILLARD: Sure. So Blue Shield I guess has received $930 million, Anthem Blue Cross $140.5 million. And then the others -- the others are just small amounts that were sort of transferred around, I don't have those exact numbers, but Kaiser paid $730 million.

MEMBER DEGHETALDI: Jeff, this is up on CMS' website. You can see it for the whole country and California is nicely enumerated.

MEMBER RIDEOUT: It's not easier to ask Shelley?

MEMBER DEGHETALDI: Well. (Laughter.)

MEMBER ROUILLARD: You won't get as much detail, though.

CHAIR GRGURINA: Jen, you had a point.

MEMBER FLORY: Yes, just on the Covered California rates. We're thrilled that the increase is less than inflation but we are also aware that a lot of that is probably due to additional state subsidies coming in as well as the reinstatement of the

individual mandate. So we are just hopeful that the rates when they are reviewed are on the rates themselves and not what people are paying based on the subsidies.

CHAIR GRGURINA: If I could just build on to Jen's comments. Congratulations to the Administration, to Covered California and the Legislature to change the mandate being brought back in in 2020 and the additional subsidies with the additional folks coming in only helps to stabilize Covered California. So it is very nice to be able to recognize and be grateful for the policy changes that enabled those kind of rates to be able to come forward.

MEMBER DEGHETALDI: A question on the .8 percent. Last year the loss of the individual mandate led to I think a 5 percent --

MEMBER ROUILLARD: I believe it was 8.5. I'm not sure what the impact of that specifically was but 8.5 --

MEMBER DEGHETALDI: Okay. Is the .8 on top of that? In other words, it's really a two-year run, we really should look at it as a two-year run.

MEMBER ROUILLARD: Yes. And Covered California does have sort of the average over three years, which I don't recall, over the life of the program.

MEMBER DEGHETALDI: Right.

MEMBER YAO: Shelley, I have a question. You mentioned about the encounter data summit. Sorry, I didn't get the date; what is the date?

MEMBER ROUILLARD: August 29th.

MEMBER YAO: August 29th.

MEMBER ROUILLARD: Here in Sacramento. And they'll be making a big announcement about it.

MEMBER YAO: So I also wanted to mention something happening in the small group market. Covered California definitely did a good job trying to keep the individual market stable. And I know we discussed before that California not encourage small group association plans. But we heard that there is a big carrier, actually just announced, publicly announced, they're going to offer small group association plans. So we are hoping that the Department will look into it.

MEMBER ROUILLARD: We will.

MEMBER YAO: Yes, because that is going to destabilize the small group market.

MEMBER ROUILLARD: Thank you.

CHAIR GRGURINA: Okay, well thank you very much. Next up we are going to go to the Department of Health Care Services and Lindy Harrington. Welcome, we are thrilled that you are here with us. We know that the Department has had a lot of legislative hearings, our last couple of meetings, we welcome you back.

MS. HARRINGTON: Thank you. So I am Lindy Harrington, Deputy Director for Health Care Financing with the Department of Health Care Services. Thank you for having us, happy to be here. And yes, we tend to have lots of budget hearings that take us away from this.

So I just wanted to quickly provide an update on some of the activities that happened with the budget passing. First I am going to focus on some changes to eligibility that were approved for the Medi-Cal program.

So what you did see beginning January 1 of 2020, an update to our eligibility for aged, blind and disabled populations, aligning that income level up to 138

percent of poverty so we had that kind of gap, if you will say. So they have resolved that issue and raised our income level up to 138 percent of property. That will take effect on January 1 of 2020.

We also expanded full scope coverage for undocumented individuals, young adults between the ages of 19 through 25. And so that also will take place on January 1 of 2020. Both of those begin January 1 to allow time for the implementation to be ready for that time period.

We do also have a change that allowed for those beneficiaries that came on through other programs, not the standard Medi-Cal, for postpartum. So if they came with pregnancy-only-related coverage, for those beneficiaries if they are diagnosed with a mental health diagnosis we have expanded their coverage. It will last instead of ending, you know, the 60 or 90 days after birth, through a one year period, so for postpartum coverage. That change did take effect July 1 of 2020, or will take effect July 1 of 2020.

We also had a restoration of previously eliminated optional benefits. That includes optical, audiology, speech, podiatry, incontinence creams and washes. So that leaves that with the previous reduction of optional benefits the only one that has not been restored is chiropractic. And those benefits will be restored beginning January 1 of 2020, again to allow time for the implementation.

And then moving on to the things that I think most of the people in this room are most concerned about, really related to the rate activities that have gone on. With the Proposition 56 funds we have continued the previous supplemental payment for physician services, for dental services, for the HIV and AIDS waiver, for the

supplemental payment for ICFDDs, for the Family PACT program, for freestanding pediatric subacutes. We have continued the rate increase for our home health agencies and pediatric day health centers.

Now those rate increases only impacted our fee-for-service and waiver program. So we did not make an adjustment for the managed care side of the house because what we had found was the access issues were in fee-for-service and managed care was already paying higher than the fee-for-service rates. And we also continued the increase for pregnancy termination.

We did also see new Proposition 56 funding come into the Department or utilization of the Proposition 56 funding. So we will now have a similar to the physician services supplemental payment a supplemental payment associated with Medi-Cal family planning services. There is a distinct list of codes that have, again, a supplemental payment associated with those.

We are also creating payments for trauma screenings and we are also creating a supplemental payment in the managed care world for developmental screenings. We have established payment rates of $29 for trauma screenings as well as a supplemental rate of $59.60 for developmental screenings. Those supplemental payments will begin in January of 2020. And the reason for the trauma screenings beginning in January is we also received funding to create trainings and to do outreach related to those trauma screenings. We believe it is important that the physicians are trained to do trauma screenings as they are delicate in nature and you need to make sure that you are approaching those appropriately, so the Department is in the process of establishing some training for physicians to be able to provide those screenings.

The final addition under Proposition 56 is for our Value Based Payments program that we have submitted to CMS, a directed payment. I will talk a little bit more about that later. But those metrics were released and we had webinars in June. Those are effective July 1 of 2019.

And the final Proposition 56 update that we had related to the budget was an additional $120 million was added to the funds we received to do a physician and dental loan repayment program and we are happy to announce that we were able to award for our first cohort. Associated with that program we awarded funds to 247 physicians and 40 dentists totalling approximately $69 million in loan repayment, and that allows us to provide up to $300,000 of funds to repay loans for physicians and dentists that agree to provide a five-year commitment to serving Medi-Cal beneficiaries at a minimum level of 30 percent of their practice of about a third of their practice. Again, coinciding with about a third of Californians are on Medi-Cal, if you want to know kind of how our logic works and how we came up with that percentage.

It was a wildly successful program, at least from our perspective in the first year when we contracted with Physicians for a Healthy California to implement the program and we were able to stand up the program in just about a year from initial appropriations. We are really excited about that. We had approximately 1300 applicants that came in requesting funds. The requested amount was approximately $300 million across those 1300 applicants and they reported having student debt of approximately $500 million. So as you can see, this is a very significant burden to physicians and dentists in California and so we think this is a really great opportunity to allow physicians and dentists that couldn't otherwise make a choice to serve these

vulnerable populations, actually allow them to make a change in the trajectory of their careers and actually make these decisions. So really excited about that.

Does anyone have any questions on the budget update before I move into some of the others?

MEMBER DEGHETALDI: Questions on the -- 30 percent is defined how? Lives touched, gross billings. How do we?

MS. HARRINGTON: So we have actually provided some flexibility in how we define that. So there is some, depending on whether, you know, specialties and how we have allowed individuals to let us know how they are calculating that and making that determination. So for some it could be time spent. So for example, we know that some Medi-Cal beneficiaries in some specialties especially require, have a greater acuity, so, you know, it takes longer to see those beneficiaries. So we kind of have created some flexibility in how we calculate that. For some it may be their caseload, for others it may be time spent, but we have worked with the physicians.

MEMBER DEGHETALDI: Would a dually insured beneficiary count?

MS. HARRINGTON: They do not, so it is Medi-Cal-only populations that we are counting. And the reason for that is a majority of dual-eligibles, physician services, Medi-Cal is not the primary payer.

MEMBER DEGHETALDI: Sure.

MS. HARRINGTON: So we really were looking for the places where Medi-Cal is the primary payer, or beneficiaries where Medi-Cal is the primary payer.

MEMBER DEGHETALDI: And last question. The 247 applicants. Did we try to encourage rural, focus on rural California?

MS. HARRINGTON: We did. So we have -- the spread is across multiple counties. So we really -- so we established an advisory council that includes -- so DHCS is not making the decisions on our own, we have an advisory council that is making recommendations on the applications. And one of the things that was did was we really went through and as we were making those choices, looked to ensure that we were getting a good spread across specialties as well as locations within the state. And we have noticed on areas where we received no applicants, those are some areas that for the next year's cohorts we will be making some targeted outreach to ensure that those areas are aware of these programs.

MEMBER DURR: So with that are you making available to the physicians the specific requirements of what you're looking for in an applicant?

MS. HARRINGTON: They do, yes. And in our previous we had -- the application included information on how those applications would be reviewed, how they would be scored, those types of things. There was a very in-depth application as well as guide to completing that application. We held multiple webinars prior to/during the application period. We also will be holding webinars for those that were not selected to talk through common mistakes, errors, things that can help applicants in the future. And we are encouraging for all of the applicants that did not -- were not chosen or were not awarded, to let them know that there is four more cohorts at least and to encourage them to apply. Again, we had more quality applicants than we could fund, so.

Okay, any others? Okay, so moving on to the next update that we are making a change to at Department of Health Care Services related to our managed care rates is really calendar year rates, if we can go back two slides. There we go. So

when we met with our CFOs at out quarterly meeting, I think this is one of the few times I have received a standing ovation from the CFOs when I announced our (laughter) -- when I announced our intention to make a change to our rating period for our health plans.

And we have proposed, and CMS is on board and is working with us to get to this point, to change our rates to calendar year rates instead of state fiscal year rates.

And this decision was really made in an effort to allow us to achieve compliance with the federal requirements to be prospective in our rate setting. It has been a goal and something we have wanted to do for a significantly long time. But if you think about what our budget cycle looks like and when we know our budget and when we have final budget decisions. You know, our budget is due by June 15th, our rating period starts July 1st.

It would be physically impossible to ever be able to have fully prospective rates and so what we looked to do was make a change to calendar year rates, which would allow us six months between the time that we have final budget decisions and the rates would go live. And so this was our attempt to actually be able to be prospective so that the health plans would have their rates ahead of time and actually be paid their rates timely instead of having to do the retroactive once we received CMS approval. So we are very excited about this change. It does create some challenges that we will talk through a little bit later on in the presentation.

The other thing that we are doing with this change to calendar year rates is a transition to regional rates. So today we provide rates to health plans on a county

basis, except for the regional model where we have the larger. However, so what we are doing -- next slide. What we are proposing to do for our first year of calendar year rates, or our January 2021, is to move to what we call Phase 1 or Region-Lite. And this is really taking and leveraging existing health plan and county combinations to create a few new regions. This will allow us to have regions that will reduce from 29 to 21 combinations that we will create rates for as well as our plan/region combinations will reduce from 56 to 44.

So we are really excited about this opportunity. One, it provides streamlining to the rates that have to be set as well as CMS review. As you all may be well aware, we continue to have a prolonged approval process with CMS and one of the reasons is because of the complexity and the number of rate cells that they have to review so we hope that this will assist in reducing some of those time frames. So we think the combination of moving to the calendar year as well as this regional model will assist with that CMS approval.

And as we say, this is Phase 1, leveraging the existing health plan and county combinations with our ultimate goal of reducing even further to defining regions and creating a regional rate within those areas that will be risk adjusted and things for the individual plans. But again, to minimize the workload both on the actuaries at Department of Health Care Services but also through the CMS review. We have not developed what those regions will look like. It will be post-2022, most likely closer to 2023 when we will implement Phase 2 and we will continue to work with our health plans collaboratively to establish what those look like. Jeff.

MEMBER RIDEOUT: So this is probably a really stupid question but is

there any thought to coordinating the regions with Covered California?

MS. HARRINGTON: That is one of the things that's out there. There are some complicating factors to that so we are really -- I mean, that is one of the things that we have looked at. But we will continue to have the conversations and really looking at what makes the most sense for the Medi-Cal and who is in the various regions for providing services. So there is a bit of complexity there.

The other piece that is there is making sure that we aligned the benefit structure. so as you know, we will have the process for our next waiver coming up, public process in the fall, and we will be talking about how do we standardize benefit packages across the state, which will be key to being able to go to full regions.

