STATE OF CALIFORNIA

DEPARTMENT OF MANAGED HEALTH CARE

FINANCIAL SOLVENCY STANDARDS BOARD (FSSB) MEETING

ONLINE/TELECONFERENCE MEETING

HOSTED BY THE

DEPARTMENT OF MANAGED HEALTH CARE

SACRAMENTO, CALIFORNIA

WEDNESDAY, NOVEMBER 18, 2020

10:00 A.M.

Reported by: Ramona Cota

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APPEARANCES

BOARD MEMBERS

John Grgurina, Jr., Chair

Larry deGhetaldi, MD

Paul Durr

Jen Flory

Theodore Mazer, MD

Jeff Rideout, MD

Mary Watanabe

Amy Yao

DMHC STAFF

Pritika Dutt, Deputy Director, Office of Financial Review

Lezlie Micheletti, Stakeholder Engagement and Outreach Coordinator

Sara Cain, Associate Governmental Program Analyst

Sarah Ream, Acting General Counsel

Jordan Stout, Associate Governmental Program Analyst

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

Melissa Borrelli
Mazars USA LLP

Kimberly Carey
MedPOINT Management

Diana Douglas
Health Access California

Derek Schneider
MedPOINT Management

Janet Vadakkumcherry
Health Center Partners

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1 PROCEEDINGS

2 10:00 a.m.

3 CHAIR GRGURINA: Welcome to the November 18th Financial
4 Solvency Standards Board meetings, our second meeting that is being virtually
5 held, so we do have some housekeeping notes for everyone. First of all for our
6 Board Members, if you could remember to unmute yourselves when you are
7 making a comment and to mute yourselves when you are not speaking.
8 Secondly for the Board Members and the public as a reminder, you can join the
9 Zoom meeting on your phone should you experience any kind of technical
10 difficulties or connection issues.

11 Questions and comments will be taken after each agenda item
12 starting with agenda item number 4. For the attendees on the phone, if you
13 would like to ask a question or make a comment then dial *9 and then when you
14 are brought up state your name and the organization you are representing for the
15 record. For attendees participating online with microphone capabilities, you
16 could use the Raise Hand feature and you will be unmuted to ask your question
17 or provide your comment. For those who haven't used the Raise Hand it is in the
18 bottom of the screen under Participants. When you click on Participants, down at
19 the bottom of that box there is a Raise Hand. For the Board Members, we will
20 have one item where we are voting so we will use the Raise Hand to vote. And
21 also for members of the public, after you are done with your comments if you
22 could remove your Raise Hand so that it no longer stays up, we would appreciate
23 that. All questions and comments when we get there will be taken in order of the
24 raised hands from when they went up.

25 So with that why don't we do some introductions. We will have the

1 Board Members introduce themselves and who they represent. Welcome, Jen,
2 why don't you go first.
3 MEMBER FLORY: Hi. I'm Jen Flory and I am with Western Center
4 on Law and Poverty.
5 CHAIR GRGURINA: All right, welcome, Jen.
6 Amy, why don't you go next.
7 MEMBER YAO: Hi. This is Amy Yao. I'm from Blue Shield
8 California and I represent the actuarial community.
9 CHAIR GRGURINA: All right, thank you, Amy.
10 Larry, why don't you go next?
11 MEMBER DEGHETALDI: Larry deGhetaldi, family physician from
12 Sutter Health's Palo Alto Medical Foundation; never sure who I represent,
13 though.
14 CHAIR GRGURINA: All right.
15 Paul, why don't you go next.
16 MEMBER DURR: Paul Durr, Sharp Community Medical Group. I
17 think I represent independent physicians.
18 CHAIR GRGURINA: All right. Yes, I believe you do,
19 congratulations.
20 Let's see. Jeff, why don't you go next?
21 MEMBER RIDEOUT: Jeff Rideout from the Integrated Healthcare
22 Association. Based on IHA's membership I think I represent much of the industry
23 at large so I guess that's how I'd put it. Maybe I'm an independent rep, I don't
24 know.
25 CHAIR GRGURINA: All right, thank you, Jeff.

1 Is Ted on? I don't see that he is at this point?
2 (No audible response.)
3 CHAIR GRGURINA: Okay. I am John Grgurina; I am the CEO of
4 the San Francisco Health Plan so I am representing the health plan community.
5 MEMBER DEGHETALDI: John, Ted sent a note that he is going to
6 be a few minutes late.
7 CHAIR GRGURINA: Okay, great, we will have him introduce
8 himself when he joins.
9 Mary, why don't you go ahead and take the DMHC team through
10 the introductions.
11 MEMBER WATANABE: Sure, yes. Mary Watanabe, I am still the
12 Acting Director. I don't know who I represent other than the Department. We
13 have got a couple of folks from DMHC here. Pritika, you want to introduce
14 yourself first?
15 MS. DUTT: Yes, hi. Pritika Dutt, Deputy Director of the Office of
16 Financial Review; I report to Mary.
17 MEMBER WATANABE: And Sarah Ream?
18 MS. REAM: Yes, good morning. This is Sarah Ream; I am the
19 Acting General Counsel for the Department.
20 MEMBER WATANABE: All right. We have got a number of other
21 folks that are on the Zoom, I don't think you see them on their video, but Lezlie
22 Micheletti, Jordan Stout and Sara Cain are all providing administrative support
23 today. Michelle Yamanaka I think you all know well and she will be presenting
24 later today.
25 CHAIR GRGURINA: All right, great, welcome everyone.

1 Our next agenda item is the transcript and the meeting summary of
2 the August 19th, 2020 FSSB meeting. Are there any comments, questions,
3 potential changes, even though they were exactly what we said, from any of the
4 Board Members?
5 I don't see any movement. Could I have a motion to move the
6 transcript forward?
7 MEMBER RIDEOUT: Motion.
8 CHAIR GRGURINA: Thank you, Jeff. A second?
9 MEMBER YAO: Second.
10 CHAIR GRGURINA: The second, was that Amy?
11 MEMBER YAO: Yes.
12 CHAIR GRGURINA: Okay. All those in favor if you could raise
13 your hands in the Participant box or you could just put them on the screen as
14 Larry is doing. Let's see. There we are, great. Amy, I don't think I see yours yet.
15 (Show of hands.)
16 CHAIR GRGURINA: There we are, we are good to go. All right,
17 that passed unanimously. Thank you, folks.
18 All right, the next agenda item, Mary for the Director's remarks.
19 MEMBER WATANABE: Thank you, John, and welcome,
20 everybody. We have a very full agenda today as you can see so I am going to
21 try to keep my remarks as brief as possible; but I will say that's tough because a
22 lot has happened since we were together in August.
23 I was going to start with an update on our Executive Team but as
24 you can see there is not a whole lot new there, I am still the Acting Director.
25 But I am excited to announce that Amanda Levy has joined the

1 Department as our Deputy Director for Health Policy and Stakeholder Relations,
2 which was my former position. Amanda comes to us from the CA Psychological
3 Association where she served as the Director of Government Affairs for the last
4 16 years. She coordinated their policy positions, lobbying strategy and
5 grassroots outreach and has extensive experience working with stakeholders; so
6 I am really excited to have Amanda join our team. At some point we will be able
7 to introduce her formally to all of you. She will be leading our implementation of
8 SB 855 on behavioral health, which I will be talking about later. So welcome
9 Amanda, I am thrilled to have her on the team, I have one less hat to wear right
10 now.
11 Moving on to our response to COVID-19.
12 Since our last meeting we have issued three All Plan Letters that I
13 wanted to flag for you.
14 The first was reminding plans about the flexibilities related to
15 telehealth, that they remain in effect during California's declared state of
16 emergency. There was some confusion about how long those flexibilities were in
17 place and they will continue as long as there is a state of emergency.
18 We also reminded plans not to include provider's home addresses
19 in provider directories. We were hearing a little bit about some instances as we
20 were moving to providers providing services out of their home, we want to make
21 sure we are protecting their privacy.
22 We also issued an All Plan Letter to clarify the requirements of our
23 emergency regulation and to answer some of the questions we've received.
24 Sarah did a big presentation at our last FSSB meeting and there's been a lot of
25 questions about that.

1 We also posted a Fact Sheet as kind of a simple message,
2 particularly for employees and consumers, about how to get tested and to have
3 your health plan reimburse if you need to get tested; so that has been posted on
4 our COVID-19 webpage.
5 Finally, we issued an All Plan Letter reminding health plans of
6 existing requirements related to vaccines and encouraging plans to exercise
7 maximum flexibility in covering and reimbursing for vaccines for enrollees. That
8 was really intended to encourage everyone to get a flu shot but also making sure
9 that people continue to get their vaccines and immunizations as appropriate.
10 And as I mentioned, all of this information is available on our
11 COVID-19 webpage, which is linked from our home page at healthhelp.ca.gov.
12 I also will point out that Sarah Ream is here today to offer support,
13 as always, to me. We normally have a regulations and federal update that we
14 have had on our agenda but due to the number of items we have today we won't
15 go through that today.
16 Now I want to just briefly highlight some of our recent enforcement
17 actions.
18 On August 25th we ordered Aetna Health of California to stop using
19 the plan's national standard to deny payment for emergency room claims. This
20 practice has resulted in Aetna wrongfully denying members' emergency room
21 claims as the plan should be applying California's broader standard to approve
22 emergency room services.
23 We also fined Aetna $500,000 for repeatedly failing to apply
24 California law and failing to implement corrective actions to correct this problem.
25 Aetna has repeatedly agreed to follow California's standard for reimbursing

1 emergency room claims but is continuing to use its national standard, which
2 resulted in denials of emergency room claims.
3 California law requires a health plan to pay for emergency medical
4 services unless it is in possession of evidence to show that either the emergency
5 medical services were never performed or the enrollee did not require
6 emergency medical services and reasonably should have known that an
7 emergency did not exist.
8 The other enforcement action that you probably saw our press
9 release about was on October 28th we announced that we have fined Blue Cross
10 of California Partnership Plan a little over $1.2 million for its failure to timely
11 implement two Independent Medical Review decisions. These were both related
12 to authorizing coverage for medically necessary services. The Medi-Cal
13 managed care plan confirmed receiving the Department's notification of the IMR
14 decisions but failed to timely authorize the enrollees' services.
15 Moving on to an update on something that we have been talking
16 about quite a bit, which is AB 731.
17 Last year the Governor signed AB 731, which now requires a health
18 plan offering a contract or policy in the large group market to file specified rate
19 information with the DMHC annually and at least 120 days before implementing a
20 rate change. The goal of AB 731 was to continue to bring transparency to the
21 rate setting process in the large group market, similar to what we have had in the
22 individual and small group market.
23 Health plans with large group products that are community rated,
24 experienced rated, or blended rated, are required to file information annually and
25 120 days before any change in methodology, factors or assumptions that would

1 affect the rate for a large group.

2 Health plans submitted their first filing to us on September 2nd and

3 we received 37 filings from 23 health plans. The filings were posted to our

4 Premium Rate Review site just on Monday, on the 16th.

5 We are in the process of reviewing the methodology, factors and

6 assumptions used to develop the rates and determine if they are unreasonable or

7 not justified. Reviewing the methodology, factors and assumptions used by

8 these plans is an important benefit to all large group contract holders because it

9 will give them a previously unavailable assurance that the methods the plans are

10 using to develop their rates are reasonable.

11 And additionally, starting in July of next year, a large group contract

12 holder that has experience-rated or blended coverage and meets certain criteria

13 can apply to the DMHC within 60 days of receiving notice of a rate change to

14 request that we review the individual rate change and determine if it

15 unreasonable or not justified. We are required to use reasonable efforts to

16 complete these reviews within 60 days of receiving all the information required to

17 make a determination. So this is something we will be continuing to bring back to

18 the Board to report on the findings and let you know how this goes but I did want

19 to provide a brief update that we have posted that information to our website.