CHAIR GRGURINA: Go ahead, Larry.

MEMBER DEGHETALDI: Yes. And maybe I'll challenge you on this but I think California's managed Medi-Cal plans have valiantly improved access, clinical quality, provider satisfaction, a host of measures, in part because they were they have been financially pretty strong.

MS. HARRINGTON: Mm-hmm.

MEMBER DEGHETALDI: Not of late, though. And we are seeing the volatility and sort of the reserves of our managed Medi-Cal plans be such that they are less empowered or emboldened to create incentive programs to really align with IHA. So I guess my question is, will the prospective payment concept buffer that volatility? Because, you know, I don't know, John and I were talking that as the managed Medi-Cal reserves go up an down, you saw Alameda Alliance, you know, in insolvency just a few years ago. That seems to me to be a problem.

MS. HARRINGTON: I don't know that that will necessarily resolve those issues. I think what it does resolve is the uncertainty that health plans have today.

MEMBER DEGHETALDI: Yes.

MS. HARRINGTON: So we provide them their base rate information but it is not finalized until we get all of the components put together and then submitted to CMS. This will improve that uncertainty because they will have their final rate prior to the start of the rating period, so I think that is a change, an improvement. The volatility of rates, I mean again, we do our best to provide reasonable, attainable rats and so we continue to work closely with our health plans to ensure that we are providing the most appropriate rate.

CHAIR GRGURINA: So Lindy, what you said was, Phase 2 either 2022 or 2023. First of all, there was good reason for getting a standing ovation, thank you very much. (Laughter.) Love to get the rates in advance when the year starts. But also one of the things you said is you are also looking to align the benefits as well, have everyone providing the same benefits. Is there a time line on when you're looking for that? Is that 2022, 2023?

MS. HARRINGTON: That is still in development and I will let JC talk more about that later in a year.

CHAIR GRGURINA: All right, thank you.

MS. HARRINGTON: The timing for this, yes.

CHAIR GRGURINA: Shelley, did you have a question?

MEMBER ROUILLARD: I did. So on the map, Lindy, Region 5 is DMB 18 Rural. I'm use to GMC in the context of Sacramento and San Diego. What is GMC

Rural?

MS. HARRINGTON: So that is actually our rural region that exists today.

MEMBER ROUILLARD: Is this California Health & Wellness? Is that their region?

MS. HARRINGTON: It is -- I don't remember off the top of my head, I apologize, there are so many that go together. But this is our 18 rural counties that are currently in what we call the regional model and so that is that. The GMC is not a referral to truly Geographic Managed Care where there's like as many as you want.

MEMBER ROUILLARD: Right.

MS. HARRINGTON: This is similar to a two-plan but both plans are commercial.

MEMBER ROUILLARD: Commercial.

MS. HARRINGTON: Yes.

CHAIR GRGURINA: I believe that is Centene and Anthem Blue Cross.

MEMBER CONKLIN: I think it is.

MEMBER ROUILLARD: Okay.

MS. HARRINGTON: I think so.

MEMBER ROUILLARD: All right. Thank you.

CHAIR GRGURINA: Amy.

MEMBER YAO: Yes, I have a question. To build on Jeff's question around coordination with the ACA market and also DHCS. Today there is a risk adjustment model. Some is based on pharmacy data and I heard there is a new diagnoses-based model that is rolling out. If there is a possibility that we use the same

model as the ACA market so make it simpler. And especially there are lots of numbers --

MS. HARRINGTON: There is --

MEMBER YAO: -- going back and forth.

MS. HARRINGTON: -- there is not currently we do not currently plan to make changes to our, to our models that we use for our rate-setting processes.

CHAIR GRGURINA: I think we are ready to continue to the next slide, Lindy.

MS. HARRINGTON: Okay. So the next update that I wanted to provide is related to the Medical Loss Ratios. And so the first is for the Optional Expansion MLR Risk Corridor as we have lovingly been calling it lately because of the institution of the full MLR reporting required for all populations. We wanted to have some distinction and so for the optional expansion it really is a risk corridor.

Originally it was intended to be for the first 30 months of the program. CMS has required that we maintain that risk corridor for state fiscal year '16-17 rates as well as for state fiscal year '17-18 rates. There were a few reasons for this that CMS wanted to ensure that we were because we were continuing to use a blended method for rate-setting that it wasn't 100 percent based on risk I mean based on the plans' data. They wanted to ensure that we continued the risk corridor.

For the first 30 months we did complete that process and the health plans have provided funds back to the state. We were covered more than $3.5 billion in funds that were returned to the federal government associated with those first 30 months of the program.

CMS has instituted plan audits associated with those risk corridor calculations. CMS has -- they have contracted with Deloitte to complete those audits. Deloitte is currently in the data collection period and working with the Department to collect data and review information submitted by the health plans; and the next steps will be they will be going out and talking to the health plans to validate the data submitted.

The second part is the annual reporting for all populations, which was required under the Managed Care Fine Rule. That reporting started in May of 2019 for state fiscal year '17-18 and will be utilized for the purposes of the next rate setting.

CHAIR GRGURINA: Lindy, before you move on, just one comment for folks to know. So the risk corridors that you talked about for the 30 months, the plans submitted those and DHCS audited them and now we are getting CMS to come in for another audit.

MS. HARRINGTON: I would say CMS did a desk review more than an audit (laughter), but yes, now a formal audit is happening.

So moving to the next slide. I did talk about there was a bit of complication with moving to calendar year rates and that is what happens during that six month window. What we have requested from CMS and received kind of the green light to move forward with is to create an 18 month rate year rather than attempting to do a 12 month and a 6 month. Again, trying to minimize workload both for the state as well as for CMS. And so we have proposed a rating period that will be July 1, 2019 to December 31 of 2020, that will then allow us to move into the calendar year rates.

And so for that rate year, just a few things. I talked briefly about these.

But what will be included in those are directed payments that we were required to submit proposals to CMS by June 30th, we have done that. And that includes Proposition 56 provider payments and those are higher payments to providers for select services. Again, I talked through those earlier. But physician services, dental services, family planning, developmental screenings, adverse childhood event screenings, also known as trauma screenings.

The next is the value-based payment program and that is $340 million. And those were really to improve quality and health outcomes in four domains, prenatal and postpartum care, early childhood preventive care, chronic disease management and behavioral health.

As well as Behavioral Health Integration Program. That is also effective January 1 of 2020 and is looking to promote integrated delivery of behavioral and physical health care. That will require applicants to actually submit applications to the Department. It will be similar to activities undertaken through the PRIME program with hospitals where there are a defined set of metrics and things that have to be included in order to be considered for the program and certain groups will be awarded. The difference in this is that it will be provided and funded through the managed care plans.

We are also continuing our hospital directed payment programs. So we will have the Private Hospital Directed Payment program, it was $2.3 billion in state fiscal year '18-19. The goals for this program were to improve and encounter data reporting as well as maintain or improve access to care. So again, this was the Department working with the hospital industry to continue the HQAF program that we could no longer do sa a pass-through program with the advent of the Managed Care

Final Rule, so this is the replacement program. About half of the funds associated with the Hospital Quality Assurance Fee are provided through this directed payment.

We are also continuing the Designated Public Hospital Enhanced Payment Program also known as EPP. It is approximately $1.5 billion in state fiscal year '18-19 and it had the same goals.

We have the Designated Public Hospital Quality Incentive Pool. That was approximately $700 million in state fiscal year 2018-19. And payments for those hospitals were linked to performance on quality measures, again leveraging information we had learned from the PRIME program under the Medi-Cal 2020 waiver.

And what we will be doing is we will also be having -- because of the end of the Medi-Cal 2020 waiver and the end of the PRIME program that actually ends on June 30th of 2020 for the program years for those programs, we did not want to lose momentum on the activities and improvements that we had seen for those programs. So what we have proposed to CMS is a transitional quality improvement program we are calling QIP 2.0 for the designated public hospitals and also adding in district and municipal public hospitals for a six month period to continue those activities.

And we will be -- as part of the Medi-Cal next waiver we will be looking to continue those programs, instead of through the waiver through the managed care plans, and we will be coming with a QIP 3.0, which leverages different metrics.

And that's what I have, does anybody have any questions?

MEMBER DEGHETALDI: What is the fate of the PHDP program in the future?

MS. HARRINGTON: The PHDP, the private hospital?

MEMBER DEGHETALDI: Yes, yes.

MS. HARRINGTON: So we anticipate that it will continue. We anticipate that as the phase-down happens on the pass-through dollars that the funds coming in through the PHDP program will increase.

CHAIR GRGURINA: Paul.

MEMBER DURR: A question on the chronic disease management programs that you've done under the Quality, do they align with what IHA has?

MS. HARRINGTON: I will have to, I would have to defer to our quality experts because I do not know what programs IHA has, I just do the funding for them (laughter).

MEMBER DURR: Just making sure the metrics are more aligned because that's what really is burdensome to the providers who are working in different camps, right? So that they have one set of metrics that if it were aligned with what IHA has it does make it easier for the provider.

MS. HARRINGTON: What I can say is that for our value-based payment program what we did do is we held -- we released the metrics, we held multiple webinars as well as comment periods and I know adjustments were made based on those comments that were received by the program staff.

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

MS. HARRINGTON: Thank you.

CHAIR GRGURINA: And continue to push forward with all the hospital directed payments. As we can see, there are more than $4 billion there and these are much-needed in our hospitals, as well as the continued push with CMS for the public

hospitals and the other hospitals doing important work, so thank you very much.

MS. HARRINGTON: Thank you.

CHAIR GRGURINA: Okay. Do we have any comments from the members of the public here today?

(No response.)

CHAIR GRGURINA: Okay. Any comments from those on the phone?

(No response.)

CHAIR GRGURINA: Okay, Lindy, you are now free to go.

MS. HARRINGTON: Thank you.

CHAIR GRGURINA: Thank you.

MS. HARRINGTON: Have a great day.

CHAIR GRGURINA: Next up on the '19-20 budget is going to be Mary Watanabe. Welcome, Mary.

MS. WATANABE: Hi, good morning. So I'm the Acting Chief Deputy Director now at the Department, at least for this meeting. I am going to provide a brief update on the Governor's budget and then the Department's budget. As I had hoped, Lindy covered probably about half of my presentation, you got most of your questions out, so maybe if we can go to the next slide.

So on June 27th of this year the Governor signed a balanced, on-time state budget of $214.8 billion, of which $147.8 is General Fund.

The budget will end the year with a total reserves of $19.2 billion, of which $16.5 billion is in the Rainy Day Fund, $1.4 is in the Special Fund for Economic Uncertainties and $900 million is in the Safety Net Reserve.

Of interest to those of us that are state employees, there is a $9 billion extra payment over the next four years to pay down unfunded pension liabilities too. So lots of positive news here.

The budget also -- the Governor clearly made a clear statement in his inaugural budget on the priority of health care for his administration so I am going to talk a little bit about that. But to give you some context, the budget for health and human services programs is $162.3 billion, so quite a significant investment there.

Again, Lindy talked about a couple of these but just to highlight. The budget invests $1.45 billion over three years to increase Covered California's health insurance premiums for low-income Californians.

It also provides premium support for the first time to qualified middle-income individuals earning up to $72,000 and families of four earning up to $150,000. This will be partially funded through the enforceable individual mandate, which you talked a little bit about already.

Lindy already mentioned the expansion of coverage to young adults regardless of immigration status up to age 26.

And the increase in Prop. 56 funding for provider payments, so I'll skip over that.

I think another exciting thing for many of those in this room is the investment to support seniors, which is a growing population here in the state, in particular the end of the senior penalty in Medi-Cal, which has been huge. I know Jen is cheering. (Laughter). This has been a long time coming.

The expanded eligibility for the Medi-Cal Aged, Blind and Disabled, which

Lindy also talked about.

There is also an $8 million investment in Alzheimer's research that is really $3 million for research grants and another $5 for investing in local infrastructure.

And then again, also allowing SSI recipients to receive CalFresh benefits is a huge thing for our senior population.

MEMBER DURR: Mary?

MS. WATANABE: Yes.

MEMBER DURR: What is the senior penalty? I am not aware of that.

MS. WATANABE: Jen, do you want to take that one?

(Laughter.)

MEMBER FLORY: Those are really a description of the same thing.

MS. WATANABE: I can't do it justice.

MEMBER FLORY: Yes. So it's basically just what was mentioned before. Moving the income eligibility limit to the same for seniors as it was for the rest of the adults.

MEMBER DURR: I've got it, thank you.

MS. WATANABE: Okay. And the next slide here just I think there has been some discussion about this as well, about establishing a pathway to transition Medi-Cal's drug benefit to a model where the state is directly bargaining for the lowest drug prices.

Just another one here is the $1 billion investment to address homelessness. This includes addressing mental health supports, expanding the Whole Person Care pilot and building strategies to address the mental health shortages in the

state. You probably noticed the Governor announced his statewide and local representatives for the task force that will be addressing this as well, so a lot of work happening on that area as well.

So moving on to DMHC's budget. For fiscal year '19-20 our budget is $91 million in spending authority and 482 authorized positions. This is an increase of $7 million over the prior year and 31 additional positions.

You can see our funding over the last eight years. It continues to go up along with our positions. You can see the significant increase that happened with the implementation of the Affordable Care Act.

And then just quickly I'll highlight a couple of the BCPs. Shelley mentioned this at the last meeting. All of these were approved and are part of our budget.

So AB 595 gives the Department the authority to disapprove health plan mergers if it violates the Knox-Keene Act or substantially lessens competition. And so in this BCP we were really requesting consultant dollars to do that competitive analysis and it includes about $1 million in this fiscal year and ongoing for those costs.

AB 2674 mandates that the Department annually review the complaints we receive through our Provider Complaint Unit to determine if there are any trends or violations of the Knox-Keene Act and take the appropriate action. So for this we requested 9 positions and $2.1 million, which will include a little bit less than $800,000 to update our provider complaint system and database.

And then lastly, AB 315. Deborah is going to be talking a little bit more about this and our task force in a few minutes. But again, this requires us to register

pharmacy benefit managers, create the task force, there is also a pilot project. So for the work related to this we have asked for two positions, $2.2 million in fiscal year '19-20, $900,000 in '20-21 and '21-22, and then about $775,000 in ongoing funding.

And with that I will take questions. Yes.

MEMBER FLORY: Just a basic question. I know, like Covered California, for example, reports the per member per month amount that is coming from premiums that is funding Covered California. Do you know what the equivalent is for DMHC? Like that $91 million, what percentage is that of people's premiums or is it just totally across the board?

MS. WATANABE: So I don't know about percentage of premium but we do have our assessment amount. We don't have that in here, maybe for the next meeting we could share our assessment amounts.

MEMBER FLORY: Yes.

MS. WATANABE: Yes, we'd be happy to do that. Other questions?

MEMBER DEGHETALDI: Just a point on the senior penalty. As cost of living rises in California disproportional to the rest of the country, having a national federal poverty definition hurts us. And just to point out that two of our federal representatives, Thompson and Eshoo, have continued to reintroduce an indexing of the FPL. It would be great. Imagine if 138 percent of poverty was California's poverty rather than Mississippi's.

MS. WATANABE: Thank you.

CHAIR GRGURINA: Paul.

MEMBER DURR: The Pharmacy Benefit Management, is that going to

cover all medical-related drugs as well, not just outpatient pharmacy and retail pharmacy? Because the whole cost of the biologics and things like that are really a concern to the medical groups.

MS. WATANABE: Yes. I will tell you that every time I read through our minutes and I remember the comments that a number of you have made about the cost for pharmaceutical that are built into the provider groups' responsibility, I think it's something definitely for the task force to take a look at.

So the task force, Deborah will talk about this, but really they are tasked with looking at what information we currently collect and making a recommendation about what additional information should be reported to the Department, either by the plans or their PBM. So we are encouraging public participation to raise these important issues.

MS. WATANABE: More questions?

CHAIR GRGURINA: No more questions or comments from the Board.

Questions or comments from members of the audience here?

(No response.)

CHAIR GRGURINA: Questions or comments from folks on the phone?

(No response.)

CHAIR GRGURINA: Thank you, Mary.

Next, Jeff is out of the penalty box from last meeting (laughter) and Jeff will be talking about his latest results. We look forward to this presentation, Jeff.

MEMBER RIDEOUT: Thank you. First of all I'd like to thank the Department for giving us a chance to give these updates annually now, which is fun. If I

slip into anecdotes about Italy it's just because I got back from vacation, so you'll hear me say gelato and chianti occasionally. First of all, about how much time do you want?

CHAIR GRGURINA: Thirty.

MEMBER ROUILLARD: Thirty.

MEMBER RIDEOUT: Thirty. Okay. I'll try to keep it under that if I can.

This is our third round of collecting information that we produced for both the Atlas program, which is a comprehensive program of performance variation across the state regardless of plan or product, and also the AMP program. And one thing I'd like to leave with the group is that really what allows this to happen is a common data infrastructure. I know that's a little bit technical and wonky but, like gelato, there are many, many flavors of what people want to see out of data. This is one slice of that, so you just have to understand that there are many, many things we can do with this infrastructure now. We do performance reporting on provider groups that take risk, we can look at QHP results, we have been looking at ACL results. So this is one very important slice but it is not the only slice of information that we can provide.

The other thing is this looks, I think for this group importantly, the relationship between the relationship financial risk-transfer and performance, both in terms of quality and total cost of care. So the emphasis here is, what are we getting for the risk-transfer, both positive and negative.

The other thing I'd say, you'll see some hints of other analyses that we are doing, we are doing some analyses on different types of risk-transfer. So my earlier comment on the minutes, when provider groups accept either just professional capitation or maybe full capitation, it doesn't matter how they accept it. So in some

arrangements there are what are called dual risk where the plan is controlling the hospital risk arrangement as well as the ambulatory risk arrangement, in others the provider group is accepting full risk and that in our parlance is called global risk. So I will try to make those differences known as we go along. So next slide.

I think most of you know this but we are organized as a not-for-profit but a 501(c)(6), which means our sole mission for our tax-exempt status is to promote activities that improve the business issues for our members collectively or as utilities. So the Provider Directory is another example. Most of the larger organizations involved in health care are members. Next.

One of the things that we have found over the last couple of years is as a not-for-profit where does our role in providing information end and advocacy start and what can we do, if anything, with regard to advocacy. There's a couple of things in this slide I'd point out. This is our mission statement, so we are here to try to make a difference in how health care is financed and delivered, I think that's pretty safe. One interpretation of our mission is we would like to advance integrated care, because the data that we are seeing suggests that integrated systems do, in fact, provide higher quality and lower cost. Whether that gets into trouble as a not-for-profit entity I don't know, but since the name of our organization is the Integrated Healthcare Association I think we're in relatively good shape there. Next.

Just so people understand sort of where we are versus where we started, five years ago the one box that is labeled AMP Commercial HMO was really our only program.

Over the last four or five years we have expanded both the type of

provider measurement we do to include commercial ACOs, Medicare Advantage and Medi-Cal Managed Care. Also the Atlas program, as I mentioned, is a more comprehensive look at how things, performance is going geographically. We use standard measures across all of these. And then Symphony is the big program addition over the last couple of years. The Future Initiatives boxes you can let your mind wander, but we have all kinds of things that the industry could use in terms of administrative efficiencies. Next.

The AMP program, formerly known as value based P4P. Align. Measure. Perform. This is actually the most intensive measurement of provider group performance for those groups accepting risk, so I will show some AMP results as well as some Atlas results just to show you how they work together.

It includes Commercial HMO, now Commercial ACO, Medicare Advantage, and we are starting to also do some work in Medi-Cal Managed Care, particularly around Promise Health Plan. And it really looks at the RBOs or the risk bearing organizations in California and how they're performing. And that has been kind of the historic program best known for IHA. And it actually covers more measures so that's the other thing. It covers many more quality measures, patient experience, utilization and total cost of care. Next.

Just to give you a little lay of the land for the provider as unit of measurement.

The AMP program for a commercial HMO, again, the historic calling card for IHA, covers not only a common measure set but reporting and benchmarking, recognition, public reporting and incentives. So it's the most comprehensive application

of the information that we generate.

Medicare Advantage does not include incentives because of the star system and the way that Medicare Advantage is paid.

Medi-Cal, as I mentioned, we are working with plans selectively that want to use the platform for an incentive program. It is a much longer discussion around whether that fits or doesn't fit with where the state is now going for Medi-Cal performance incentives.

And then Commercial ACO is a program that really just got launched about a year and a half, two years ago, and is really getting quite a bit of national attention. We are now on the national ACO measurement standards committee as well as getting a lot of interest from other states and other national carriers around how to apply this kind of program. Next.

The Atlas, which I will spend most of the time on today.

Two dozen standardized measures of clinical quality. Quick to say those same measures are applied in the AMP program, so we are trying to be consistent across the programs that we have direct control over. It also includes the standard definition of Total Cost of Care. All of these are NCQA or NQF endorsed. And also we look at patient cost sharing and utilization measures.

It covers nearly 30 million Californians. I'll describe some of the nuances of what 30 million means because we do a lot of double counting in general as an industry but that's pretty, pretty good.

And then what's viewable. Information by geography, as I mentioned, by product and by sub-products to the extent that the use agreements allow us to share

that information. Next.

A wonky slide here but this is how sausage is made. And I am putting this up mainly because I also want to highlight sort of -- we would love to play a role in the AB 1810 legislation that has come out. We submitted our RFI response, it seemed to be well-received, but a lot of the work that we have done over the last two decades hopefully has a role in what the state tries to create so we are not recreating a lot of the work. And some of this is just the work and some of it is the relationships, because a lot of the nuance of any all-payer-claims database is what people are actually giving you when you ask them for something and how easy it is to get.

And we are moving our collection cycle. We have moved it up to make it strictly annual and we will probably be moving to quarterly in the next couple of years and even monthly, because a number of the large plans that provide the data, it's actually easier to provide it on a monthly basis. So it not only gets us a chance to do more regular reporting but also gives us a chance to correct errors on a more iterative basis as opposed to sort of once a year.

MEMBER ROUILLARD: Jeff.

MEMBER RIDEOUT: Yes.

MEMBER ROUILLARD: AB 1810 had a lot of provisions in it. Why don't you just clarify which one you are specifically interested in.

MEMBER RIDEOUT: Oh, I'm sorry. This is the statewide all-payer-claims database that would supposedly support a number of these cases. Next.

This is one of the nuances about the $30 million. We do cover with information about 75 percent of the California population. The big Achilles heel is the

Medi-Cal line and we have gone around and around on this. We get results from Medi-Cal, we don't get the actual data. And as much as we have tried and others have tried there is some hesitation to provide that to essentially a voluntary, private infrastructure.

So while we can do some comparisons across Medi-Cal versus Commercial Medicare they are limited to what Medi-Cal provides us. I will say it is not our goal to do straight up Medi-Cal versus Commercial or Medicare Advantage comparisons, that is just a nuance, a limitation of what we can't do. We did get some richer data, richer information a couple of years ago and there are some pretty interesting differences between different Medi-Cal managed care models, so GM versus COHS versus others. So there are things you can do within the Medi-Cal bucket if you have that kind of information, we have some limitations there. All right.

This was supposed to build but I'll try to explain it. The middle line, the gray line, those are actually actual data points for 200 risk bearing organizations on a composite for diabetes care, so that is the average. The bottom orange line, or whatever color that is, that is actually if you measured that same measure at those same groups with one health plan at a time; so you could be anywhere. And the top line is the highest across these multiple plans.

So if you are a physician group or a unit of analysis that is being measured multiple times by different entities you could be very good or very bad, it is only when you start aggregating the data that you get some reliable signals. So I put that one up just to remind people why pulling all this together in one place actually has some advantages. Next.

Another criticism, not criticism but just a caution we have is why measure

just a few things, you know? What can you learn from that? This actually, the story on this slide is basically whatever we have been measuring, it's correlated to almost anything else in the right way. So any subset of clinical measures seems to be correlated to another subset of clinical measures. Access or preventive health seems to be correlated to better access and lower ED use. So we can do this all day if people want but the story is if you think about measures not sort of as necessarily an end in themselves but as a signal for what a provider group or health plan is doing, you can learn a lot from a very parsimonious set of measures. Next.

Okay, so here we go. So risk sharing. That's the point of today. Next.

This is the end of the story, so we can stop after this and ask questions. But what we found again this year is that organizations that take some level of financial risk actually perform better across eight standardized quality measures, both preventive and chronic care.

The also demonstrate lower total cost of care per member and lower member cost sharing on average.

It also -- the new finding is the fourth one, that Commercial ACOs actually now seem to show, we have done this now for two years, higher quality on average and lower costs. And these are ACOs that are being used in both HMO products and PPO products. So there is actually a nice trend emerging that ACOs, regardless of the sort of product chassis they are put on, seem to be performing well.