20 And I wanted to provide an update on a public hearing we have

21 coming up.

22 On May 14th the Department received a Notice of Material

23 Modification from Stanford Health Care Advantage proposing a corporate

24 conversion from a nonprofit public benefit corporation to a for-profit corporation

25 for the purpose of facilitating a change of control. Stanford is a full-service health

1 care plan licensed to offer Medicare Advantage products to consumers in the
2 Bay Area in the counties of Alameda, San Mateo and Santa Clara.
3 We will hold a public meeting on December 8th to review this
4 transaction and solicit public comment. We sent out a notice about the public
5 meeting, it has been a couple of weeks now, but you can find additional
6 information on our website about the public meeting that will be held on
7 December 8th.
8 And before I take questions from the Board I did just want to
9 mention that there were a lot of recommended future agenda items that were
10 discussed at the very end of our last meeting, right at the tail end, so I did just
11 want to take a moment to acknowledge that we are going to address a couple of
12 those today. We have a presentation on risk adjustment transfer, the medical
13 loss ratio, 2021 rates, more information on health plan financials; there have
14 been a number of other comments about RBOs on CAP that we will give some
15 additional information today. But there are some additional items that we just
16 wanted you to know that we haven't forgotten about them but we just couldn't
17 squeeze everything into the agenda today, so more to come on some of those
18 additional items.
19 With that, that concludes my update and I would be happy to take
20 any questions from the Board.
21 CHAIR GRGURINA: All right. For the Board Members either raise
22 your hands or raise them within sight of the Participants place. I don't have
23 everybody's video up right now. In fact I apologize, I can't see Amy, I can only
24 see so many at one time. Are there any comments, questions, from Board
25 Members for Mary?

1 Larry, go ahead.
2 MEMBER DEGHETALDI: Sorry, I don't know how to do it virtually,
3 just like in second grade. Mary, we are preparing for hundreds of thousands of
4 vaccines, right? We are preparing. What is the message to California's
5 consumers and health plans on how to best protect patients from the cost of the
6 vaccine? What can we do as a state to encourage the acceptance of the
7 vaccines? And we don't even know what the costs are going to be yet.
8 MEMBER WATANABE: Yes, no, a really good question and I will
9 tell you that it is something that is top of mind for us right now. I will tell you that I
10 think -- I don't have an answer for you yet. One of the things that we are looking
11 at is just kind of what our authority is, what guidance we will give to the plans.
12 We will be working very closely, obviously, with our sister agencies and with the
13 administration on the messaging. But obviously given the experience we had
14 with testing and some of the barriers and challenges there we want to make sure
15 we are coordinated. Obviously we will have a lot more to talk about in terms of
16 vaccines at our next meeting but definitely we acknowledge it and I think it is the
17 top priority we are all thinking about right now.
18 All right, any other questions or comments from the Board? Jen.
19 MEMBER FLORY: Yes, and just building on the same issue
20 around vaccines. I did want to point out that we do believe that plans play an
21 important role in normalizing the vaccines. We have heard from some partners
22 who have done some focus testing on Medi-Cal recipients, particularly in
23 communities of color, that a lot of times Medi-Cal can be viewed as something
24 that is kind of less-than or second-class, but when they get that plan card that
25 feels like they're getting the same thing that everybody else is getting.

1 And we have already heard, you know, I know that the Governor's
2 office is looking at, you know, trying to have California certify the vaccine as well
3 to get around some of the doubts that people have around the Trump
4 administration protocols. I know that there's been other efforts, you know, trying
5 to work on folks who deny vaccines in general. But there is also real concern
6 among communities of color that they are being tested on or are being used as
7 guinea pigs because of past historical problems. And so I think there is a role for
8 plans to just help normalize this across the population, that we are not asking
9 anything different of anybody else. While things may be rolled out faster to
10 essential workers it is important for everybody to get it and for people to hear
11 that, not just from trusted community partners but also from partners that just feel
12 like, you know, part of the health care establishment that everybody else is
13 involved in.
14 CHAIR GRGURINA: Good points, Jen.
15 Jeff, I see you have your hand up.
16 MEMBER RIDEOUT: Is it completely understood that this will all
17 be distributed through plan provider relations or would this be possibly more of a
18 public health mass immunization distribution process? I'm thinking more like
19 college campuses with meningitis outbreaks and things like that. I didn't know
20 that it had been determined yet.
21 CHAIR GRGURINA: I don't believe it has, Jeff.
22 MEMBER WATANABE: I don't think that's been decided. I will tell
23 you that at this point we are more in the stages of looking at what our role would
24 be and taking a lot of the questions that obviously the plans and providers are
25 starting to raise. We are, I would say, in the early planning phases of that and

1 working closely with the Administration, of course.

2 CHAIR GRGURINA: Okay, Paul, I see you had your hand up.

3 MEMBER DURR: Yes, and to build on that is really kind of -- we

4 really appreciate the Department's role in setting the guidance with regards to

5 testing, COVID testing, and Sarah did a great job with a separate meeting and

6 talking about that. But I really want to encourage the Department to be ahead of

7 the vaccine cost and responsibility because that will be a significant burden if that

8 is interpreted by plans that that has been delegated to the delegated groups. If

9 we are talking about financial solvency with regards to some of those groups and

10 the cost burden that has been borne by the groups in additional supplies and

11 things needed by our providers in order to get through this, if there is some

12 interpretation that that responsibility for the cost of those drugs is borne by the

13 groups that would be another problem.

14 So, you know, we are here to try to support the distribution of those

15 vaccines and I know there is legislation for high cost pieces, but I just would like

16 to encourage the Department to continue your review, Mary, and to think about

17 setting regulations or, you know, notices that would be prospective, knowing that

18 this is just an inevitability right now, that these vaccines will get traction, and then

19 certainly the distribution. But I think the financial responsibility is something that I

20 am concerned about not just for our group, but other groups. Thank you.

21 CHAIR GRGURINA: Thank you, Paul.

22 MEMBER WATANABE: Thank you, Paul.

23 CHAIR GRGURINA: All right. If there are no other comments one

24 last one that I'll just add, Mary, is congratulations on having Amanda come and

25 join the Department. I believe that takes you from three positions down to two,

1 we will hopefully get you down to one someday. I just wanted to be able to say
2 thank you for your continuing acting in dual roles and multiple responsibilities
3 along with your team there at DMHC, thank you for continuing to do that. Okay.
4 MEMBER YAO: John?
5 CHAIR GRGURINA: Yes.
6 MEMBER YAO: John, I have a comment.
7 CHAIR GRGURINA: Sorry, Amy.
8 MEMBER YAO: I just had the same comment on the vaccine. So
9 Medicare has announced that the federal government will pay for all the
10 Medicare vaccines. For the Medi-Cal population has there been any discussion
11 around if the federal government will help to pay part of the cost, at least for the
12 matching revenue part of the cost?
13 CHAIR GRGURINA: I think those are discussions that are
14 continuing to happen on an ongoing basis and I think that many of the members
15 have raised great points about the implementation and the financing of this. That
16 is continuing to be discussed and we will all be a part of that.
17 With that, Mary, I would turn it back to you so that you can talk
18 about the next agenda item, which is the Board Member recruitment.
19 MEMBER WATANABE: Yes. I was actually hoping that we would
20 be announcing at this meeting our potentially new board members or continuing
21 board members. But we heard from a number of our stakeholders that the email
22 with the solicitation either was not received or was going to people's spam folders
23 and we had what I will refer to as kind of a lukewarm response to the solicitation.
24 So given some of the concerns that were raised we have made the
25 decision to go back out with the solicitation that was sent out and posted to our

1 website, I want to say about a week and a half ago. So we are going to allow
2 additional applications to come in through the end of the year. We will make a
3 decision about our selection of members and continuing members and have
4 them start at our what we are now proposing as a February board meeting, so
5 we will make those decisions in the new year.
6 For any of our Board Members that indicated they would like to
7 continue you do not need to do anything else, we will just carry over that interest.
8 And for anybody that has submitted an application previously same thing, you do
9 not need to reapply, we will continue to carry over any of the applications and
10 letters of interest that we received.
11 But I would just for anybody else that may be interested in applying,
12 you can review the information on our website and submit your application.
13 I will just quickly before we move on and we take questions,
14 acknowledge that at our last meeting there were a number of questions about
15 kind of the purpose of the Board, what the charter was and where we go from
16 here. It is not a topic that is on our agenda today. We did receive a letter from
17 America's Physician Groups which we will note as part of our comments for this
18 meeting and I have shared that with the Board. We would like to bring that back
19 to the Board at a future meeting for discussion and it is probably timely and
20 appropriate to do that once we have our Board Members solidified, or at least the
21 five members that will continue for the next three years. Dr. Mazer and Jen will
22 be continuing for at least another year.
23 So with that, happy to take questions from the Board. I will just
24 thank you for your flexibility in pushing this out to make sure that we allow
25 everybody an opportunity to apply that is interested. With that I'll take questions.

1 CHAIR GRGURINA: Questions or comments from the Board
2 Members?
3 Not seeing any raised hands. Looking like, no.
4 Okay. Thank you, Mary. We will look forward to the next meeting
5 to see who will be continuing along with Jen and Ted going forward.
6 Okay, with that let's go ahead and move on to the next topic, which
7 is the Department of Health Care Services Update with Lindy Harrington. I know,
8 Lindy, you have got a lot to cover here and perhaps if you could take the
9 opportunity, Lindy, you know quite a bit about at least where things reside with
10 COVID and the vaccines and discussions around financing and delivery. So, I
11 will leave that as part of your presentation because you know you will get those
12 questions when you're done.
13 MS. HARRINGTON: And I will just brief everyone that my answer
14 is going to be very similar to Mary's around the vaccine in that we are in the early
15 stages of discussions and deciding and making plans for how that will roll out.
16 So I have no answers today that I can provide to anyone other than it is actively
17 under discussion within the Department. And we also are working within the
18 overall administration structure and so what our role will be and how that will roll
19 out in California is still under discussion.
20 Good morning, everyone. My name is Lindy Harrington, I am the
21 Deputy Director for Health Care Financing and I have been asked to represent
22 the Department of Health Care Services today and do an overall update for the
23 Department. I will caution everyone, there's a few of these items that I will be
24 presenting to you that I do not have an in-depth knowledge of. I am presenting
25 on behalf of the Department so some of your questions we may have to take

1 back and get back to you all.

2 First just an update on CalAIM. On September 16th the

3 Department, we officially submitted our request to extend the 1115 waiver

4 through December 31st of 2021 due to the COVID pandemic and the delays that

5 that caused in our ability to do our standard work.

6 On October 1st CMS notified DHCS that the extension was

7 determined to meet completeness requirements. That was really the first hurdle

8 in our extension request.

9 The extension request was posted on the Medicaid.gov website for

10 a 30-day federal public comment period which ended on November 1st. We

11 have now received our first round of questions from CMS related to that request

12 so we will start the negotiations now on that extension.

13 Additionally, we are continuing to work with CMS on the 1115 and

14 subsequent 1915(b) waiver extension requests and to develop applications for

15 the new waivers that would now become effective on January 1 of 2022 post this

16 extension.

17 Around COVID-19 updates. As many of you know, the federal

18 public health emergency declaration was renewed on October 2nd of this year,

19 which extended for a full 90 days through January 21st of 2021.

20 Previous extensions of the COVID-19 public health emergency had

21 come within only days of the expiration date so having this extension come early

22 was a very welcome change in the process.