Now the first thing I'd say is averages hide a lot, so really what you want to look at is the range and we don't really have time to do this today. But in general the averages do reflect also the narrowness or the width of the ranges in a lot of these too.

So bottom line here is financial risk sharing seems to be a good thing for quality, for cost and for patient cost sharing. So there it is first: Better clinical quality for commercially insured members. And I should caveat, this is all commercially insured. Next.

So this gives you the statistics across those eight measures, an average. Provider organizations that don't take any risk. And this is largely PPO products. And I am being very cautious here because the unit of analysis here is the member. We collect information from the plans on a member-specific basis, so we are dividing these based on the member and their choice of product type. But when you get to organizations that take full risk, that's the far right, you actually get a pretty high level across these eight measures. The eight measures include two preventive health measures and six measures of chronic care, with a heavy emphasis on diabetes. Next.

This is more dramatic when it builds but I'll just explain it. Again, this is looking at those 200 provider groups arrayed from left to right in terms of performance. If you look at the -- I'm going to do it by diamond color. So if you look at the Integrated Care Average of 58.9 percent, that is the average across those 200 risk bearing groups for this composite of diabetes care. If you look at the best integrated groups, that's the top quartile, they are up around 73 percent. If you look at the statewide average across all product types it is as low as 53 percent.

So one way to interpret this is a random choice in an integrated network is almost as good as the highest regional average in a geographic assessment. And it really goes to what the people get, so about 118,000 more diabetics would be under better blood sugar control if they were at the high end of the integrated care average.

So these kind of analyses actually tell a better story. I mean, the best story is individual patients but these kind of tell the differences that we are seeing, in this case in quality, through integrated care versus non-integrated. Next.

Lower total cost sharing for members in provider groups taking risk. Next slide.

These are averages. These are geographically wage adjusted and clinically risk adjusted. As we know, there's fairly dramatic differences in wages and costs north to south. Also if a population is healthy or sicker that dramatically changes the cost profile so we try to adjust for both of those as best we can. I'm sorry, they are not labeled quite right but number 1 is the No Risk Sharing, 2 is Professional Risk Only, and 3 is full Capitation. Next.

It has its biggest impact on members. So any sort of risk sharing model. And again, this kind of comes back to who is sharing risk and what product is being used. It's usually an HMO so these are really reflective of HMO benefit design as much as anything else. But members exposed to benefits designs where there is not risk sharing generally pay quite a bit more on average. And these are averages across the entire membership so they are about three times higher for patients with chronic disease. So there is still quite a bit of exposure and growing for individuals enrolled in non-risk sharing products. Next.

This was interesting too. This actually shows there is even more exposure for patients with -- for pharmacy costs in non-risk sharing products; and this is also clinically risk adjusted. When I saw this first I thought, well, that's just because we haven't accounted for more people in fee-for-service taking -- with their pharmacy load.

But this actually is reflective of clinical risk adjustment. Next.

Lower bed days. Not consistently. The professional capitation in number 2, bed days of 141, is actually higher than the fee-for-service but in full risk groups it is quite a bit lower. And so I think we know -- one thing I always try to remind myself and everybody when I do this, these are observations, so we are looking at what we see, we are not trying to draw conclusions. And oftentimes when I see this it's like, yes, we knew that, yes, this is just, it's obvious. But it's obvious in a way that could allow someone, legislatures, policy makers, regulators, to actually say, well let's base our oversight on sort of what we see happening here or let's base our policies based on what we see happening here. Next.

When you put the two together. So value is tricky to define but in this case - next slide if you would - what we see -- and this is sort of the punch line. The diamonds, the purple diamonds, that is the average quality score. So as you saw, you have seen all of this but just separately. The quality score seems to go up with the more risk an organization takes and the total cost of care on a risk adjusted basis goes down. So I don't know what your equation is for value but if those things are going in the right direction for both of them I think you have to say that there is some value proposition in risk sharing arrangements that doesn't occur when there is little or no risk sharing. Next.

This actually works really when it's built but it works really not well when it's not built so I'm sorry about this because these came through as a PDF. The punch line here is any sort of risk sharing puts you in a high quality/ low cost quadrant. There are no -- and these are all regions, geographic regions of California. There are no

geographic regions where it is high quality, lower cost when there is no risk sharing. So again, just an iteration of the highest levels of risk sharing often produce the best value. Next.

CHAIR GRGURINA: Excuse me, Jeff, can you hold on a moment?

MEMBER RIDEOUT: Yes, sure.

CHAIR GRGURINA: It is as you said, and you mentioned earlier, the great variability within -- inside of each of the different components. But you look at this and you see from the Series 1, the no risk sharing, even on the upper end it barely reaches above the average.

MEMBER RIDEOUT: Yes.

CHAIR GRGURINA: So it just shows that even though three is variability, it is not coming close to what is happening when you take the risk.

MEMBER RIDEOUT: That's right. That's right.

CHAIR GRGURINA: Thank you.

MEMBER RIDEOUT: Next. The last point on ACOs because they are all the rage and flavor, so like flavors of gelato (laughter). So this is actually a new finding. I think everything you have seen up to now we demonstrated in Atlas 2 and, you know, I am not going to kind of keep telling the same story every year so we are trying to find some new things.

We actually had enough participants in our ACO program now to provide some information about whether that provider organizational model has some advantages or disadvantages. Up to this point I think most of what we have seen and what you see in most of the literature is ACOs are pretty much a label, a marketing

label. It is not clear what is under the hood and that actually makes a difference.

We thought this year was actually - if you go to the next slide - oh, this is actually who is in the program. So again, we are getting very good traction from health plans, from purchasers and provider organizations, such that now we cover about 80-plus contracts, so an individual plan ACO contract. So we are getting to be fairly large in the number of contracts and that amounts to about $700 enrollees. About half the enrollees that are in ACOs are being monitored by this program. Next.

This is a long list of measures. What I would say is our goal is to retire measures that don't really help the cause and introduce measures with the partnership of our ACOs and purchasers where we need to go. So our big push has been on PROMs (phonetic) for depression, patient oriented outcomes. And this is where our work nationally is now -- we are starting to have a little bit of impact because we are trying to help rationalize what happens at the national level for ACOs so that we don't get out of sync again; and there is a lot of out of sync measures, that's for sure. Next.

This is a summary of who is in the program and who is being measured. The measurement included those three health plans, we are now up to five as I mentioned. For the next year we will have United and Health Net as well. Forty provider organizations representing over 80 individual plan provider contracts and covering about 700,000 individuals.

So actually what we found is Commercial ACOs, regardless of whether they are PPOs or HMOs seem to also offer higher quality and lower costs. Next.

And what I've done is I took that same slide and put just the ACO component on it as well. And as you can see, even when ACOs are on a PPO chassis

they seem to perform better. So there is some suggestion, again observational, that the ACO construct can, in fact, provide better value. Next.

These are the numbers. So again -- These are reversed, PPO is now on the right, ACOs are Series 2 there. Next.

ACOs Series 2, PPO Series 3. Next.

And the same messy quadrant but again the same story. When you look at ACOs they seem to perform -- they have the chance to perform in the higher value quadrant, not always but better.

The last thing I'm just going to highlight is the provider group analysis. All of this up to this point on ACOs was based on members that the plan believes it's assigned to an ACO. This is if we look at the ACOs themselves. Next.

A little bit hard to read but basically what the punch line on the next two slides is, it doesn't matter whether you are an HMO or a PPO/ACO and it doesn't matter whether the person is designated to be in an ACO prospectively or retrospectively. There are ACOs in each of those categories that can perform well but not all of them do. So it kind of brings us back full circle that the only way to really know who is performing well is to measure performance, and then you'll see who is performing well.

So there are organizations that seem to have retrospective attribution and are on PPO chassis so you might think oh, that is going to be the worst combination for value, that do quite well, and there are some that are on attributed models on HMO chassis that don't do as well as you think. So I think what -- and again, this is the commercial for IHA or somebody. It's important that we keep measuring this and we look at longitudinal trend and that we reward those that perform well as opposed to

assuming that categories, designations, are good or bad. Next.

And I'll go through the last slide. So I have some final thoughts. And again, this is sort of mine one slide.

Financial risk sharing is associated with higher value observationally and ACOs can contribute to that.

The type of information we are producing with the Atlas and AMP I think is the kind of thing you'd want out of a functional all payer claims database and I think it can really help inform the volume to value push. And by 'inform' I mean which things should be accelerated and which things should be looked at more closely.

The other thing is most of what is causing better value is under the hood, so I would be real cautious, as I think most of us that have been in the industry, in assuming that an HMO is good or an ACO is good or bad, you really have to measure performance to understand sort of what is happening.

And taking risk in and of itself doesn't guarantee anything but it is maybe a necessary but not sufficient condition for performance.

And the last thing which we didn't cover here but which is kind of in the water is we are looking at financial risk sharing between plans and providers. It is very difficult to know how that relates to the level of clinical integration. There are some organizations that use that financial risk sharing to build great infrastructure for care management and data systems, there are others that don't, so one of the things that we are trying to understand is what is that relationship.

And there are a number of academic individuals, Sarah Singer at Stanford being one, that have looked at this a lot and it is actually quite difficult. There are no

obvious markers that you can say, okay, you take risk and it relates to this. But what we do know in our own data is there are groups that take risks that perform well and there are groups that take risk and don't perform well. So the goal there is to say, over the long run, two, three, four reporting cycles, which organizations continue to struggle, because that would be kind of the marker of where to start.

And then the other thing that has been in the water is consolidation. A couple of observations there. We don't know and I don't think anybody does, the relationship between risk sharing, clinical integration and consolidation. So again, that relationship probably needs to be better defined.

What we do see in our data, and I am not sharing it here but we just started looking at this is, there are actually -- full risk sharing is much more of a Southern California phenomenon than it is in the north. In fact, there are 80 percent of the members that are being taken care of under full risk arrangements are in Southern California, and there is absolutely no global risk of any note being shared in Northern or Central California. So if you believe that transferring financial risk leads to good things or the need for more oversight, it seems to be largely Southern California where most of this is still happening. So I will stop there. Thank you.

CHAIR GRGURINA: Jeff, what you are saying there, what you are talking about is you're talking about the commercial world.

MEMBER RIDEOUT: Yes, yes.

CHAIR GRGURINA: Thank you.

MEMBER RIDEOUT: We would love to replicate this. We can and have replicated the Medicare Advantage versus straight Medicare world, we would love to be

able to do the Medi-Cal environment as well.

CHAIR GRGURINA: Comments, questions from the Board? Jen.

MEMBER FLORY: You touched briefly on overall patient health but I'm wondering in terms of measuring the cost and quality if they're, you know, they're looking at all or adjusting at all for either potential selection bias where I think, you know, a lot of people still assume, you know, if I am sick or if I have complex conditions I should get a PPO or whether it's something through policy. Like in Medi-Cal, for example, people with complex conditions can apply for an exemption from managed care and stay in that fee-for-service. So is there any like evidence or thought that perhaps the people in less risk sharing are actually less healthy to start with?

MEMBER RIDEOUT: We do clinically risk adjust all those results. I guess a couple of things. And this is my opinion and others can disagree; and Larry, you may have an opinion on it better than I do. But some things you don't necessarily need to risk adjust. You know, whether somebody needs a preventive health screening or not it's really it has nothing to do with their risk. So what we are trying to figure out is, how do you apply clinical risk adjustment to those where that would make an important difference in how you interpret the results?

Now having said that, if you are risk adjusting for total cost of care and you are still seeing it being higher costs for people that aren't able to access integrated care systems, and that cost is being borne by the individual, it's hard to kind of say, well why is that advantageous at the macro level? I think at the macro level staying with a provider that you know, staying with systems of care that you have kind of figured out. My mother-in-law is always a good story of why not to do that but I'll spare you that

(laughter).

MEMBER DEGHETALDI: Jeff, this is profoundly pivotal work. This validates the California model, this validates my decision 35 years ago to join an integrated, multi-specialty group practice. Because that is what is under the hood. It's an integrated, multi-specialty group practice, typically integrated with care management, with case managers, the whole nine yards.

What surprises me is, and maybe it doesn't, is that quality seems to get a boost before total cost of care. And so -- but that makes sense because you control the A1C, it takes ten years to get the ROI, right? So we may not see the impact on total cost of care for years when you invest in quality and access.

So this is fabulous work and what is under the hood, it's the Berkeley Forum, it's the California Dreaming, it's integrated, coordinated care where the front line PCP owns the patient, owns everything about the patient rather than it's a transactional -- that's what's under the hood, so thank you.