23 And also just to update everyone, our California State Medicaid

24 Director formally wrote to Secretary Azar in mid-September requesting at least

25 three to six months notice prior to ending the public health emergency. Our

1 desire for that is the hope that we have some notice and can do the wind-down
2 activities in a thoughtful manner rather than having this public health emergency
3 end with little notice.
4 And one of the main reasons for that ask is under the federal public
5 health emergency DHCS obtained more than 50 programmatic flexibilities
6 through CMS, many of which will expire at the end of the public health
7 emergency.
8 These flexibilities impact everything from Medi-Cal eligibility, health
9 care delivery, service delivery, for example telehealth, provider reimbursements,
10 for example a 10% increase in reimbursement for our long-term care facilities,
11 and many other aspects of the program.
12 The Department has communicated these flexibilities to our Medi-
13 Cal managed care plans through various All Plan Letters. However, these
14 flexibilities are subject to the time frames of the public health emergency and
15 state executive orders and will expire at the end of the public health emergency.
16 That is our big push with the federal government to provide us more notice so
17 that, again, we can have that thoughtful transition.
18 Coming in to do some financial updates for everyone. First, an
19 update on the Adult Expansion Medical Loss Ratio Risk Corridor. As we had
20 presented at previous board meetings, CMS did expand that request beyond the
21 initial 30 months that were required and required DHCS to impose those risk
22 corridors for state fiscal year 2016-17 and state fiscal year 2017-18.
23 The risk corridor required recoveries from managed care plans with
24 an MLR below 85% for their enrolled adult expansion population; and additional
25 payments to managed care plans with an MLR above 95% for their enrolled

1 expansion population.

2 For state fiscal year 2017-18, the Department is in the process of

3 finalizing these calculations. However, the average managed care plan reported

4 MLR is about 90%. DHCS anticipates recovering significantly less than we have

5 in prior years and these calculations are on track to be completed by December

6 31st of 2020.

7 As you can see here, we provided some information. In the initial

8 30-month calculation the average MLR was about 75% and we recouped a net

9 $2.5 billion from the health plans.

10 The next time period was that 2016-17. And as you can see the

11 average MLR increased to approximately 82% and we recouped a significantly

12 smaller amount of $403 million.

13 Now we are looking at an average MLR of about 90% so we would

14 anticipate significantly lower recoupments in that time period.

15 The next financial update is really looking at the COVID-19 impacts

16 to managed care. This is something that the Department is continuing to monitor

17 very closely and we are working closely with our managed care plan partners to

18 make sure we can monitor these activities.

19 So the first thing that we have seen is sharp decreases in the

20 utilization of hospitals and professional services that began in March of 2020.

21 Anecdotally we have heard from our managed care plan partners that there has

22 been a bounce-back of that utilization close to pre-pandemic levels by the

23 summer months.

24 We have also seen higher managed care enrollments, mainly due

25 to fewer disenrollments, and I will provide some additional information on the

1 next slide.

2 And finally, as a result of AB 80 that was chaptered this summer,
3 we will be making financial adjustments for our bridge period rates that include a
4 1.5% reduction to the Gross Medical Expense component of the Child, Adult,
5 Adult Expansion, and Seniors and Persons with Disabilities rates as well as
6 implementing a two-sided symmetrical risk corridor for that time period.

7 Again you can see in this chart really looking at the managed care
8 enrollment changes. And as you can see, we are seeing a significant increase
9 moving up in those four memberships within the managed care plans, which is
10 something we again are continuing to monitor and working closely with our plan
11 partners.

12 Next is the COVID-19 risk corridor.

13 A two-sided risk corridor that is symmetrical with respect to gains
14 and losses will be in place for the entire bridge period rating period, which is July
15 1, 2019 through December 31 of 2020.

16 The main purpose of this risk corridor was to mitigate potentially
17 significant upward or downward risk associated with the COVID-19 pandemic
18 and its impacts, consistent with guidance we received in May of 2020 from CMS
19 on responding to COVID-19.

20 The final structure of the risk corridor is being finalized and will be
21 submitted to CMS for review and approval.

22 Those risk corridor calculations will begin no sooner than 12
23 months following the end of the rating period, so the soonest we would begin
24 those calculations will be January 1 of 2022.

25 We are proposing at this time that the calculation will be performed

1 at the plan level so statewide, not at a county or risk rating region level.

2 The calculation will apply across all aid category groupings with the

3 exception of Cal MediConnect. And that will include supplemental payments, for

4 example, behavioral health treatment or hepatitis C, maternity payments.

5 The risk corridor will exclude revenues and expenses related to our

6 Proposition 56 Directed Payments, which are already subject to distinct corridors,

7 any pass-through payments, or pooled directed payments.

8 And finally, DHCS will require managed care plans to provide and

9 certify medical expense data necessary for the risk corridor calculation. And that

10 data will be subject to review and adjustment by the Department, similar to the

11 information that we have done on the AEMLR risk corridor calculations.

12 Next, also included in the calendar year 2021 rates we have

13 included two new efficiency adjustments that are being implemented.

14 The first is the Healthcare Common Procedure Coding System or

15 HCPCS adjustment. And on this adjustment we will be identifying the top 50

16 HCPCS in total statewide spend, removing outlier data, and compared to

17 Medicare Part B unit price. And so what will happen is rates will be reduced if

18 the managed care plan team has exceeded those Medicare benchmarks. The

19 total estimated impact statewide is about .3% of capitation revenues.

20 And the next is our Low Acuity Non-Emergent or LANE adjustment.

21 This adjustment really looks at identifying potentially preventable emergency

22 room visits for conditions that should have otherwise been addressed in lower

23 level settings. We are really looking to remove avoidable ER costs and add

24 replacement costs for those lower level settings. We would exclude ED events

25 that result in an in-patient or an observation stay. And again, total estimated

1 impact statewide is approximate .3% of the capitation revenues. And again,
2 these are really adjustments that would happen to the base data that is used
3 going forward. We are not going back and removing revenue from the plans.
4 And then finally the underwriting gain included in calendar year
5 2021 rates is slated to be reduced by .5%. At the lower bound it would decrease
6 from the historical 2% to the 1.5%. All of these are subject to actuarial
7 soundness in our working through the process.
8 Quickly on the Medi-Cal Rx Project update.
9 So I will say my first bullet says DHCS and Magellan are just over
10 two months from go-live, we will now change that to we are just under five
11 months from go-live. I think as you all are aware and was announced earlier this
12 week that we will be lengthening our transition time to full implementation.
13 The project is currently in a green status, which means all of our
14 major milestones and deliverables are on track.
15 And as of October 23rd the overall project implementation was 76%
16 complete.
17 The requirements and validation phase is complete.
18 And DHCS and Magellan are well into testing those requirements
19 and our policy build through the three stages of testing.
20 However, as we messaged earlier this week, in order to allow
21 everyone more time to become comfortable with those systems and really make
22 sure we have a clean turnover we wanted to allow that extra time.
23 And so this is a really important time and reminder that we
24 encourage all stakeholders to stay informed. To please sign up for our
25 subscription service to receive those updates in nearly real-time.

1 We also have a dedicated secure web portal that has been
2 launched.
3 And finally, for detailed registration and training instructions, access
4 to the *Medi-Cal Rx Web Portal and Training Registration* article is located on our
5 Pharmacy News page.
6 And for more information about the Medi-Cal Rx transition we have
7 a dedicated website that contains some really great reference material that can
8 be helpful.
9 And if anyone has any further questions or comments regarding the
10 Medi-Cal Rx we do invite stakeholders to submit those via email to our Medi-Cal
11 Rx Carve Out email box.
12 Next we have the Medi-Cal Managed Care Procurement.
13 As you all know we are in the process of starting the process for
14 our procurement.
15 Our Request for Information was released on September 1st. The
16 Department held a webinar on September 10th. We requested information that
17 was due on October 10th. And we are currently assessing all of the feedback
18 that we received.
19 We received a great deal of feedback regarding that RFI and so we
20 are currently assessing all of that feedback to help inform our Draft Release of
21 our RFP, which we are targeting for early 2021.
22 We are targeting the Final RFP release for late 2021.
23 With proposals being due late 2021 to early 2022.
24 Expecting Notice of Intent to be issued in early 2022 to mid 2022.
25 And then we would Managed Care Plan Operational Readiness

1 from mid 2022 through late 2023.

2 With a targeted implementation of January 2024.

3 Planned updates for our managed care plan contract. So really we

4 are looking to update requirements to reflect CalAIM and program policies, new

5 state and federal statutes and regulations, and all published All Plan Letters.

6 We are looking to update to include value-based purchasing

7 requirements.

8 Strengthening language regarding our network adequacy and

9 quality.

10 Update contract language to address California State Auditor and

11 medical audit findings.

12 Review and update the contract to ensure consistency across

13 citations, acronyms and terminology.

14 We are looking to resolve outdated, duplicative or conflicting

15 contract language.

16 And then finally, to update based on the RFI feedback and Draft

17 RFP.

18 So we are looking for managed care plans that demonstrate their

19 ability to deliver services that align with DHCS' priorities; and as you can see, we

20 have listed a few of our priorities here.

21 So we are really looking to reduce health disparities; looking at

22 value-based purchasing; increase oversight of delegated entities; access to care;

23 continuum of care; coordinated and integrated care; quality, of course, is

24 forefront. Really focusing on children services; behavioral health services; how

25 we can address Social Determinants of Health; having a local presence and

1 engagement; emergency preparedness and ensuring essential services; a big
2 one, CalAIM; as well as administrative efficiency.
3 And that was my very fast run through all of the Department of
4 Health Care Services presentation here today. I am happy to take any questions
5 that the Board may have.
6 CHAIR GRGURINA: Comments or questions from the Board
7 Members? It looks like Jeff has his hand up first.
8 MEMBER RIDEOUT: Lindy, thank you for a great overview of a lot
9 that's going on. Can you comment, if you could, on the public health emergency.
10 If there are explicit triggers or whether that is more discretionary?
11 And then just a comment, your comment about sort of utilization
12 trends. IHA has actually seen that in its data. We collect it now quarterly so we
13 did see the same dip but we are actually trending back up in terms of utilization
14 volume, pretty much back to normal, so if that's helpful to you.
15 MS. HARRINGTON: Yes, that's very helpful. And unfortunately,
16 the declaration of the public health emergency, it really is at the discretion of the
17 Health and Human Services Secretary, so there is no requirement that would say
18 they have to extend it, it really is up to the discretion of the Secretary.
19 MEMBER RIDEOUT: And also I would like to tag on one more,
20 John?
21 CHAIR GRGURINA: Go ahead, Jeff.
22 MEMBER RIDEOUT: Also, Lindy, can you tell us how the
23 definitions of the managed care re-contracting in each of those subcategories will
24 be determined? Is there going to be panels for each of those? Is there
25 something that is publicly available? How are you defining value-based care?

1 Things like that.

2 MS. HARRINGTON: So it will go through the standard contracting

3 processes that we have in the Department or in the State for our procurement.

4 So how those exactly will be defined, I don't have that available today, but there

5 are very strict rules that the Department has to follow associated with

6 procurement.

7 CHAIR GRGURINA: Other comments, questions from Board

8 Members? Larry.

9 MEMBER YAO: Yes, I have a -- sorry.

10 CHAIR GRGURINA: Amy and then Larry.

11 MEMBER YAO: Okay. So my question is on the COVID risk

12 corridor. It's ending at the end of 2020. We all know there is a utilization dip in

13 2020 due to COVID; but we are also anticipating there could be a bump back

14 maybe even beyond normal levels in future years. So if we are trying to smooth

15 the impact have we considered extending the corridor beyond the end of 2020?

16 It feels like it could be a little bit more one-sided right now.

17 MS. HARRINGTON: We do have statutory authority. Under AB 80

18 the risk corridor was required for the bridge period but it is authorized to extend

19 into 2021. And we are currently having those conversations internally as well as

20 with the plans about the appropriateness of a continuation of the risk corridor for

21 2021.

22 MEMBER YAO: Okay, thank you.

23 CHAIR GRGURINA: Larry and then Paul.

24 MEMBER DEGHETALDI: Yes. First of all, you did not need to

25 qualify, Lindy, that excellent presentation with lack of knowledge base, that was

1 fabulous.

2 The MLR trends for the expansion population from 75% to greater
3 than 90, does that portend problems with either utilization increasing, sort of the
4 overall risk of the population increasing, or are payments declining relative to the
5 cost of care? And then the second question related to that is, if it's 90% overall
6 for the state what are the error bars? Are there plans that are above 100% or
7 really at a point where they can't sustain the business model and will access and
8 payments to specialists in particular will suffer, leading to network inadequacy?

9 MS. HARRINGTON: So I think I would say there's a couple things
10 that were happening in that area. So when you look at the start, when you are
11 looking at the 2014 through 2016 time period, that was a time period when we
12 didn't have data, we didn't have that information to really identify what those
13 costs would look like. And so as we had those discussions we really wanted to
14 ensure that the rates we provided were high enough to provide the level of care
15 that was necessary. So we made those assumptions and knowing that we had
16 the risk corridor there.

17 So what happened then was the actual cost of care came in lower
18 than those and so what you saw was kind of a balancing of both things. You are
19 seeing changes in the cost of care that was needing to be provided to those
20 beneficiaries as well as the rates coming down to more accurately reflect what
21 those costs represented.

22 So initially it was based on assumed data and by the time we got to
23 '17-18 it was based on actual plan data that was used to set the rates. So during
24 that time period we went to 100% assumed costs and data based on not the
25 historical utilization or cost data for the plans themselves but a blend of the adult

1 population rates as well as the seniors or persons with disabilities rates, and how
2 those blended together. And by the time we got to 2017-18 rates we were using
3 100% plan data. So we shifted through that time period of blending assumed
4 data with actual experience from the plan to get us to our final '17-18 rates.
5 Now, there were a few plans that are currently projected to be over
6 the 100%, but not many, and I think that can be a reflection of multiple activities.
7 It doesn't necessarily speak to an ability to continue or around access to care.
8 CHAIR GRGURINA: Okay, thank you.
9 Paul, you are next.
10 MEMBER DURR: So Larry asked the question that I was going to
11 ask but to kind of ask another question, maybe an easy one. I know the
12 Department asked CMS, basically the Secretary of Health and Human Services,
13 about providing advanced notice if the PHE is not going to be extended. Given
14 that we are November 18th and that emergency only goes to January 21st, was
15 curious if you had received any feedback on that letter that was sent to Alex
16 Azar?
17 MS. HARRINGTON: So we have not received any formal
18 feedback. What I can say is we are not the only state that is asking for similar
19 consideration. But unfortunately we have not received any feedback or
20 confirmation of that extension or what the decision will be and so at this point we
21 are simply waiting.
22 CHAIR GRGURINA: Amy.
23 MEMBER YAO: Yes, hi. Yes, I want to echo everybody, this was a
24 really great, concise presentation. My question would be related to the Rx
25 Project. Totally understand how hard it is to keep a project this big on track, on

1 schedule, and internally we deal with our challenges as well. So when they got
2 pushed out to 4/1, so as a health plan we have been starting to planning our
3 side -- how can one -- providing the Rx services. So there are going to be some
4 implications to the health plans. My question is around the 4/1 date. How firm it
5 is at this point? If there is the possibility it could get extended out again?
6 MS. HARRINGTON: So again, I am a representative of the state
7 and I do not oversee this project. However, my understanding is the 4/1 date is a
8 very firm date. Again, we were on track, everything was in place and it really was
9 around the -- for the lengthening of this transition time was really around allowing
10 for that additional time and to provide, you know, opportunities for providers,
11 beneficiaries, plans, and other interested parties to become better acclimated
12 and familiar with the new policies, processes, and being able to engage with
13 those systems early, and so we do not anticipate that there would be any further
14 delay.
15 MEMBER YAO: Great, thank you.
16 CHAIR GRGURINA: Okay, if I can, I will step in. So as you heard
17 Lindy say earlier, she knows several areas very well but is here just representing
18 the Department so she can't always answer everything; but that doesn't stop us
19 from asking anyway or making our lovely comments. So the one that I'll make is
20 I'll build off what Paul and Amy said which is, first of all, appreciation to Jaycee
21 for sending a letter to Secretary Azar asking for three to six months notice before
22 any change in the public health emergency, for obvious reasons of being able to
23 execute and administer to it. And so I would say the same holds true on the
24 Pharmacy RX change that we just found out about on Monday, which was
25 supposed to start in January, which is moving now to April 1 and then Amy

1 asked, might it be delayed. Obviously, I know the Department knows this but for
2 those of us what we would say is, number one, it's about being able to protect the
3 members. This is the benefit they use most in the Medi-Cal program.
4 And then secondly, it's being able to help the providers, the plans,
5 and obviously the state administration and Magellan to be able to hit what Lindy
6 said, which is that smooth transition. And I would just ask the Department to
7 continue to take a look, is this the time to be making this transition during this
8 pandemic and this difficult time that we're going through now? So that would be
9 my comment. I don't expect an answer, Lindy. I know that you will be able to
10 take it back and you are going to be hearing much for many folks on an ongoing
11 basis because it is such a key, critical component of the delivery to the members;
12 and making that transition for upwards of 13 million members is a huge, huge
13 change.
14 Any comments questions from other members on the Board?
15 No, it doesn't look like it. Okay, I believe, Lezlie, it is now time for
16 members of the public for comments or questions, and if you want to go ahead
17 and call them out in the order that you see.
18 MS. MICHELETTI: Okay, yes, we do have one and I'll go ahead
19 and open it up for Bill. Go ahead, you can unmute yourself.
20 MR. BARCELLONA: Thank you, Lezlie. Good morning,
21 everybody. Lindy, thanks a lot for your comments today.
22 Just a couple of observations on utilization since the pandemic. A
23 lot of our Medi-Cal groups noted that they did take a dip in April but it came right
24 back up almost immediately. And COVID costs are now running at
25 approximately $2 to $3 PMPM in Medi-Cal groups so they are seeing a lot of

1 increase in this area at this time.

2 CHAIR GRGURINA: Bill, could you do us a favor, even though we

3 all know who you are could you say your full name and the organization you are

4 representing for the process, please?

5 MR. BARCELLONA: Sure, John. Bill Barcellona, America's

6 Physician Groups.

7 CHAIR GRGURINA: Thank you, Bill. Any other comments or

8 questions, Bill?

9 MR. BARCELLONA: No, thank you.

10 CHAIR GRGURINA: All right, thanks, Bill.

11 Lezlie, anyone else? Any other members of the public who have

12 comments or questions?

13 MS. MICHELETTI: No, there are no further questions or

14 comments.

15 CHAIR GRGURINA: All right, thank you, Lezlie.

16 Okay, Lindy, it looks like you are going to be set free. Thank you

17 very much, did a very nice job. Obviously an awful lot going on. We encourage

18 you to continue to do as you are doing which is to work with all the plans, the

19 providers, the advocates, and all those that are looking to do better by the

20 members in the program. So thank you, Lindy, we appreciate it.

21 MS. HARRINGTON: Thank you all so much for the opportunity.

22 CHAIR GRGURINA: All right, next up on the agenda is the

23 legislative update. Once again, Mary, you are up.

24 MEMBER WATANABE: I am back. This may be the last time I

25 have to do this now that we have got Amanda on board. So for our legislative

1 update, as you all know, this was a little bit of a light year, with COVID obviously
2 putting a hamper on a lot of the activities in the Legislature and the focus really
3 was on many of the bills related to COVID response. But I did want to highlight
4 for you a few that impact the Department and that we will be tracking for
5 implementation.
6 So the first is AB 80, which was a budget trailer bill, and you heard
7 Lindy mention this as well. But the pieces that impact us is beginning July 1st of
8 2020 the trailer bill revises the permitted range for the actuarial value of specified
9 bronze-level health plans offered by Covered California.
10 The other piece is it gives the DMHC the authority to take
11 enforcement action if a health plan is not in compliance with the requirements
12 related to the Health Care Payments Data Program administered by the Office of
13 Statewide Health Planning and Development. I know there's a lot of excitement
14 about the HPD getting up and running here in the next couple of years and we
15 will have an enforcement role in that.
16 The next one is AB 1124, which authorizes the Department to
17 approve two four-year pilot programs that would permit risk-bearing organizations
18 and restricted health plans to undertake risk-bearing arrangements with either a
19 qualifying voluntary employees' benefit association or a qualifying trust fund; and
20 these arrangements are not subject to the full requirements of the Knox-Keene
21 Act. The VEBA or trust fund and participating entities will report information to
22 the Department annually and we will include those findings in a report to the
23 Legislature. The key dates here are we need to approve the pilots by May 1st of
24 2021. The pilots will run from January 1st of 2022 through the end of December
25 2025; and then that report to the legislature will be in January of 2027.

1 Let's see. The next one here is AB 2118. Beginning October 1st of
2 2021 health plans will annually report rate information on premiums, cost sharing,
3 benefits, enrollment and trend factors for the individual and small group market.
4 This really is mirroring the requirements that we have had as a result of SB 546
5 on the large group side.
6 And then beginning in 2022 we will start publicly reporting this
7 information in our annual, now biennial meeting that we have in San Francisco or
8 LA where we report on large group rate information prescription drug costs.
9 Let's see. AB 2157. This really codified some of the changes that
10 we made to our independent dispute resolution process to address the
11 confidentiality of information that is submitted for review. And again, this is really
12 consistent with some of the changes we made earlier, earlier this year and last
13 year, to protect the confidentiality of information that's submitted by both
14 providers and (inaudible).
15 Let's see. SB 406 was a healthcare omnibus bill that preserves the
16 existing ban on lifetime and annual limits on healthcare benefits and the existing
17 requirement that health plans cover preventive services without cost sharing, by
18 making these requirements independent of federal law. It also extended the
19 sunset date of CHBRP, the California Health Benefit Review Program, by two
20 years.
21 And the big one for us this year that I mentioned that Amanda Levy
22 will be heading up our implementation is SB 855. This is related to behavioral
23 health. It amends California's mental health parity statute requiring commercial
24 health plans in all group and individual markets to cover treatment for all
25 medically necessary mental health and substance use disorder conditions.

1 It also defines medical necessity and it establishes specific
2 standards for what constitutes medically necessary treatment and the criteria for
3 the use of clinical guidelines when making medical necessity and level of care
4 placement decisions.
5 It also has an out-of-network provision requiring plans to help
6 arrange for coverage for medically necessary mental health and substance use
7 disorder treatment services when they cannot provide that in-network.
8 So lots of work to do on this bill, it takes effect January 1st of 2021.
9 Lots of questions we are getting around the clinical guidelines. So for those of
10 you that are interested in this bill just be on the lookout because Amanda will be
11 leading our stakeholder effort for that.
12 And with that I think that concludes our legislation that we will be
13 tracking. And again, we will be bringing back more information over the next
14 year to the Board on our implementation of these efforts but I would be happy to
15 take any questions.
16 CHAIR GRGURINA: Any questions or comments from the Board
17 Members?
18 Amy, go ahead.
19 MEMBER YAO: Yes, I just have a comment regarding AB 80. I
20 just want to appreciate DMHC's great work on this one to create a level playing
21 field among all the health plans. Thanks for that.
22 MEMBER WATANABE: Thank you.
23 CHAIR GRGURINA: Other comments or questions from Board
24 Members?
25 Okay, if not, Lezlie, any comments or questions from members of

1 the public?

2 MS. MICHELETTI: There are no comments or questions from

3 members of the public at this time.

4 CHAIR GRGURINA: All right, thank you, Lezlie.

5 All right, well, thank you, Mary. I think you can take a break. We

6 are going to move on and Pritika is going to take us through multiple items

7 coming up here. So actually our first one next on the agenda item is the 2019

8 risk adjustment transfers. So with that, Pritika, you are up.