MEMBER RIDEOUT: I'm glad you can sleep better, Larry, that's good (laughter). I sleep better as well.

I guess one thing that -- this is just speculation but the big jump in quality seems to be between no risk and some risk as opposed to no risk and all risk. And my speculation is that is the mind shift change to population care versus transactional care, as you called it. And then the full risk allows for over the longer term the value equation to kind of blossom a little bit more.

MEMBER YAO: Yes. So Jeff, I have a clarification question. Other than the last one, the ACO, clearly you don't have Kaiser in there. How about the other?

MEMBER RIDEOUT: Yes, Kaiser is in the other ones but not in the ACO.

MEMBER YAO: Kaiser is -- okay. They are labeled as a full risk?

MEMBER RIDEOUT: Oh, I'm sorry. No, they are not in the full risk. And the reason is because they would dominate the results. So this is all the network model.

MEMBER YAO: Okay, so it does not include it.

MEMBER RIDEOUT: I'm sorry, I should have made that clear.

MEMBER YAO: Okay.

MEMBER RIDEOUT: As I think we all understand, Kaiser performs pretty well, at least on the quality, I think on the cost they are more competitive geographically. If they were in the problem with the graphs would be all of the results would reflect Kaiser --

MEMBER YAO: Because Kaiser is --

MEMBER RIDEOUT: -- because they are 60 percent of the HMO.

MEMBER YAO: Okay.

MEMBER RIDEOUT: And we talked a lot to Kaiser Permanente about that and they understand why we want to present it this way, because it actually is a more true representation of the risk sharing model in general and they can then claim that they are a part of that too.

MEMBER YAO: Okay, I have a second question.

MEMBER RIDEOUT: Yes.

MEMBER YAO: The second column, is that professional risk? But how about hospital? Does that mean the hospital is totally fee-for-service or there is risk

sharing?

MEMBER RIDEOUT: No, I don't know about reinsurance but it means that the capitation that's shared is just for professional services.

MEMBER YAO: Okay. So I think it makes sense to see the jump. Like I agree with Larry, that's what we believe too, is the PCP actually makes a difference in terms of quality and cost. So your last two columns, professionally they have the risk so that totally makes sense.

CHAIR GRGURINA: Go ahead, Paul.

MEMBER DURR: I was just going to reecho that. I think what you find in this, Jeff, you've done a great job of really portraying how valued the delegated model medical groups are and the provision of care that they are giving to the patients in their community. And I would say that there is another added benefit, and Jen you kind of alluded to this, which is, you know, the other fee-for-service patients that don't get that.

But when you are doing this for all the patient population that you have, Medicare Advantage and Commercial HMO, that is a big halo effect that every fee-for-service patient that walks in that office is getting that same level of care and not being reflected. That only comes about from what IHA has done and coordinated that care delivery with the delegated medical groups and I think that is also with APG has led that in aligning those initiatives. And that that really makes a difference in how all the citizens in California are getting much better care delivery and have lower costs, better quality, because it is all focused around initiatives that clinically make sense for the patient and every other patient that walks through that office.

So I think you need to keep doing this every year because what I see is

that we need to get this information more out into the public, into the community, to help them realize the value equation that is really being generated by this. Thank you.

MEMBER YAO: Can I just add one more. We have done a study with Covered California because they were wondering whether -- even in the PPO environment we have the PPO plan. Even in the PPO environment does it make a difference if you have a member that has an assigned PCP whether there is a -- probably not as strong a relationship as the HMO environment. So based on our results, the members with assigned PCP, their costs lowered actually, the quality also higher. Even in that kind of loose kind of relationship. So that may make a difference.

MEMBER DEGHETALDI: Just pay the PCPs more (laughter).

MEMBER YAO: Yes, we are going to, we are going to.

MEMBER RIDEOUT: Amy, one thing that we are talking to Covered California about is whether we can use this infrastructure to look at QHP performance separately. Which we have done already, but because of the use agreements with plans like Blue Shield we can't share it directly with Covered California. And one of the things that they would like us to do is not only look at QHP but QHP versus the book of business for say, Blue Shield.

MEMBER YAO: Right.

MEMBER RIDEOUT: So that they can start to make those inferences about, you know, what products are being provided and whether there is that halo effect or not.

MEMBER CONKLIN: One more?

CHAIR GRGURINA: Go ahead.

MEMBER CONKLIN: So probably connecting the dots wrong but I'm thinking about the next presentation about solvency. Maybe it's out of scope but it would be interesting to understand as you peel the onion, the concentration of memberships in a group as opposed to their fee-for-service book. We see there is a pretty big difference.

MEMBER RIDEOUT: Yes.

MEMBER CONKLIN: And the key ingredients, whether that is infrastructure, leadership. What are the things that actually generate that result? You said Southern California more so than others. It would be fascinating to know from a regulatory perspective. For instance, does a group that also happens to have poor management and solvency challenges also have low quality? So it would just be interesting to connect those dots over time. Is that sort of within the scope of your work?

MEMBER RIDEOUT: So a couple of things. Shelley did ask the Department to try to connect the dots between solvency and the groups that we see as being high or low quality and there really wasn't any.

MEMBER CONKLIN: There isn't? Okay.

MEMBER RIDEOUT: I think it may -- my speculation, again, is that we are looking at a very small tip of a tail. One study that Cheryl Damberg did from RAND using our data was to look at which groups are maximizing their investment to get the most out of quality.

MEMBER CONKLIN: Okay.

MEMBER RIDEOUT: So instead of saying 'We are going to compare you

to each other' it's 'We are going to compare you to what you could be achieving' and that is a very different and interesting way of thinking about improvement.

MEMBER CONKLIN: Yes.

MEMBER RIDEOUT: The last thing I'll say, Jeff, is that what we also are able to do is look at those chronically under-performing groups and also sort of the total number of enrollees in those groups; and it's not insignificant, it's hundreds of thousands. And some of the things that you see are a lack of infrastructure investment as much as we can assess. Because some of these things you can't see. Again, you can see sort of what they might or might not be doing.

MEMBER CONKLIN: Yes.

MEMBER RIDEOUT: So I think that's a fruitful area for someone to say, 'Well look, why are they continuing to under-perform? Is that accurate? What are they putting the money into?' kind of thing.

MEMBER CONKLIN: Yes.

MEMBER RIDEOUT: And I think with the risk regulations, you know, those kind of stratifications would be very helpful.

MEMBER CONKLIN: Yes. So for us it would be fascinating to take those learnings and for group -- everybody wants to get better.

MEMBER RIDEOUT: Yes.

MEMBER CONKLIN: But people struggle with how do we actually do that? How do we invest resources? How long does it take? It would be fascinating to take this into an action plan about if you really want to demonstrate great value here are some of the things you should try. That would be great. Thank you.

CHAIR GRGURINA: And I would build off Jeff's comments. First of all, thank you very much for doing this. Part of the great part is, the same results as what we have seen before, which tells us there wasn't something odd about the key findings. The next part is, how do we not only look at those who are performing on the lower end to improve them, how do we look more deeply into those that are performing so well to say, what is it that you are doing that can be replicated elsewhere? This is just that everyone wants to be able to get better. What we want to do is those who are doing well, what are you doing well that we can share those experiences to improve the care for everyone? So thank you very much for your work. Don't go away. Any more last questions or comments? Larry.

MEMBER DEGHETALDI: Just what does keep me up. I understand managed Medi-Cal plans are going to be penalized if they don't achieve P50 national HEDIS for clinical quality. The P50 for HEDIS nationally is lower than the P50 for IHA's commercial world, and there's a lot of reasons for that. But until we get our managed Medi-Cal data as a self-reported, auditable performance measure from physician organizations like the commercial ACOs and HMOs, we're never going to close the gap between Medi-Cal performance and commercial lives. We've got to -- there is a Tower of Babel in the managed Medi-Cal world. We have got to have standardized quality measures and allow groups to report into IHA, make it visible, and we will close the gap. It's on you. (Laughter.)

CHAIR GRGURINA: Okay. Questions from members of the audience?

(No response.)

CHAIR GRGURINA: Questions from those on the phone?

THE OPERATOR: I am currently showing no questions or comments from the phone, standing by.

CHAIR GRGURINA: Thank you very much.

Thank you, Jeff.

Okay. Next we have Sarah is going to come up and give us regulation updates and then stay there and provide federal updates.

MS. REAM: Good morning. I am Sarah Ream, the Acting General Counsel of the Department of Managed Health Care. As John mentioned I will be providing an update on some regulations we are either implementing or working on currently and then I will also be providing some updates on some activities at the federal level.

So with respect to regulations. As you have probably noticed the Department has been very, very busy this year. I am going to talk about a regulation we are implementing, the newly enacted general licensure regulation which we also sometimes refer to as the risk regulation. It is timely given the presentation we just heard. And then I will also cover three regulations that are currently in the formal rulemaking process as well as some that we are in the process of developing, working with stakeholders.

So first regarding the general licensure regulation. On March 3rd the Office of Administrative Law adopted the regulation and it took effect July 1st. This regulation requires any person who accepts any amount of global risk to either have a DMHC license as a health plan or obtain an exemption from licensure for that particular contract under which they are accepting global risk. And for purposes of the regulation

'global risk' means any amount of professional risk coupled with any amount of institutional risk. So those two together, global risk.

After the regulation was approved by the Office of Administrative Law we started receiving questions and concerns from stakeholders and we heard that entities may need more time to - this was somewhat of a sea change for entities who may never have heard of the DMHC before, were not subject to our regulation - and they said they would appreciate more time and more clarification so they could come into compliance with the regulation.

In response to those questions and concerns last month we issued guidance that does a number of things. First, the guidance provides a one year phase-in period for implementation, full implementation of the regulation. So during this phase-in period entities that want to receive an exemption from licensure because they are accepting some amount of global risk merely need to submit their contract to us with a short template form explaining who they are and who their contact info is.

Once we receive that exemption request we would we refer to that as a File in Use. So they file it with us. They don't need to wait for the Department to say, yes, exemption granted, they can assume they will get an exemption. In talking with stakeholders we realized that during this phase-in period having that sort of certainty really helps entities. It doesn't interfere with their contracting. It allows them to have that certainty they need to continue doing the business they have been doing. So during the phase-in period it's a File in Use Exemption Request.

When we receive an exemption request during the phase-in period the duration of the exemption request is either the term of the contract if there is a Knox-

Keene licensed health plan as a party to the contract, or two years, or the lesser of two years or the term of the contract if there is no Knox-Keene licensed health plan that is a party to that contract.

We additionally received input from stakeholders, particularly hospitals, asking whether they could submit contracts on behalf of their projected provider groups. Some hospitals expressed concerns that they had small provider groups of three, four or five providers in a group, and those provider groups really were not -- were not equipped to step forward at this time and submit the contracts. So the hospitals said, can we do that for them, and our answer was, yes, yes you may. So we have been receiving exemption requests bundled together for multiple provider groups and it seems to be working fairly efficiently.

We also clarified in the guidance that there are certain types of arrangements that while they may involve some amount of global risk we don't, at this point, see that they need to be -- come in for an exemption. So those arrangements include bundled payment arrangements, case rate arrangements, DRG or diagnostic-related group payments, per diem arrangements, and then also a CMS/ACO arrangement, so where CMS has approved that ACO arrangement, or arrangements where the payer is a CDI-licensed insurer. So those also do not need to be submitted to the Department for an exemption.

To date we have received 96 -- as of yesterday we had received 96 exemption requests. The vast majority of these requests, so 91 of the 96, are from RBOs that are registered with the Department. And most of these contracts or these requests have a DMHC licensed health plan as a party to the contract, 73 of the 96. So

it's been interesting to see the requests that are coming in and the nature of those. I don't have information at this point, we have not had a chance to really dig in and analyze those contracts yet, but I am hoping that by the next FSSB meeting we will be able to provide some more information about the type of risk sharing we are seeing and a little bit more information about the substance of those contracts.

Turning now to the regulations we have in formal rulemaking, so we have three. The first is the --

MEMBER RIDEOUT: Sarah?

MS. REAM: Oh, sure.

MEMBER RIDEOUT: Real quick. I'd again just stress, I would love it if you guys can make that inventory formal in some way, because I think it's really, really important to understand kind of the degree of risk sharing, who is doing it. Ninety-six sounds like actually a pretty small number relative to what you probably are going to get.

MS. REAM: And I think in response to -- thank you for that question. And 96 is -- you know, we had from -- from talking with stakeholders we had some concerns that we were going to be just -- it was going to be a tidal wave of information coming to us. And it's been -- I mean, 96 is a significant amount but it hasn't been the just flood. That may partly be because we have -- our guidance and also the regulation says that entities don't have to file their contracts that were in effect as of July 1st, so they're I anticipate that -- but they do as those contracts renew or as the entities enter into new contracts. So in the coming year I think we will continue to see a steady input of information of contracts and it will allow us to get a better sense of the types of risk

sharing arrangements that are out there.

MEMBER DEGHETALDI: Sarah, you excluded CDI-regulated plans.

MS. REAM: Yes.

MEMBER DEGHETALDI: I assume that includes ERISA-sponsored plans?

MS. REAM: So it doesn't. CDI, because they're a payer and they have - there is a regulatory backstop there are excluded. And also, you know, our jurisdiction does not extend to CDI-licensed insurers.

With respect to ERISA fully insured employers. There is still the issue that if a fully insured -- so if an employer delegates risk to a provider group or to a hospital, delegates global risk, there is a question as to whether that employer now is fully insured. They have transferred, essentially, insurance risk to another entity and that entity -- the longstanding law is that for an entity to accept global risk or insurance risk from an employer that entity needs to -- they are subject to the insurance laws of the state, that would be the Insurance Code or the Knox-Keene Act.

So in response to that, an ERISA employer, they are not subject to the regulation. But if they transfer risk to a provider group or a hospital such that that hospital or provider group is now -- meets the definition of an insurer or a health plan, then that provider group or hospital would need to either obtain an exemption or a license. And that's really outside of the regulations. That has been the existing, the existing framework for a long time.

All right, I will move on to the three regulations we have in the formal rulemaking hopper.

So we have the -- we are working on a standard prescription drug formulary template as required by Senate Bill 1052. That bill was enacted by the Legislature in 2014. It requires the DMHC and CDI to develop the standard formulary template.

The purpose of the formulary template is to provide more information and to assist consumers in understanding the formularies that they receive from their health plans or their insurers.

This regulation has been approved by the Office of Administrative Law and takes effect on October 1st.

The second regulation that has recently been approved by the Office of Administrative Law concerns changes to our RBO tangible net equity requirements and reporting requirements. This regulation also takes effect October 1st so October 1st is going to be a busy day.

The regulation updates the financial requirements, it increases the minimum tangible net equity for risk bearing organizations, specifically starting October 1st of 2020, so one year after the effective date of the regulation. All RBOs must have TNE equal to the greater of one percent of annualized revenue or four percent of annualized non-capitated medical expenses, so it's the greater of those two.

The regulation also provides the DMHC with greater authority to oversee sub-delegated organizations. So when an RBO delegates to a downstream RBO, that RBO, we now have authority to look through and have authority over that sub-delegated RBO.

The delegation also removes the dichotomy or the split between the larger

RBOs, the ones with more than 10,000 lives, and the smaller RBOs, and requires reporting and tangible net equity requirements for all those RBOs.

And then finally the RBO limits the use of - excuse me - the regulation limits the use of unsecured affiliate receivables when calculating TNE and limits an RBO's use of a sponsoring organization to meet the tangible net equity requirements. We, and I don't want to take Pritika's thunder, but we had been seeing situations where an RBO might be struggling financially and using an affiliate or a sponsoring organization as a crutch to hold them up financially and this regulation addresses that issue.

CHAIR GRGURINA: Sarah?

MS. REAM: Yes.

CHAIR GRGURINA: So you said it limits it. Could you speak a little more?

MS. REAM: Sure. For a sponsoring organization the RBO who needs a sponsoring organization may use that organization for up to one year. They need to be financially stable and become compliant within that one year time.

CHAIR GRGURINA: So it's, shall I say, cut the cord (laughter). For one year you could have the sponsor.

MS. REAM: Right.

CHAIR GRGURINA: But after that, no --

MS. REAM: There you go.

CHAIR GRGURINA: -- you are not counting any of the dollars from the sponsor.

MS. REAM: Yes, fly the coop, little bird. Any other questions on that one before? Yes.

CHAIR GRGURINA: Question. With all of this I would assume that if it is active October 1 of 2019 you are working with the RBOs to highlight for them that they need to be in compliance by October of 2020.

MS. REAM: We will be, yes.

CHAIR GRGURINA: Because there are some who may be in compliance today but under the new regulations may be short.

MS. REAM: Correct. The reason there is that one year lag is to allow everyone to come into compliance.

So the third regulation that we have in formal rulemaking is to update our existing regulations regarding cancellations, rescissions or non-renewals for non-payment of premium. So we are updating this regulation. We also refer to it by the code section in the Knox-Keene Act, Section 1365, or AB 2470. It goes by -- it has lots of different names. But we are updating this regulation to address questions and questions regarding interpretation that we have received.

So the amendments to this regulation make a number of changes. They update the names of notices that plans are required to give to enrollees to better reflect the function of each notice and to clarify the timing for when the plans must give the notices. It can be somewhat complex because there are different triggers. If an enrollee fails to pay premiums a certain notice has to be sent. So we are clarifying to help eliminate some of the confusion that has been in this area.

We also clarified that if an enrollee complains, if they have a complaint

regarding cancellation, rescission or renewal, those are grievances under the law and the plan has to treat them as such.

We have also clarified that a plan's failure to comply with the notice and timing requirements can be a basis for reinstatement of an enrollee. So if an enrollee does not receive timely notice there are consequences for the plan.

The regulations also align with state law -- state law with federal law by acknowledging that suspension during the three month period when an enrollee fails to pay their premium is permissive, it is not a mandatory suspension. We had received feedback from some plans that their systems simply did not -- they were not capable of truly suspending an enrollee's enrollment during that three month period. They were concerned, well are we out of compliance, what do we do; so this fixes that situation.

So the DMHC submitted the final rulemaking package to the Office of Administrative Law for approval. We submitted it in June and we expect a final decision by July 31st. And again, with an effective date of October 1st.

Any questions I can answer about that regulation before I move on to some that we are in the process of developing?

All right. Not that that, that was a lot, we have more, more going on. So I am going to talk about three regulations that we have in the informal rulemaking where we are still drafting and working with stakeholders.

So the first is our timely access to care regulation. We are in the process of adopting a standardized methodology for health plans to report compliance with the timely access requirements. We have been operating, the DMHC has been operating under an exemption from the Administrative Procedures Act. This allowed the DMHC to

develop reporting requirements without having to promulgate a formal regulation. However, the exemption expires January 1st of 2020, thus the need for the formal, the formal rule. We expect to have a draft to share with stakeholders by early fall, with a goal of submitting the regulation to the Office of Administrative Law in early 2020 to get the formal rulemaking process started.

We are also working on a regulation regarding out-of-pocket maximum tracking. That's a mouthful. The DMHC understands from stakeholders that it can be difficult for enrollees to track or keep track of where they are with respect to meeting their deductibles and out-of-pocket maximums. So to help remedy the situation we are developing a regulation that will direct plans as to how to track the amount enrollees have spent towards his or her deductible or out-of-pocket max and also to provide time frames within which an enrollee must -- a plan must inform an enrollee upon request as to how much the enrollee has accumulated so far towards that maximum. We plan to release a draft of this regulation to stakeholders for feedback by the end of the year with a goal of starting the formal rulemaking process in 2020 as well.

And then finally I'll just quickly touch upon we SB 1008 from last year directed the Department and the Department of -- our Department and the Department of Insurance to develop a standard benefit matrix for dental plans. So we have -- the California Association of Dental Plans and the CDA, the California Dental Association, have been working together to develop a draft matrix. We understand they will be sharing that with us shortly and we will be moving on and preparing that as well.

And with that I am happy to take any questions regarding regulations.

CHAIR GRGURINA: Any more comments or questions from Board

Members?

(No response.)

Questions or comments from members of the audience?

MS. KEMP: I am Amber Kemp, Vice President, Health Care Coverage, with the California Hospital Association.

MR. BARCELLONA: And I am Bill Barcellona, Senior Vice President for America's Physician Groups. We were here today to talk about the general licensure regulation.

Thank you for the presentation on the regulations, by the way, and congratulations on getting those regulations implemented (laughter) because it has created full employment for lawyers and accountants across the land.

We have a letter we would like to submit to the Director today and make part of the record.

On the licensure regulation. The California Hospital Association and America's Physician Groups have joined the request of the Department to provide greater transparency around the exemption filing process. Thank you for mentioning today that 96 or so groups had submitted applications already.

The Department has for many years provided public disclosure on its website of licensure and surrender applicants under the health plan section of the web page. We would like specific and also aggregate information posted regarding the exemption submittals. We believe there is a strong public interest in this and would request that the Department do so.

MS. KEMP: Thank you. In addition, wanted to thank the Department for

the work that they did on the implementation guidance. During the regulatory process many stakeholders expressed concern regarding the regulation in the Department because it was -- the regulatory process was unwilling to engage in those important discussions with stakeholders.

However, post-promulgation of the regulation the Department has been very collaborative with stakeholders, meeting with our members on a very frequent basis. We sponsored legislation this year, SB 714, to address the concerns that we had regarding the regulation, the expansive scope of the regulation, and really to promote important discussions amongst stakeholders on these various models of improving care, the delivery of care.

So the Department has partnered with us in having those important discussions, has committed to having those important discussions over the course of the next year, and we are really grateful for that partnership and for the work that they have been doing with stakeholders. So just wanted to thank the team for that work.

MR. BARCELLONA: Okay. And I have one more comment just on behalf of APG regarding the licensure regulation. We had a question regarding the treatment of Medicare ACOs under the new regulation. The Department stated in the guidance that Medicare ACOs would be exempted, would be deemed exempted in the process, at least for now. It is unclear, of course, what an ACO is across much of the marketplace; however, in Medicare ACOs are well-defined under the Affordable Care Act.

However, the CMMI has been active in Washington DC and has just issued four new models of risk bearing entities that can qualify for risk bearing payment in a direct model with CMS. And so we don't believe those would be covered under the

Department's statement concerning ACO exemption and we would like some clarification by the Department as soon as possible in that regard. Two of the models include the geographic local risk and 100 percent upside/downside global risk as well. And so given the concern the Department has expressed in the creation of the licensure regulation it would be good to know whether or not the Department wants to attempt to regulate those models.

There is some lack of clarity in terms of the Department's statement in the guidance document concerning Medicare-related risk-bearing models. In the last -- in the last go-around, I think it was the fifth version of the licensure regulation, the Department made statements in response to specific stakeholder comments on the federal ACO model, to the extent that any products issued by CMS would not be subject to state regulation. And this statement was so broad that it creates more uncertainty because obviously the Department has been regulating MA plan financial solvency and any related plan-to-plan relationships that encompass global care in that market for several -- well, for over 15 years.

So we would like some clarification on this as soon as possible so that our groups can determine whether or not to participate in the new CMMI models and what level of state regulation that might encompass. And we are happy to engage further with the Department if you have more questions. Thank you.

MS. DIAZ: Hi, good morning. M.J. Diaz here on behalf of Health Access California. I am going to provide comment on the two regulations that have been finalized.

First on the general licensing set of regulations. We appreciate the DMHC

and your continued commitment in looking into various risk sharing arrangements, whether they are upside or downside arrangements, especially with regards to how those entities accept risk on behalf of providing care to many consumers. We are obviously committed to ensuring that those entities are financially solvent and are also providing appropriate and timely levels of care to the consumers that they are supposed to be serving.

We think that the work that the DMHC is doing on this issue is really important, especially as we think about these arrangements as the status quo in our health care delivery system and also in lieu of the recent information that Health Access has received where hospital providers, based on OSHPD data, where 38 percent of them are financially at-risk and potentially on the red. And so to us these instances make us really concerned, of any providers accepting risk when they are already stretched thin or potentially at risk for other services and other liabilities. So we appreciate your diligence and we are looking forward to working with you on learning more about what types of arrangements exist out there.

And then the other rule we would like to thank the DMHC on is the risk bearing organizations' TNE changes. We provided comments in the reg process last year. While we are -- while our recommendations were not taken we appreciate your responses to our recommendations. At this point we are still willing to look forward to seeing what data the DMHC has in terms of TNE levels and how that differs and inform which RBOs end up in a cap or not. And so we are going to keep looking at those data and make sure that those RBOs are financially solvent. Thank you.

CHAIR GRGURINA: Thank you.

Any comments or questions from folks on the phone?

THE OPERATOR: For questions or comments hit star-one and record your name. I am standing by for any questions or comments.

CHAIR GRGURINA: Okay.

MEMBER YAO: John, I have a question; can I ask?

CHAIR GRGURINA: We're coming to the Board. Amy.