9 MS. DUTT: Thank you, John. Good morning. I am Pritika Dutt,

10 Deputy Director for the Office of Financial Review; I will provide you an update on

11 the 2019 risk adjustment transfers. Please refer to the report titled 2019 Risk

12 Adjustment Transfers available on the FSSB page. The risk adjustment transfer

13 program is intended to transfer funds from health plans and insurers with lower

14 actuarial risk to those with higher risk.

15 Okay, so moving on to page 2 of the report. Page 2 shows the risk

16 adjustment transfers for the 2019 benefit year for the DMHC health plans. For

17 benefit year 2019 a total of $1.26 billion was transferred between California

18 health plans and insurers. Blue Shield, Anthem, Sharp and Ventura County

19 Health Plan received payments from the risk adjustment transfers, or sometimes

20 they are referred to as the RAT. Eleven health plans, 11 DMHC health plans had

21 to pay into the risk adjustment pool. Risk adjustment transfers represent an

22 average of 8% of premium.

23 CHAIR GRGURINA: Pritika, can I step in for a moment? I am not

24 sure about the rest of the members or members of the public but I am only

25 seeing the opening slide. Is that what other --

1 MS. DUTT: Yes. You have to refer to the report that was included
2 as part of your packet.
3 CHAIR GRGURINA: All right, thank you Pritika, I should pay closer
4 attention. I apologize. Continue.
5 MS. DUTT: Thank you. Okay. And then moving on to page 3 of
6 the report. Here you can see the high-cost risk pool payment received by DMHC
7 health plans for benefit year 2019. So in 2018, CMS added a high-cost risk pool
8 program to risk adjustment transfer methodology. The high-cost risk pool helped
9 ensured that risk adjustment transfers better reflect the average actuarial risk,
10 while also providing protection to issuers with exceptionally high cost enrollees.
11 The California health plans and insurers received an additional
12 $157 million via this program in 2019. So that $157 million is the total between
13 the DMHC health plans and the CDI insurers.
14 To fund this program the high-cost pool collects a charge from
15 issuers of risk adjustment covered plans that is a small percentage of the issuers'
16 or health plans' total premiums. In 2019 the high-cost risk pool charge was .24%
17 of premium for the individual market and .37% of premium for the small group
18 market nationally. So it was less than a penny for the plans to fund this program
19 for every dollar of premium. The high-cost risk pool reimburses issuers for 60%
20 of an enrollees aggregated paid claim costs exceeding $1 million dollars, so it is
21 intended to help plans that have high-cost enrollees where their claims costs
22 exceed $1 million.
23 And the next two pages of this report shows the risk adjustment
24 transfers and high-cost risk pool payment for CDI insurers. Overall it appears the
25 DMHC-licensed plans are transferring funds to CDI insurers in the risk

1 adjustment program, demonstrating that CDI plans have higher risk than the
2 DMHC plans; except for Blue Cross and Blue Shield because, again, Blue Shield
3 and Blue Cross have PPO products similar to the CDI plans so we see that the
4 HMO plans end up transferring risk adjustment transfer payments to PPO
5 products, and that's like the trend we see nationally as well.
6 So with that, that brings me to the end of this presentation. I can
7 take any questions. I think Amy can help me answer some questions there too.
8 CHAIR GRGURINA: All right, questions or comments from the
9 Board Members?
10 Yes, Larry, go ahead.
11 MEMBER DEGHETALDI: First of all, I think this is great public
12 policy, to smooth risk across. And my question is, and maybe this is for Amy, are
13 we capturing the full risk of the population? That is, the HCC, the commercial
14 HCC codes? Is this truly representative of the amount of risk transfers that
15 should occur? I know it's hard to answer. And then the second question is, in
16 the Medi-Cal world, in the Medicare world, other payers, we don't do this, and I
17 just would look for a day when we appropriately smooth risk to make whole the
18 plans and the providers that care for sicker Californians. So I guess my question
19 is, is this risk adjustment working? Is it adequate? Are we moving in the right
20 direction over time?
21 MEMBER YAO: Yes, I think, Larry, you are right, it's a very hard
22 question to answer. And I definitely believe the concept and the operations and
23 the trending is in the right direction so that we could -- to be sure that the
24 consumers with a broad choice of plans. Without risk adjustments I don't think
25 anybody is going to be offering like the PPO type of product. So from that

1 perspective I do think it is working and I think it is working just as good as we
2 designed it. And whether there are going to be improvement areas, for sure, I
3 am sure. As we continue to work with our providers to improve the data
4 submission quality that will improve the accuracy of this program.
5 Secondly, you are asking about Medicare. The Medicare risk
6 adjustment is different, it is not a zero sum game. It is really paying you for your
7 health plan specific risk so I do think that also is working there. When it comes to
8 Medi-Cal, that's where I think what we have is like a pharmacy-based kind of risk
9 adjustment right now. I do feel there could be improvement in the Medi-Cal
10 space, how we pay health plans, by incorporating medical diagnoses into that
11 process.
12 CHAIR GRGURINA: And I'll just add on to Amy's comments. We
13 are seeing and appreciate Amy coming forward and showing us; and we can see
14 in the results that there is a difference of risk that's going on in the individual, the
15 small group market in Covered California, so those risk payments are helping.
16 Certainly as we are all aware, and for those of us that were back in the PAC
17 Advantage (phonetic) and HPPC (phonetic) days, watching a PPO be lined up
18 against an HMO does draw extra risk because of the openness of the ability to
19 go anywhere that you want, so there needs to be that. But I think also, as Amy
20 said, if you think about it, Medicare, if you will, is doing it on the front end, which
21 is taking a look at that individual member and paying for that individual member
22 in advance, versus doing it on the back end. I would also agree with Amy's
23 comments on the Medi-Cal side is using an Rx model; and we think there are
24 stronger models that are available and we are talking with the Department about
25 trying to look at other models.

1 Comments, questions from other Board Members on this topic?
2 Paul?
3 MEMBER DURR: Yes. I was just going to comment. I think it
4 does speak well for being able to normalize it. I think that is really very well
5 received and noticed. I think it does help diminish some of the risk there that a
6 plan would be mindful of getting. You do wonder though, and I am wondering
7 more from a trending perspective, I can't help but notice the HMO transfer to
8 PPO, right? And the fact that in an HMO delegated model we are coordinating
9 and managing that care better. So that when you think about overall the total
10 spend could be better if more patients-one would presume I don't know this-if
11 they were in a coordinated HMO model then they would be in the PPO. Just odd
12 because, you know, PPO patients obviously can go anywhere. But you know,
13 seeing that trend.
14 I think this report is great. I think it is very eye opening and very
15 appreciative of you sharing it. And I think Amy's comments do add a lot of insight
16 into that and having that is a good perspective. But you wonder if you dig deeper
17 into some of that as to sort of why the shifts are happening and is it true when
18 you go back and look at it over history? So just a comment, thank you.
19 CHAIR GRGURINA: Thank you, Paul.
20 And of course, obviously, we can all recall the couple of meetings
21 where Jeff brought the results from Atlas to be able to show us what was going
22 on with the more capitation or the more risk an entity was taking off at the end of
23 the day was higher quality and lower overall costs. So all of these things are all
24 tied together.
25 Any other comments or questions from Board Members?

1 MEMBER RIDEOUT: I would just say, if we are going to level the
2 financial playing field we ought to level the quality playing field as well.
3 CHAIR GRGURINA: Thank you, Jeff.
4 Okay, if there's no other comments or questions from the Board
5 Members, Lezlie, do we have any comments or questions from members of the
6 public?
7 MS. MICHELETTI: No raised hands or requests to speak at this
8 time.
9 CHAIR GRGURINA: All right, thank you, Lezlie.
10 Okay, well, thank you, Pritika. And if you will stay and get ready the
11 next item is the 2019 federal medical loss ratio, the MLR summary. Go ahead,
12 Pritika.
13 MS. DUTT: So thank you, John. I will provide you an overview of
14 the 2019 annual federal medical loss ratio reports that we received from health
15 plans on August 17 2020. Again for this presentation please refer to the 2019
16 Federal Medical Loss Ratio Summary Report that is available as part of the
17 meeting handouts electronically on our Financial Solvency Standards Board
18 page; for the Board it was included as part of your meeting packet.
19 Federal laws require health plans that sell healthcare products
20 directly to enrollees and employer groups to spend a certain percentage of their
21 premium dollars on health care or medical expenses. The medical loss ratio
22 requirement went into effect for reporting year 2011. Health plans in the small
23 group and individual market have to spend 80% of their premium revenue on
24 medical services, so that's 80 cents on every dollar. And for the health plans in
25 the large group market the requirement is 85%, so 85 cents on every dollar for

1 the large group health plan has to be spent for providing health care services.

2 If the plans fail to meet this requirement they have to pay a rebate

3 to the enrollees or employer groups. For rebate purposes MLR is based on three

4 year data. So for example, for reporting year 2019, the report that we are looking

5 at right here, the MLR and rebate calculation is based on the three year average

6 health plan's premium and medical expenses. So it includes 2017, 2018 and

7 2019 data to come up with the MLR percentage as well as the rebate calculation.

8 Moving on we can turn to page 2 of the report. So page 2 of the

9 report shows MLR for the health plans in the individual market. All plans that

10 offer products in the individual market and are subject to the federal MLR

11 reporting requirement met the medical loss ratio of 80%. The MLR for the 12

12 health plans in the individual market ranged from 80.1% to 97.2%; so there were

13 no rebates paid in the individual market.

14 Page 3 of the report. So turning to page 3, it shows the MLR for

15 the health plans in the small group market. For the small group market the MLR

16 requirement is 80%. For the 12 health plans in the small group market MLR

17 ranged from 77.7% to 105.4%. Four health plans, which is Aetna, Anthem Blue

18 Cross, Blue Shield and Health Net reported MLR below 80% and were required

19 to pay rebates to the enrollees. Aetna paid rebates of $2.3 million, Anthem paid

20 rebate of $53 million, Blue Shield paid rebate of $34.9 million and Health Net

21 paid almost $10 million in rebates.

22 The four plans had to issue rebate checks by September 30, 2020.

23 The rebates may be issued in a number of ways. Enrollees might receive a

24 rebate check in the mail, a deposit paid into the account or receive direct

25 reduction in future premium, so it is like a premium credit for their future

1 premium.

2 Moving on to page 4, the table shows the MLR for full service plans

3 in the large group market; 21 health plans offer products in the large group

4 market. The MLR requirement in the large group market is 85%. The MLR for

5 the 21 large group plans ranged from 82.6% to 119.5%. One plan was required

6 to pay a rebate. Community Care Health Plan reported MLR of 82.6% and paid

7 rebate of $1.3 million. The plan had around 10,000 enrollees in the large group

8 market and all the enrollees are employees of the plan or its affiliated hospital.

9 Table 4 on page 5 shows the MLR for four specialized plans

10 subject to federal MLR reporting requirement for their large group products.

11 OptumHealth Behavioral Solutions of California did not meet the MLR

12 requirement of 85%. OptumHealth Behavioral Solutions of California reported an

13 MLR of 57.8% and paid rebate of $859,000. The plan had 21,000 direct lives.

14 The plan also has an additional 1.6 million enrollees where they act as

15 subcontractors to provide behavioral health services to enrollees of full service

16 plans where Optum is not subject to the MLR requirements because these are

17 sub-delegated lives.

18 Moving on to page 6. Table 5 here shows the MLR rebate trends

19 for health plans since 2011.