MEMBER YAO: Sorry, I should have -- so Sarah, I have a question around this out-of-pocket max tracking.

MS. REAM: Yes.

MEMBER YAO: The rule that is in development. As a health plan we challenge ourselves to do this, especially on the HMO side because we have capitation. And how to calculate, you know, what's the dollar amount associated with the encounters and then therefore how much should be accumulated toward the deductible is always a challenging issue for us.

MS. REAM: Mm-hmm.

MEMBER YAO: So in your rulemaking is that covering both PPO products and HMO products or is there going to be distinction between those two.

MS. REAM: So we are contemplating that we cover both HMO and PPO products. But we are very cognizant of the fact that there is definitely a time lag between when the enrollee pays the co-payment to the provider, for example, and when the health plan obtains that information, or even if the health plan obtains that information. So these are still some issues that we are thinking about and talking with stakeholders about as we try to craft a solution that works for the plans, that works for

the providers and that also provides the enrollees with the information with the information that they -- you know, they need to make decisions about their health care.

MEMBER YAO: Okay, thank you. So you are considering the member co-pay as an out-of-pocket max. On the HMO side we are developing PPO-like plans so there could be co-insurance and also deductible.

MS. REAM: Sure.

MEMBER YAO: And how to calculate the member share of the value, especially when capitating providers, that's the complication that we are facing.

MS. REAM: Okay.

MEMBER YAO: So I just want to raise that issue.

MS. REAM: Yes, thank you for that.

MEMBER DEGHETALDI: Just a comment on oversight of Medicare ACOs and CMMI stuff that's coming. We started six or seven years ago talking about whether the original Medicare Assured Savings Programs, the pioneer ACOs, what qualifies for the significant downside risk. Over time Medicare losses are looming in California to such a degree that the looming -- and Medi-Cal has done well, done well over time versus inflation. I worry about Medicare beneficiary access. So I would just encourage us to be as careful and as nuanced in terms of regulatory stuff in the Medicare ACO world, to the extent that those represent an option to keep access open going forward. Just my gut says we have a problem and it is going to get worse on Medicare. Fee-for-service Medicare.

MS. REAM: And just if I could follow up with some clarification. So we have received questions about the Medicare ACOs, so the ones where they are

contracting with CMS, they're approved by CMS. And I think in some ways that is conflated with the Medicare Advantage plans. So we have received questions of, well, you said the Medicare ACOs, what about the Medicare Advantage health plans. Well, we regulate those health plans for solvency and administrative capacity. So when we're asked, may an entity take global risk from a Medicare Advantage plan without having a license or exemption the answer has been, no, they need to also obtain an exemption there for the Medicare Advantage plans.

MEMBER DEGHETALDI: Because when we say Medicare ACOs we're talking about a fee-for-service risk-based opportunity, completely distinct from Medicare Advantage.

MS. REAM: Sure, okay. Thank you.

CHAIR GRGURINA: Okay, Sarah, why don't we go ahead and move on to the federal update.

MS. REAM: All right, federal updates. As you probably know there's a lot going on at the federal level. I won't attempt to address all of it, I have actually chosen just two things to briefly discuss here.

So the first is just a quick update on the case, the big case, Texas vs. Azar. This is the case where a federal district judge in Texas found that the entirety of the ACO (sic) was unconstitutional because --

MEMBER DEGHETALDI: ACA.

MS. REAM: I've got ACOs on my mind (laughter). The ACA is unconstitutional because the individual mandate, the penalty was zeroed out. Essentially the judge found that the ACA -- that Congress' authority to enact the ACA

was premised on Congress' taxation authority. Once the tax went away it was the three-legged stool, you kicked out the leg and the whole thing would collapse.

So the states, a number of states, including California, filed an appeal. Last Tuesday a three panel a three judge panel in the Fifth Circuit Court of Appeal heard that case. The commentators, they -- there's lots of commentary and they sort of cut both ways, I think, as to the predictions as to what is going to happen. But what we do know is pretty much no matter which way this goes it will likely end up in the Supreme Court, most likely next year, so I think we're in for a slog. The Fifth Circuit Court of Appeal, apparently they have a goal of issuing decisions within two months of hearing, so this decision could come out as early as this fall, early fall. But then most certainly whoever is the losing party will appeal it to the Supreme Court and that will take probably another year or so, so we have more to come on that.

The second update I have is regarding the new final federal rule regarding Health Reimbursement Arrangements, which are often called HRAs. And the reason I am bringing this forward today is because it is not a particularly sexy topic but it may impact the financial stability, the stability of markets in California and nationwide.

So the new rule is part of the federal government's push to expand access to different types of coverage, including coverage through association health plans and short-term, limited duration plans. So the rule that was issued jointly by three departments, Treasury, Labor and I cannot recall the third, but issued by the feds. It takes effect August 19th and will apply to plan contracts issued as of January 1, 2020.

An HRA is typically, is a type of account-based group health plan that allows employers to fund medical expenses for their employees on a pre-tax basis. So

an HRA must be -- so there are some requirements of them. They must be funded solely by employer contributions and can only be used to reimburse an employee for his or her medical expenses or those of dependents.

But under current law an HRA, this is before the new rule, HRA contributions can be used to pay premiums for group coverage that's provided by the employer. Historically HRAs were treated as group health plans and because of this employees in the HRAs were not able to use those contributions to purchase individual coverage.

The new rule changes this and it expands an employer's ability to use -- an employee's ability to use these contributions to purchase coverage on the individual market. So essentially what an employer can do is they can fund the HRA and then the employee goes and buys individual coverage through either off-exchange or on an exchange. The employee then simply affirms to the employer, yes, I bought the coverage, pay my premium, I'm going to use these contributions to pay my individual premium.

So one of the primary concerns is that by expanding the use of HRAs for the individual market employers would -- it would incentivize employers to have a bifurcated system. So to push their sicker, more risky, costly enrollees into an HRA for an individual product and retain the healthier group for the group plan that the employer may offer and then change their experience rating and potentially cause some destabilization to the individual market.

So to address this rule the HRA -- the rules to address this problem, the rule put some limitations on how employers may use HRAs. They cannot offer both an

HRA and a group product to the same class of employees. Meaning class being, for example, full-time versus part-time employees. Rather, only one option can be made available to a particular class of employees.

The rule also sets out requirements for how big each class -- how small, I should say, each class can be. You can't have a class of one employee.

And then also the number of classes that a particular employee may have and what those may be based upon.

Another concern is that employers may choose to eliminate their group coverage altogether and just go with an HRA and have everyone, have everyone move into the individual market. Whether or how that would impact the individual market and the group markets is unclear.

So we don't know at this point a lot about how or the extent to which this rule is going to impact California but that's -- it can give us some heartburn if we don't know what to expect. So there's more to -- it will be interesting to see how this impacts our market and the nation generally. And with that I am happy to take any questions. Yes.

MEMBER YAO: Definitely we share the same concerns. You know, talking about the employer. The employer, the less-healthy employees, they could end up dumping the whole thing into the individual market.

MS. REAM: Yes.

MEMBER YAO: We are concerned more small employer groups are going to do the dumping rather than the larger ones. There definitely is a concern.

MEMBER DEGHETALDI: Will these patients that move into, let's say the

exchange, will they -- and let's say they come from a large employer. Will they be subject to the risk adjustment transfers as if they were in the individual market?

MS. REAM: I don't know that question and there are some -- there are a number of questions about how those enrollees, for risk adjustment and for other purposes, would be treated. Will they be treated as part of the group or will they be treated as individual market enrollees? So there is that, I think that remains to be determined.

MEMBER DEGHETALDI: I don't mean to be glib but Blue Shield is doing the lion's share of coverage for sicker Californians here. You may have two billion next year.

MEMBER YAO: Yes.

MEMBER RIDEOUT: Just more observation. I remember in the early days of the ACA the latter provision you talked about, about using the HRA dollars to get people to go to the individual exchange. I was aware of several small employers that wouldn't provide any coverage at all, and this was a way to at least provide incentive to have people enroll in the individual market. And again, I don't know the regulations well enough anymore to know what people are required to do or not. But there may be, I don't know, a silver lining in that, if it's a substitute for no coverage or poor coverage.

MS. REAM: Right.

CHAIR GRGURINA: Any other comments or questions from Board Members?

(No response.)

CHAIR GRGURINA: Comments or questions from members of the audience?

(No response.)

CHAIR GRGURINA: Comments or questions from folks on the phone?

(No response.)

CHAIR GRGURINA: Okay.

MS. REAM: All right, thank you.

CHAIR GRGURINA: Thank you, Sarah.

Okay. I think Deborah is going to come up and she is going to talk about the Task Force on the Pharmacy Benefit Management Reporting.

MS. HADDAD: Hello, Deborah Haddad. I am going to talk a little bit about the Task Force for the Pharmacy Benefit Management Reporting. In the interest of time I am going to keep it pretty short. We have had some excellent presentations and we are running a bit over.

So I would just like to note that the Department has announced our task force members, the names as well as short bios of the members can be found on our website. The first meeting will be July 31st in Sacramento. It will actually be here in this room from 9:00 to 12:00 and the agenda will be posted shortly on our website. The task force will advise the Department on what information related to pharmaceutical cost, if any, the Department should require to be reported by plans or the PBMs and the Department will be submitting a report to the Legislature.

The Department is collaborating with other agencies, departments and the public for this task force and we welcome attendance and input at this meeting. And if

you are interested in more information about it you can contact me. And I would also like to note that the DMHC has a press release up on our website which provides more information about what the task force will be looking at and information about the members. So any questions on that?

CHAIR GRGURINA: Questions from the Board Members?

(No response.)

CHAIR GRGURINA: Questions from members of the audience?

(No response.)

CHAIR GRGURINA: Questions from the folks on the phone?

(No response.)

MS. HADDAD: Thank you.

CHAIR GRGURINA: Very nice.

Okay, Michelle is going to come up and do the Provider Solvency Quarterly Update.

MS. YAMANAKA: Thank you. Michelle Yamanaka, Supervising Examiner with the Office of Financial Review. Today I am going to give an update on risk bearing organizations or RBO financial reporting for the quarter ended March 31st, 2019.

We have 187 RBOs that are required to file financial information with the Department.

All RBOs are required to file annual reports with us, which are due 150 days after the RBO's fiscal year-end. For the fiscal year-end 2018 we have received all of the reports.

For quarterly reporting there's two types of reports, the Quarterly Survey

Report, which are the financial statements and a calculation of the grading criteria. Survey reports are filed by RBOs that have more than 10,000 lives or they are RBOs that are on a corrective action plan. And we have the Compliance Statements, which is an attestation by the RBO if they are compliant with the solvency criteria. Compliance statements are filed by RBOs that have less than 10,000 lives. And so for the quarter ended March 31st, 2019 we have 130 RBOs filing survey reports and 57 RBOs filing compliance statements. We also have 11 RBOs filing monthly financial statements, which are a requirement of their corrective action plan.

MEMBER ROUILLARD: Michelle, before you get on this chart I just want to point out this is one of those changes that I mentioned earlier where we used to see like four different pie charts; we are going to see it in a chart format here instead.

MS. YAMANAKA: Thank you. Moving on to financial reports received. The last column on this table contains the reporting results for the quarter ended March 31st, 2019, which shows 177 RBOs filed compliance with the grading criteria.

We kept the pie chart in for you. So the Department has three categories that can be assigned to each survey report, a Superior filing, Compliant or Non-Compliant. For the quarter ended March 31st, 2019 we have 31 or 17 percent of the RBOs filed that were captured in our Superior category. This includes 1 RBO on a corrective action plan. Eighty-nine or 48 percent of RBOs were captured in our Compliant category; this includes 3 RBOs on a corrective action plan and 7 RBOs on our monitor closely list. And we have 10 RBOs or 5 percent of the RBOs that were captured in our Non-Compliant category.

Moving on to corrective action plans. Again the last column on the table

represents the reporting results for the quarter ended March 31st, 2019; and we currently have 19 corrective action plans or CAPs.

Moving on to CAPs, another pie chart for you. Again the 19 corrective action plans. Eight corrective action plans or CAPs were New as of quarter ended March 31st, 2019. Regarding the 11 continuing CAPs, 7 RBOs are improving from the previous quarter, 4 are not improving. And of those 4, 3 RBOs came non-compliant with additional grading criteria and one RBO failed to meet its CAP compliance date. And this RBO, we have been working with this RBO and they have taken steps to ensure future compliance.

The handout provided -- titled CAP Review Summary. It's sorted by MSL and reflects the duration of our CAP monitoring as of the quarter ended March 31st, 2019.