20 For MLR reporting year 2019 health plans paid a total of $102

21 million in rebates; and since 2011, $455 million was paid out to enrollees by the

22 DMHC plans in the form of rebates. The rebates paid by health plans have

23 fluctuated through the years. Health plans set their rates based on historical

24 claims cost and utilization data with the goal of meeting MLR requirements and

25 that is one of the things we look at when we do a rate review. When we get rate

1 filings from a plan we make sure that they are projecting to meet the minimum
2 MLR requirement for that market. However, medical expenses are driven by how
3 much enrollees utilize their healthcare benefits and provider costs and this may
4 vary from year to year, even quarter to quarter, and as such some plans go over
5 the minimum requirement and some do not meet the MLR requirement and end
6 up paying rebates.
7 I think one question we keep hearing is, you know MLR and what's
8 happening with MLR with COVID-19. So, the impact of COVID-19, we would not
9 see it until we receive the 2020 annual federal MLR report. And the report is due
10 on July 31, 2021 and any rebates for that reporting would need to be paid by
11 September 30, 2021. However, since MLR and MLR rebates are calculated
12 using data for a three year period the 2020 MLR report will include information for
13 reporting in 2018, 2019 and 2020. With that I can take any questions that you
14 may have.
15 CHAIR GRGURINA: Comments, questions from members of the
16 Board? It looks like, Jeff, you had your hand up.
17 MEMBER RIDEOUT: Yes. Pritika, as problematic as MLR is,
18 obviously our eyes go to MLRs above 100, 110%, and those very low; the Optum
19 behavioral health group is reminiscent of our dental MLR discussions. But can
20 you give us any color on those that are above 110% and the financial stability of
21 those organizations? I realize there's a lot of small enrollment but they are still
22 worrisome that, you know, that clip is obviously not sustainable.
23 MS. DUTT: Right. Jeff, in addition to looking at the MLR reports
24 we also get quarterly financial statements for health plans, so MLR is one report
25 we look at. We also look at their rate information as well as financial statements

1 that we receive on quarterly and monthly annual bases. So we see how these
2 plans are doing across all their product lines and just not specific to that market.
3 That's one of the things like we look at also as part of our rate review, what's the
4 plan's projected MLR. And if we see somebody is projecting towards 100
5 percent we ask additional questions on, you know, how they will be able to
6 sustain their operations.
7 MEMBER RIDEOUT: So I am taking that to imply that you don't
8 have any concerns about those plans that are well above 100%; is that correct?
9 MS. DUTT: Some we may. It depends on, like I said, we look at
10 their financial statements. So we will see how they are doing with meeting the
11 financial reserve requirement, our TNE requirement. We ask questions there
12 with the financial statement review process. So again, one of the driving factors
13 for concern would be like, okay, what is this plan's financial reserve levels, how is
14 their TNE looking?
15 MEMBER RIDEOUT: Right. I don't want to pin you down if I
16 shouldn't but can you share the ones that you are concerned about since we are
17 looking at them by name or is that not appropriate?
18 MS. DUTT: I would have to take that one back, see if that's
19 something I can share.
20 CHAIR GRGURINA: Maybe I could just add in, Jeff. If we are
21 looking at page 4, and you are seeing some of those marks, my plan is on that
22 mark at 102.9% for under 12,000 members, which is less than 10%. And as
23 Pritika said, obviously we are not pleased with that but you have to look at our
24 entire book of business in addition to our MLR overall and where our reserves
25 are. And so it is concerning to be above 100% but this is not a huge problematic

1 thing for us, given that this is a small piece of our business.

2 And so that is what I assume. And what we heard Pritika say is

3 they are looking at every single one of them. And I could see some of our sister

4 public health plans who are on here as well, with, again, small portions of their

5 overall business being here. These are generally lines of business that we stood

6 up to help provide insurance because others weren't coming forward.

7 MEMBER RIDEOUT: John, I said 110 on purpose, I didn't want to

8 pick on anybody. But I just want to make sure as a member of this committee I

9 am either asking the right questions or not asking the wrong questions. But, you

10 know, that I don't really have any ability to kind of see that other information so I

11 am reacting to what I am being shown.

12 CHAIR GRGURINA: And it's correct. And I'm sure as Amy would

13 tell us, no plan wants to be even at 100% because there's no dollars for your own

14 administration to run it so it is at a loss, so it is the appropriate question. But of

15 course, as Pritika said, it is a combination of factors, taking a look at the overall

16 revenue, the overall MLR, as well as what the reserve factors are for the plans.

17 And Pritika will take a look and come back to see in the future if they can

18 highlight for us where they have concerns.

19 MS. DUTT: Right. So most of these plans in the large group

20 market that have above 100% MLR are in-home support service plans. Again,

21 like John said, it's a small piece of their business. And so we look at, again, like

22 these are some of the Medi-Cal plans, right, that offer IHSS products and are

23 subject to the MLR reporting requirement. So we take a deeper dive when we

24 start looking at the Medi-Cal plans, financial health, financial condition, and we

25 will discuss that when we talk about the financial summary of Medi-Cal managed

1 care plans, because we're looking at their overall picture on how they're looking.
2 So MLR is just one piece of what we look at, we have financial statements, we
3 have other compliance reports we look at. So again, I can take a look at where
4 there are concerns and share that with the Board at a future meeting.
5 CHAIR GRGURINA: Paul, I believe you had your hand up and
6 then Amy.
7 MEMBER DURR: Yes. So nice information. I guess my question
8 has to do with I know that it is a three year average trend. But when you look at
9 the last page of the report, page 6 that shows '17, 18 and 19, all where the
10 rebates are over $70 million and growing, I mean 72, 71 and then it jumps to 102.
11 It would kind of lead one to suspect that if the rebates are growing and it's a
12 three year average are the rates being set appropriately? Is there something that
13 we need to look at more specifically at the rate review process that we are being
14 more diligent in that review? Because I am concerned -- not concerned it is just
15 an observation about the growing dollars in the rebate. And it may be plan
16 specific so it may indicate something more unique about those plans.
17 MEMBER DURR: So Paul, one thing I wanted to correct is it is not
18 really an average where you divide it by three. It is like you add the three years
19 worth of information and then you divide it by the premium information, and you
20 add the three years worth of medical expenses and then you divide it by
21 premium. So one of the things is like for example if a plan has low MLR in 2017
22 that will keep showing in the 2018 reporting, 2019 reporting, so it will keep
23 showing in there. I don't know, Amy, if you wanted to add something to what the
24 what plans look at for rates?
25 MEMBER YAO: Yes. So, Pritika, you are definitely correct. What

1 happened to Blue Shield is back in '17 somehow I think we missed the mark on
2 pricing. We priced too conservatively so it carried forward. But if you look at our
3 most recent couple of years the rate increases actually have been below 3% and
4 we have been doing the pricing correction. But there is the trailing effect; I
5 expect the number will come down next year.
6 CHAIR GRGURINA: Pritika, I might add, what might also be
7 helpful in the information is I appreciate Paul's comment of when you look at the
8 years you see it growing, particularly since '17. What is this as a percentage of
9 the overall premium that was taken in? Are we talking about .5 point, 1 point, are
10 we talking 5%? That also gives us a gauge, because of course this -- no offense,
11 Amy, but it is not an exact science of getting the rates exactly correct; so that will
12 just be an additional piece of information that is helpful for us to take a look to
13 see how much of the overall rate is this off. But I do appreciate Paul's comment
14 that it is seeming to climb. And of course what everyone is really interested in is,
15 as Pritika mentioned, it won't be -- the results will be given I believe you said July
16 of 2021 for calendar year 2020 to see what happened in that year in those
17 marketplaces.
18 Jen, I believe you have your hand up.
19 MEMBER FLORY: Yes. I mean, similar to what Paul was saying.
20 And thank you, Amy, for that. I mean, pointing out that, you know, what
21 happened in one year can carry on through other years and I think we all know
22 there was a lot of uncertainty in the insurance market in the last few years. But I
23 was wondering if there was also another way that we should be looking at trends
24 by plan to see if certain plans are off, you know, beyond just missing the mark
25 one year but continually being off.

1 CHAIR GRGURINA: Thank you, Jen.

2 Larry, did you have your hand up?

3 MEMBER DEGHETALDI: I did. I have two sort of maybe dumb
4 questions. If I am a Covered California enrollee and I select a plan and I am
5 subsidized and there is a rebate does it all come to me or does it go to the
6 federal government as well? That's the first maybe dumb question.

7 MS. DUTT: So that's a good question, which I did ask
8 (indiscernible) at CMS that question earlier this week. It will go to you, the
9 enrollee, it will not return to the federal government. The premium tax credit, it
10 will just go to you.

11 MEMBER DEGHETALDI: And the second question. When you
12 calculate the total premiums do risk adjustment transfers factor into the
13 calculation? Amy is nodding her head, okay.

14 MS. DUTT: Yes.

15 MEMBER YAO: Yes, it is part of it.

16 John, I have a question.

17 CHAIR GRGURINA: Go ahead, Amy.

18 MEMBER YAO: Yes. I have a question around the rebating
19 process. And, Pritika, you mentioned some of the health plans actually rebating,
20 directly give it back to the members and some of the health plans applied it as a
21 premium credit in the future. For Blue Shield we always gave it back to the
22 members because we have the point of view of that we cannot give a premium
23 credit, future premium credit, because that could be viewed as incentive to entice
24 the member to stay with the health plan. I am surprised to hear some of the
25 plans actually apply it as a premium credit.

1 MS. DUTT: It is an option where it has to be a credit for that
2 enrollee's direct premium. So let's say if you owed somebody $50, it has to be
3 taken off that enrollee's bill for next month.
4 MEMBER YAO: Yes, I hear you. But still, we still view that you
5 gave the incentive to the member to stay with that plan. So anyway, I just
6 wanted to point that out. That's why we don't do it that way, because we want
7 make sure we separate out the future premium versus this is a historical
8 premium you were overcharged; so we do give it back to the member directly.
9 And then just one observation on the individual market. You see all
10 the rebates out there for all 11 plans so there may be some lessons learned
11 there that can be applied to the small group market. Just pointing that out.
12 CHAIR GRGURINA: All right, thank you, Amy.
13 Other comments or questions from the Board Members?
14 Okay, not seeing any, Lezlie, do we have any comments or
15 questions from members of the public?
16 MS. MICHELETTI: Yes, we do have one. Bill, go ahead.
17 MR. BARCELLONA: Thank you, Lezlie.
18 I just had a comment about the MLR calculations that we are
19 seeing for this year in 2020 with the COVID response. A lot of our members at
20 the physician group level -- John, I am sorry, Bill Barcellona, America's Physician
21 Groups. Okay, got it.
22 CHAIR GRGURINA: Thank you, Bill.
23 MR. BARCELLONA: Yes, sorry.
24 When the pandemic started and we had kind of across the board
25 waiver of co-pays by the commercial plans without any back-fill. This is affecting

1 the overall negotiated capitation rates of the groups because capitation is
2 negotiated on an age/sex-adjusted basis for base rates and then it's adjusted by
3 the co-pay revenue that the actual treating physician would collect at the time of
4 the service. And when you waive the co-pays the plan is not waiving receipt of
5 the co-pays, the group is not waiving receipt, it is actually, you know, money that
6 is taken out of the pocket of the primary care provider or the specialty provider
7 who is rendering the care.
8 And one of the things I don't understand is why the commercial
9 plans are not back-filling this revenue because it seems like it's just going to end
10 up being rebated you know. If utilization is indeed lower than it was projected for
11 2020 all of this unspent money that would go to providers for the services is just
12 going to get rebated and it just doesn't make much sense. I don't know if
13 anybody has any other observations or feels that there is a conflict in what I am
14 saying, but I think it's a big problem going forward to the stability of the primary
15 care providers in California.
16 CHAIR GRGURINA: All right, thank you, Bill.
17 Any comments, Pritika?
18 MS. DUTT: Thank you for the comment, Bill.
19 CHAIR GRGURINA: Lezlie, do we have any other comments from
20 members of the public?
21 MS. MICHELETTI: Yes, we do have one more. Derek, if you can
22 go ahead and speak and introduce yourself please. Derek? You might need to
23 unmute.
24 Hi, this is Derek Schneider, I am the CFO for MedPOINT
25 Management. In relation to some of the questions on how to view the increasing

1 dollars related to the rebates, it might be good to have a companion calculation
2 showing per member/per month, because that would normalize for membership
3 changes year over year, because if the membership is growing the total dollar
4 rebate is going to grow as well. But a PM/PM would normalize for that and let
5 you know is the conservatism consistent or increasing or decreasing?
6 CHAIR GRGURINA: Thank you, Derek.
7 Lezlie, any other comments from members of the public?
8 MS. MICHELETTI: No other raised hands or requests to speak at
9 this time.
10 CHAIR GRGURINA: All right, thank you, Lezlie.
11 All right, Pritika, thank you.
12 Let's move to the next agenda item which is the 2021 rates in the
13 individual market, with Pritika.
14 MS. DUTT: Thank you, John. I have to find the right handout over
15 here. Okay.
16 The purpose of this presentation is to give you a brief overview of
17 the 2021 rates for health plans in Covered California's individual market. For this
18 presentation please refer to the report titled 2021 Rates in the Individual Market
19 on the FSSB page on the DMHC's website. This is only a one page report.
20 The table on page 1 of the report displays the proposed and final
21 rate increases as well as the estimated enrollment for 12 health plans that offer
22 individual products. Eleven of these plans offer individual products on Covered
23 California's Health Benefit Exchange. Sutter Health Plan offers all non-exchange
24 individual products and projected enrollment -- it had projected enrollment of
25 3700 lives and an average annual increase of 3.5%.

1 As seen on this chart, the average rate change ranged from a
2 decrease of 4.6% to an increase of 8.77%. Overall the average rate increase
3 amongst the plans was 0.5%. The rate changes are driven by medical cost
4 trends, which include emerging and projected experience, changes in risk
5 adjustment, administrative costs, anticipated changes in market-wide health
6 status of the covered population.
7 Health plans were also asked to provide estimated impact of
8 COVID-19 on their proposed rate. So one of the questions we did ask the health
9 plans was how they projected the impact of COVID on their rates? So there
10 were some plans that included changes in their rates as a result of COVID, as a
11 result of the pandemic. A majority of the plans stated that there wasn't enough
12 data at the time of the rate projections to forecast the impact of COVID-19 on the
13 2021 rates.
14 While the DMHC does not have the authority to deny rate
15 increases, through the DMHC's rate review efforts we hold health plans
16 accountable and ensure consumers get value for the premium dollars they
17 spend. And through the rate review process we have saved enrollees $296
18 million since 2011. That is all the update I have for this one. Any questions?
19 CHAIR GRGURINA: Comments or questions from the Board
20 Members?
21 Not looking like we do, okay. Lezlie, any comments or questions
22 from members of the public?
23 MS. MICHELETTI: No comments or questions from the public at
24 this time. Wait, we do have one that just came through, one second.
25 CHAIR GRGURINA: Okay.

1 MS. MICHELETTI: Janet, if you can unmute yourself and introduce
2 yourself, please.
3 MS. VADAKKUMCHERRY: Yes. Good afternoon, good morning,
4 everyone. This is Janet Vadakkumcherry of Health Center Partners in San
5 Diego. And I am just -- and I am going back, sorry, from Bill's question in the
6 previous segment.
7 There was an All Plan Letter, I think DMHC was collecting data
8 from the health plans, it was entitled Network Adequacy and Unnecessary
9 Burdens on Providers, collecting what the health plans were typically doing to
10 support the provider network and the provider community. And I don't know that I
11 saw any results of that survey and maybe those results are not going to be
12 public. But I guess that's my question. If there are, are the results going to be
13 public? If they are available where would I find those?
14 MEMBER WATANABE: I can respond to that. Thank you, Janet,
15 for your question. So we did, this was going back early in the in the pandemic,
16 asked the plans about the things that they were doing to support providers. And
17 we did get a response; it is available through our Public Records Act request
18 process. The plans identified a number of things that they are doing to support
19 providers including loans and grants and PPE. That was a one time data call.
20 What I will say is we are working on another All Plan Letter that we
21 have shared with some of our stakeholders and are in the process of finalizing
22 that will collect more information about the impact on providers, potential provider
23 closures and what the plans are doing to support providers. So I think it is
24 definitely on all of our radar that particularly our physicians and our small
25 practices have been impacted by COVID, the decrease in utilization and the cost

1 of PPE. We are working on another APL so keep your eyes out for that, we are
2 hoping to get that out quickly. But it will -- the purpose is to really assess the
3 impact on the network so more to come on that.
4 MS. VADAKKUMCHERRY: Thank you.
5 CHAIR GRGURINA: All right, thank you, Janet.
6 Lezlie, any other comments or questions from members of the
7 public?
8 MS. MICHELETTI: No further comments or questions.
9 CHAIR GRGURINA: All right, thank you very much.
10 The last thing, you know, in these tough times it is always good to
11 find the pieces of positive news. And as Pritika walked us through and the chart
12 was there the overall rate, even though small as it may be, a decrease for
13 calendar year 2021 in Covered California is a positive thing going forward.
14 So with that, Pritika, you are up with the financial summary of the
15 Medi-Cal managed care health plans.
16 MS. DUTT: Thank you, John. I will provide you a quick update on
17 the financial summary of the Medi-Cal managed care report for quarter end June
18 30th, 2020. A copy of the detailed report is available on our public website under
19 the FSSB Financial Solvency Standards Board section. This report is prepared
20 by the DMHC on a quarterly basis and highlights enrollment and financial
21 information for local initiatives, county organized health systems and non-
22 governmental Medi-Cal plans. Non-governmental medical plans, or NGMs as we
23 refer to in the report, are plans that report greater than 50% Medi-Cal enrollment
24 but are neither an LI or Local Initiative or a COHS, which is the county organized
25 health systems. So the report is divided into three distinct areas, first focusing on

1 LIs, next COHS, and then we look at the non-governmental Medi-Cal plans.

2 There are nine local initiative plans that serve 5 million Medi-Cal
3 beneficiaries in 13 counties.

4 For the second quarter, I think it was the fourth quarter for most of
5 the government plans so it's for the June 30 quarter, the Local Initiatives reported
6 total net loss of $15 million.

7 TNE to required TNE ranged from 439% to 749%. So two Local
8 Initiatives reported net losses for the June 30th quarter. LA Care reported a net
9 loss of $64 million. The plan reported an increase in its medical expenses for in-
10 patient services. So we went back and looked at the cause for the loss and then
11 we noticed that the plan's in-patient service expenses had increased for the
12 quarter. LA Care had TNE of 722%. The other plan that reported a net loss for
13 the Local Initiatives was Health Plan of San Joaquin. The plan reported a net
14 loss of $100,000. The plan reported four consecutive quarterly losses and
15 attributed its losses to its rate adjustment. At June 30th Health Plan of San
16 Joaquin had TNE to required TNE of 749%.

17 There are six County Organized Health System plans that serve 22
18 counties. We received financial reports from five COHS. Gold Coast does not
19 report to the DMHC and the details of why they don't report is in the report itself.

20 The five County Organized Health Systems that report to the
21 DMHC serve over 1.9 million Medi-Cal beneficiaries.

22 For the second quarter The COHS plans reported total net loss of
23 $47 million.

24 TNE to required TNE for the COHS plans ranged from 596% to
25 1,041%. So with the exception of CalOptima the four remaining COHS plans

1 reported net losses for the quarter. CenCal reported a net loss of $22 million,
2 which appears to be as a result of the plan booking its MCO tax of $29 million at
3 its quarter end June 30 financials. The plan had TNE to required TNE of 595%.
4 Central California Alliance for Health reported a net loss of $25
5 million at June 30. The plan has continued to report net losses for several
6 quarters now. The plan's losses are due to its high medical expenses and Medi-
7 Cal rate adjustments, per the plan. We have talked to the plan as part of our
8 financial oversight of the plan. The plan has indicated that it is working on its
9 cost containment efforts. The plan had reported TNE to required TNE of 765%.
10 Though the plan's TNE may seem high it still causes us concerns because the
11 plan's TNE has continued to decline as a result of its continued net losses. We
12 have been working with Central California Alliance for Health asking them
13 additional questions, tracking their progress every quarter.
14 Health Plan of San Mateo reported a net loss of $5 million and
15 reported TNE to required TNE of 1,041%.
16 Partnership Health Plan reported a net loss of $33 million because
17 the plan booked MCO tax of $67 million at June 30, which caused a net loss for
18 the plan. Partnership reported TNE to required TNE of 604%. Next slide.
19 There are 7 NGM plans that serve 3.1 million Medi-Cal
20 beneficiaries in 31 counties. So for the 7 NGM plans they are either contracted
21 directly with DHCS or they act as subcontractors to other Medi-Cal plans that
22 hold direct contracting with the DHCS. NGM plans reported total net income of
23 $117 million. TNE to required TNE ranged from 105% to 1,053%.
24 The Medi-Cal managed care plans continue to meet the DMHC's
25 financial reserve or TNE requirement. The DMHC will continue to monitor the

1 enrollment trends and financial solvency of all LI, COHS and NGM plans
2 reporting to the DMHC. With that, that brings me to the end of this presentation, I
3 can take any questions.
4 CHAIR GRGURINA: Comments and questions from the Board
5 Members?
6 MEMBER DEGHETALDI: Yes, John.
7 CHAIR GRGURINA: Larry, go ahead.
8 MEMBER DEGHETALDI: I have disclosed that I have been a
9 board member for CCAH for 15 years. I am quite concerned about the trends
10 and it is not an anomaly. I just worry whether or not the revenue is appropriately
11 tied to the complexity of, you know, essentially the risk of the patient served. I
12 don't know the answer to that question. This plan is pretty well managed. It has
13 great engagement by its providers in all three counties and willingness across the
14 continuum to care for the Medi-Cal beneficiaries. Something is wrong and it is
15 not -- certainly cost containment efforts are underway, let's watch it carefully, but
16 I am concerned.
17 MS. DUTT: Larry, I know you sit on the board for Central California
18 Alliance for Health; I have a question. What kind of efforts are they, what kind of
19 conversations is the board having to correct, you know, to change this declining
20 trend?
21 MEMBER DEGHETALDI: Yes. Payment reductions to physicians,
22 particularly specialists, and renegotiations with hospitals. There is a great deal of
23 variation and it is not transparent to even the board members on -- and I think
24 that would be true across the state. It is not clear what our managed Medi-Cal
25 plans are paying various hospitals as a percent of the Medi-Cal fee schedule or

1 Medicare DRG or other, because that may be an opportunity. But clearly there is
2 an acuity increase in the outlier patients that cost, you know, the tragic
3 endocarditis patient, et cetera. This was true even before COVID. Yes, it's
4 complicated but I am concerned.
5 CHAIR GRGURINA: Well then I will just add to Larry's comments;
6 many of the public plans are struggling. Part of it is the times that we are in and
7 part of it is decisions that have been made over at DHCS and the Administration
8 and the Legislature. So just as an example, the one health cut that went through
9 for last fiscal year going retro was the 1.5% cut that Lindy talked about earlier
10 that went all the way back to July of '19. That was a huge cut for many of us. I
11 know that many of the public plans did not go back to try and reclaim those from
12 the providers or the clinics or the hospitals so that just came straight out of
13 reserves or the bottom line or increasing losses.
14 And there have been a couple of other decisions where DHCS has
15 gone back to clean up their books and find that they have had some mistakes in
16 eligibility and have gone back and taken those going all the way back to 2014.
17 Once again we have had issues there where dollars have been pulled back and
18 we have not gone back to our providers or our clinics or hospitals to pick them
19 up, so those have lowered those as well. And I think that this happens
20 particularly in an area where we are not talking about a commercial marketplace
21 where the plan is setting the rate that they feel is appropriate, it is the rate that is
22 basically coming out of the state and CMS. And we are in tough times so it is
23 something that we do need to keep a close look at.
24 MEMBER DEGHETALDI: John, let me just follow up with just sort
25 of a macro observation. The hospitals in California that care for Medi-Cal