The table shows 15 RBOs that filed 19 corrective action plans and this represents 8 percent of all RBOs. Of the 19, CAPs 8 are approved and 11 are in review. Of those 11, 3 CAPs are in review from the previous quarter, and as I mentioned, 8 CAPs are new as of March 31st, 2019.

The Office of Financial Review conducts an analysis of RBOs that have Medi-Cal lives --

CHAIR GRGURINA: Michelle, you have a question.

MS. YAMANAKA: Oh, yes.

MEMBER RIDEOUT: Can you give us a rough idea of the enrollment that's involved in RBOs with corrective action plans as opposed to the percentage of the number?

MS. YAMANAKA: Yes. I don't have those numbers with me. Let's see.

MEMBER RIDEOUT: I'm assuming it's pretty small.

MS. YAMANAKA: Yes. When you're asking -- hold on a second, let me see if I have those numbers with me.

CHAIR GRGURINA: The next couple of slides show it for the Medi-Cal.

MEMBER RIDEOUT: Yes.

MS. YAMANAKA: For the Medi-Cal but not for all.

MS. DUTT: We can get it.

MS. YAMANAKA: I can get you --

MEMBER RIDEOUT: It's not urgent.

MS. YAMANAKA: That's available, yes. Okay.

Okay, moving on. RBOs that had Medi-Cal lives assigned to them, we did some analysis on those. There were 3.9 million Medi-Cal lives assigned to 93 RBOs. We took the top 20 RBOs that had an estimated 2.9 million lives assigned to them. And of those 20 RBOs, 2 RBOs are on a corrective action plan, 2 RBOs are on our monitor closely list and 16 RBOs had no financial concern.

Looking at the remaining 1 million lives assigned to 73 RBOs, 9 RBOs were on a corrective action plan, 5 RBOs were on our monitor closely list and 59 RBOs had no financial concerns. And with these new slides we do have the Medi-Cal enrollment assigned for those, for those RBOs.

The Office of Financial Review also conducts claims and provider disputes as well as financial audits of risk bearing organizations. For the year 2019 we had 24 audits scheduled. Eight of those audits have been completed. Four are in progress

and of those 4 -- of those 8, 4 of those audits, field work has been completed and 4 have been scheduled. And we have the remaining 8 are planned for the remainder of 2019.

And with that, are there any questions?

CHAIR GRGURINA: No questions or comments from the Board.

Questions or comments from members of the audience?

(No response.)

CHAIR GRGURINA: Questions or comments from folks on the phone?

THE OPERATOR: I am currently showing no questions or comments from the phone.

CHAIR GRGURINA: All right, thank you very much.

MS. YAMANAKA: Thank you.

CHAIR GRGURINA: Thank you, Michelle.

Okay, Pritika is going to give us the Health Plan Quarterly Update.

MS. DUTT: Good afternoon. I am Pritika Dutt, Deputy Director for the Office of Financial Review. So the purpose of this presentation is to provide an update on the financial status of health plans at quarter ended March 31st, 2019.

But before I jump into my presentation I would like to answer Jeff's question with respect to our budget for the fiscal year '19-20. So the assessment amount per enrollee for the whole year is $1.98 for full service, which equates to about 17 cents per enrollee per month. For specialized plans, for the enrollees in the specialized plans, it is 77 cents per enrollee for the whole year and it equates to about 6 cents per member per month. So if you look at, you know, the percentage off of

premium it's significantly small.

Okay. So June 12, 2019 we had 126 licensed health plans, which is one more compared to the same period last year. So we licensed two additional full service plans. So one was a restricted Medi-Cal, which is AltaMed Health Network, and one restricted Medicare, which is Global Health Plan, and one of our vision plans surrendered its license.

So we are currently reviewing 6 applications for licensure, 3 full service and 3 specialized. So of the 3 it includes 2 restricted full service applicants and one Medicare Advantage plan that will directly contract with CMS.

As Shelley mentioned, we had pre-filing with 8 entities interested in coming in for a MA license. So for these entities that we meet for pre-filing, some of them do materialize into applications but then, you know, they have to decide if they want to enter the health plan market.

As of March 31st, 2019 there were 26.3 million enrollees in the full service plans licensed by DMHC. And as you can see in the table, total full service enrollment decreased 220,000 enrollees, which is a less than 1 percent decrease overall; and the decline was mainly driven by the Medi-Cal enrollment.

This slide shows the makeup of the HMO enrollment. The Large Group HMO enrollment had the largest increase so there were more enrollees receiving health care benefits through their employers. The Small Group and Individual HMO enrollment also increased but it was a slight increase on March 31st, 2019.

This slide shows the makeup of PPO/EPO enrollment. Overall PPO enrollment decreased compared to last year. As mentioned earlier, HMO enrollment

increased and it appears more enrollees transitioned to HMO products, which tend to be more cost-effective.

This table shows government enrollment, which is Medi-Cal and Medicare Advantage. So overall the government enrollment decreased. And this is, as mentioned earlier, driven by the decrease in Medi-Cal enrollment while we have been seeing slight increases in the Medicare Advantage enrollment. And this is similar -- compared to the last presentation in April, for December 31st, 2018 we saw similar trends.

So we are currently monitoring 32 health plans closely due to various reasons, including but not limited to declining financial health, issues with claims processing, or if a plan is going through claims system transition issues identified during our financial exams. If a plan is newly licensed we monitor them very closely. Concerns with parent entity, low enrollment, et cetera. So we have various reasons why somebody could make the watch list. So there are 12 restricted licensees that are on the watch list. There's 5 restricted commercial, 6 restricted Medicare Advantage and 1 restricted Medi-Cal. So that makes up the restricted health plans that are on the watch list.

The total enrollment for the closely monitored full service plans is 7.5 million. Of the 29 closely monitored full service plans 12, as I mentioned earlier, are restricted licensees and there are only 1.4 million enrollees in these 12 health plans. The total enrollment for the specialized plans on the watch list is only 143,000. Again, these are the smaller plans.

And as Shelley had mentioned during her update, we have one health

plan on March 31st, 2019 that reported deficiency with our tangible net equity requirement; it's Vitality Health Plan of California. So it's a Medicare Advantage plan and we are currently working with the plan and also CMS to address this deficiency.

This chart shows the tangible net equity of plans by total enrollment. More than half of the health plans are reporting TNE of over 500 percent.

And this chart here shows the TNE health plans by line of business. A majority of health plans with over 500 percent of required TNE have specialized health plans. This is because the required TNE for a full service plan is higher because of medical expenses or risk is higher for full service plans. For most plans the required TNE is driven by medical expenses, so the higher the medical expenses for a plan the higher the reserve requirement is.

This chart shows the enrollment for plans that are being monitored closely. Three plans with over 300,000 lives have more than 500 percent of required TNE.

And this chart shows the TNE by line of business for plans that are being closely monitored. So I wanted to point out there are three plans that we closely monitor right now and they have over 500 percent of TNE, which looks like a large number, but we are watching them closely because of claims processing issues that have been either identified during our exam process or there has been significant uptick in complaints that we received in our provider complaint queue.

CHAIR GRGURINA: And Pritika, let me stop you.

MS. DUTT: Sure.

CHAIR GRGURINA: An important point that you are raising is, closely monitored is not just strictly due to financing.

MS. DUTT: Yes.

CHAIR GRGURINA: It also has to do with the administration as well.

MS. DUTT: Yes. Thank you, John.

So we currently have 25 health plans on corrective action plans and this is as a result of what we found at our routine financial examination. So most of the CAPs are due to claims processing issues identified during the exams. So one of the plans that reported a TNE deficiency, we are in the process of getting a corrective action plan for them so it is not included in this 25 count.

So on average we complete 47 examinations each year. These are the health plan examinations. So for fiscal year 2018-2019 we completed 48 routine examinations, and these also include the three medical loss ratio exams that we do. And so fiscal year 2019-2020 we plan to complete 48 exams. So we have 13 already in progress and then 35 are planned for this year.

Okay. And this brings to the end of my presentation. Any questions? Yes, Jeff.

MEMBER RIDEOUT: I should know this but are the names of the organizations that are closely monitored or under CAP publicly available or not?

MS. DUTT: They are not.

MEMBER RIDEOUT: I kind of ask that question in one way or another every meeting I think. Sorry, I'll get it, I'll get it right. Back to the small table (laughter).

MS. DUTT: Yes, Jen.

MEMBER FLORY: Is there any more that you can say about the Medi-Cal plans that are being closely monitored? Because it is a lot of Medi-Cal lives, it's over a

third of them.

MS. DUTT: Let me move back to that slide.

MEMBER FLORY: Okay. You just kind of mentioned claims processing or provider complaints. The total of what gets people on the closely monitored?

MS. DUTT: So the majority of the plans that are on the watch list and that are Medi-Cal, they are on there because of claims processing issues and they were discovered during our examination. So then we decide what we are going to do, if we are going to do a non-routine or we have an enforcement referral or get a CAP from these plans. So depending on the extent we might go do a non-routine.

MEMBER YAO: I have a question on the Medi-Cal membership decrease. Is that because the economy is good?

MS. DUTT: That's what we were talking to John about earlier so I'll let him take that.

CHAIR GRGURINA: The economy, certain areas of the state like in San Francisco with a $15 minimum wage changes things.

MEMBER YAO: Okay.

CHAIR GRGURINA: And then what we don't know is how much of the effect of the charges, various things, another one. And then the piece that we don't know is, you remember the mandate is actually gone in this current calendar year. So thankfully with the Administration and the Legislature, the policy change where we will have a mandate going forward. But all of those confluence of events together. And what we are seeing in Medi-Cal is particularly in the large urban areas, a reduction of 1, 2, 3, as much as 4 to 5 percent. Some areas of the Central Valley are just hanging

steady or a slight increase. Which, overall, you say is a good thing as long as folks are able to either have insurance through their job or pick it up through Covered California, that's a positive.

MEMBER YAO: Mm-hmm.

MS. DUTT: Any other questions?

CHAIR GRGURINA: Any questions from members of the audience for Pritika?

(No response.)

CHAIR GRGURINA: Questions from folks on the phone?

(No response.)

MS. DUTT: Thank you.

CHAIR GRGURINA: Okay, thank you very much.

Okay, do we have any public comments on matters that were not on the agenda from folks in the audience that you would like to raise?

(No response.)

CHAIR GRGURINA: No. Any comments from folks that are on the phone?

(No response.)

CHAIR GRGURINA: All right, thank you.

THE OPERATOR: Currently showing no questions or comments from the phone.

CHAIR GRGURINA: Thank you.

To the Board Members, are there any agenda items for future meetings

you would like to hear? Jeff, it's your last meeting, this would be a good chance (laughter).

MEMBER CONKLIN: No, but thanks for asking.

CHAIR GRGURINA: Anyone else have any future items they would like to see?

MEMBER DEGHETALDI: Last year we had a nice discussion on risk adjustment transfers, the 8 percent that Shelley referenced. I would like to understand that and see what's happening.

MEMBER ROUILLARD: Yes, we're planning to do that in the October meeting.

MEMBER DEGHETALDI: Great. I figured.

MEMBER ROUILLARD: Also at the October meeting we will have the proposed agenda for the 2020 meetings and I will also mention that we will be recruiting -- we will do a solicitation to replace Jeff on the Board.

CHAIR GRGURINA: Are we sure it isn't November?

MEMBER ROUILLARD: You're right, it is November 7th. Never mind, the November meeting.

MEMBER DURR: I was just going to say, John, to get an update on the pharmacy task force. To make sure that we stay abreast of what is happening with that would be good.

CHAIR GRGURINA: Also it was great to able to have Lindy from DHCS here. I know that they are often busy with legislative hearings but if we could have another update from them that would be fantastic.

Okay. So with that, as Shelley said, the next meeting is November 7th. It is a Thursday, it is here in this room, so mark your calendars. Normally we would think it would be the third Wednesday and in October, but we are doing it in November. So November 7th.

Jeffrey, thank you very much for your time on the Board, we appreciate it.

MEMBER CONKLIN: Thank you.

CHAIR GRGURINA: Jeff, thank you for your presentation today.

(Several people speaking at once.)

CHAIR GRGURINA: I was doing the mental math in my head thinking, I don't know how we're going to make it.

All right, thank you folks for attending and we look forward to seeing you in November.

(The meeting was adjourned at 12:37 p.m.)

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CERTIFICATE OF REPORTER

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

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

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

IN WITNESS WHEREOF, I have hereunto set my hand this 10th day of August, 2019.

RAMONA COTA, CERT*478

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