1 beneficiaries are mostly made whole through the hospital fee program.
2 RFQHCs, of course, have a cost-based reimbursement that mostly keeps them
3 whole, the primary care physicians were enticed positively in 2012 and 2013.
4 But Medi-Cal rates, those have started to erode and the specialists in particular.
5 So I am worried about specialty access for our Medi-Cal beneficiaries because
6 prop 56 is a small bump, not adequate to cover costs. I just worry as we go
7 forward, John, with payment reductions to certain providers that access network
8 adequacy will be a problem.
9 CHAIR GRGURINA: I agree with your comments, Larry. Of course
10 many of us who have been around for a very long time know what happened
11 when there is difficulty with the state budgets. No one wants to be able to cut
12 back on eligibility, no one wants to cut back on benefits, so the third piece of the
13 balloon is the rates to the plans and the providers and we will have to keep a
14 close eye on that.
15 Comments or questions from other Board Members? Paul.
16 MEMBER DURR: Yes. My question has to do with Partnership
17 Health Plan because I see that they are also having a slow tic where they seem
18 to be losing. On page 22 they are certainly well reserved on TNE but overall if
19 you go back to 2019 in June, 665. In every quarter it seems like for the most part
20 there is a slow erosion there. I know that you are watching it, Pritika, but I think I
21 will reemphasize what Larry and John were just talking about is that in order to
22 have a specialty care network there does need to be adequate reimbursement
23 for the providers. You know, the additional cost that they are bearing with
24 regards to just staying open and having to back-fill their office staff who are trying
25 to work from home or, you know, the whole thing about do they have kids and

1 managing through that, is something that needs to be considered. So I know,
2 Pritika, you would be watching Partnership Health Plan as well but I do get
3 concerned when you see that there is a slow decrease over time as to what is
4 that trajectory?
5 MS. DUTT: Thank you, Paul, for that question. We are tracking
6 on, okay, what is driving the decrease? I think, as you may recall from past
7 presentations, there were some of these local plans that were making community
8 investments, they were looking at their reserves and investing it to better their
9 network, strengthen the provider networks, et cetera. Again, that's something
10 that we are asking questions on when we see a declining trend. With
11 Partnership and similarly with other plans we will continue tracking their
12 decreases and what's driving that.
13 CHAIR GRGURINA: Pritika raises a good point which is -- I'm a
14 good example of that. If you go back for the last several years you see that the
15 fiscal year-end statements we have lost money. But from our operations and
16 running the program outside of this last year and the take-back it has basically
17 been break even or a small margin. It is because we have been spending our
18 reserves to improve outcomes for our members, working with our providers.
19 Although you'd imagine, as we have talked about with our board, that has now
20 come to an end as we are just losing money on the natural. But Pritika is raising
21 a good point that several of the public plans had been doing that on an ongoing
22 basis. In fact, I think Larry, the plan that you sit it on the board also had been
23 making community investments as well, using some of the dollars for that.
24 MEMBER DEGHETALDI: John, the plans have also invested
25 earnings back into quality incentives for providers and those are being curtailed

1 at a time when we see disparity gaps between Medi-Cal beneficiaries and other
2 Californians in quality. So that's another area of concern. As the plans struggle
3 financially we may see quality scores go the wrong direction.
4 CHAIR GRGURINA: Right. Other comments or questions from the
5 Board Members? Paul.
6 MEMBER DURR: Yes, just to tag on to what Larry was just talking
7 about. It is something that we all need to be mindful of, it's even more important
8 that we focus on quality. And yet in order to do that in this pandemic requires
9 more resources on the behalf of the medical groups to do that and the providers
10 to reach out to the members who may not want to come in or who want to come
11 in, there's a variation on that. You know, the increase, or what we expect to see
12 a decrease in overall quality scores, is because we need to be mindful about how
13 we are reaching out to those members and how do we capture that information.
14 Are there different ways that that information can be captured and be counted as
15 being valid? Because our goal is the same; we want to provide quality care to
16 members in a cost efficient manner. But with costs going up, trying to enable our
17 patients with more tools to be able to show they are receiving quality care,
18 remote monitoring, for example. Those things cost the groups money in trying to
19 raise that bar. That would be my comment. Thanks, John.
20 CHAIR GRGURINA: Thank you, Paul. Other comments or
21 questions from the Board Members? Amy.
22 MEMBER YAO: Yes. Maybe I am late to this, maybe you guys
23 already discussed this. The California Health and Wellness looks like their
24 reserves are very low and they are continuing to lose money. Are we
25 concerned? They have like 192,000 members with them. I am not familiar with

1 the plan so I don't know which plan that is.

2 MS. DUTT: Good question, Amy. California Health and Wellness,

3 the parent company is Centene. Again, like for these plans that have parent

4 entities that are publicly traded we also look at the publicly traded parent's

5 financial statements to make sure that those parent companies are doing well.

6 And if, you know, our plans, the DMHC-licensed plans need resources, you

7 know, the parent plan could infuse capital if needed.

8 CHAIR GRGURINA: Thank you, Amy.

9 Any other comments or questions? Jeff.

10 MEMBER RIDEOUT: Just to pick up on what Paul said, and Larry,

11 they are both aware of this. But at least on the commercial and MA side IHA

12 actually modified and reduced its metric for incentives next year to reflect more of

13 a pandemic focus. Now that does not say that is going to save anybody money

14 but at least allows organizations to focus their outreach. I don't want to weigh too

15 much in on what DHCS is or isn't doing around sort of kind of coming to a core

16 set of quality measures, but that approach has been, I think, pretty well received

17 among the risk-bearing medical groups and the health plans and really came

18 from the bottom up. So if people want any of that information about where we

19 landed in terms of the measure set and things like that I am happy to share it, it is

20 all publicly available.

21 CHAIR GRGURINA: Thank you, Jeff.

22 Any other comments or questions? Jen.

23 MEMBER FLORY: Yes. You know, to the point about where cuts

24 were made. We totally hear the point about quality and access to specialists but

25 will point out that in last year's budget cycle there were some really tough

1 proposals that were put forward that included cutting beneficiaries off Medi-Cal
2 that, you know, ones that would be getting it in December that won't be getting it.
3 And that did include reducing a lot of services that, you know, in other areas are
4 now considered essential services.
5 So, you know, this is a really tough economic time but we are
6 grateful that those services were continued and that, you know, we were able to
7 expand health care to seniors as is happening in a few days. But, you know, I do
8 hope and trust that this information is also being shared with Department of
9 Finance and DHCS. As you know, people are trying to figure out, you know, all
10 of the moving pieces that they are doing in the budget that it really is sustainable
11 moving forward.
12 CHAIR GRGURINA: Thank you, Jen.
13 MEMBER RIDEOUT: John?
14 CHAIR GRGURINA: Yes.
15 MEMBER RIDEOUT: One follow-up that I forgot to mention. One
16 of the things that we learned in that process of reducing the set was that NCQA
17 made a tremendous effort to make many of the typical HEDIS measures
18 appropriate for telehealth. So meeting those compliance requirements with a
19 different axis approach. So that I think should be thought of as sort of a great
20 tool in the tool kit of actually improving access and even in spite of some of the
21 cuts.
22 CHAIR GRGURINA: Thank you, Jeff.
23 Okay, if there's no further comments from the Board; Lezlie, any
24 comments or questions from members of the public?
25 MS. MICHELETTI: Yes, we do. Bill, go ahead.

1 MR. BARCELLONA: Hi, Bill Barcellona from APG. Great
2 discussion, everybody. Really, really good discussion, troubling. I do remember
3 the days from the early 2000s when the Department had to shut down five health
4 plans as well as a lot of RBOs and this is very concerning. When Jerry Brown
5 first became Governor he told me that we all had to learn to do more with less
6 money. He also said don't quote him on that but it doesn't matter anymore.
7 So here's the thing. In the earlier presentation today by DHCS they
8 stated that they would pursue increased oversight of delegated entities. And
9 what we have seen, especially in the recent policy draft that they sent out on
10 network adequacy, is this duplication of effort between existing DMHC
11 compliance and increased DHCS compliance on the same issues, same
12 programs, same topics, with varying standards, creating a conflicting, duplicative
13 environment that is redundant and that consumes a lot of administrative costs.
14 And I am concerned that administrative costs are rising significantly in the
15 delegated model because of this oversight because I don't see that we are
16 getting any better quality or outcomes from all of it. So we need to take this into
17 account. It is not just about higher rates, it is about using the rates that we have
18 more efficiently. End of story.
19 CHAIR GRGURINA: Thank you, Bill.
20 Lezlie, any other comments or questions from members of the
21 public?
22 MS. MICHELETTI: No, there are no comments or questions.
23 CHAIR GRGURINA: All right, thank you.
24 Okay, Pritika, thank you very much.
25 We will be moving on to the next agenda item which is the provider

1 solvency quarterly update and welcome, Michelle, take it away.

2 MS. YAMANAKA: Thank you very much.

3 MEMBER WATANABE: Michelle, if I could just really quickly, I was

4 just going to give a few remarks before you start your presentation.

5 MS. YAMANAKA: of course.

6 MEMBER WATANABE: I really wanted to kind of tee up this

7 presentation and talk about some of the questions that we have had. We have

8 had a number of comments and questions, particularly about our provider

9 solvency quarterly update and the corrective action plan chart that we have been

10 including.

11 And I wanted to just quickly talk about our oversight of RBOs but

12 also acknowledge that if we were all sitting in the room together I think you would

13 probably see Pritika and I scribbling notes on feedback on our reports. For those

14 of you that have joined our Financial Solvency Standards Board meetings over

15 the years you know that our reports and our presentations have continued to

16 evolve. We are trying to be responsive to the feedback that you give us but just

17 wanted to flag that, let us know when we get it right and let us know if we've

18 missed the mark in our changes because we do want to be responsive and

19 transparent.

20 I do want to just note, and many of our Board Members know this,

21 but more for the public, just that we do not directly regulate risk bearing

22 organizations. Our authority with respect to RBOs really comes from our

23 authority to regulate health plan contracts and their contracts with these

24 organizations.

25 RBOs do submit financial enrollment and other information to the

1 DMHC in their contracted health plans and they are required to meet financial
2 thresholds to ensure the RBOs have the necessary resources to provide health
3 care services to enrollees and to prevent financial insolvency. The plans are
4 actually required to provide adequate oversight of the RBOs to ensure they meet
5 the financial and compliance requirements. And if an RBO fails to meet the
6 financial solvency requirements they are required to submit a corrective action
7 plan to their contracted health plan and the DMHC which provides the actions the
8 RBO will take to correct its deficiencies and the timeline to correct those
9 deficiencies.
10 We have had a lot of discussion about the reasons why RBOs
11 become deficient and end up on a corrective action plan and I just wanted to
12 highlight that these can range from fairly minor issues or issues associated with
13 new systems or changes, to some of the more concerning ones of like the TNE
14 deficiencies and financials. It also could be an increase in medical costs, an
15 increase in high-cost enrollees or audit adjustments, contracting with a new MSO
16 or a new claim system. I really just wanted to take this opportunity to say that our
17 goal with these corrective action plans is really to work with the RBO and the
18 plan to correct the deficiencies and help them come into compliance.
19 I think the piece that we maybe have not highlighted in these
20 forums is what our tools are in our tool kit. If the RBO does not meet the
21 corrective action plan there are really two steps we can take: One is to extend
22 the corrective action timeline, which you will see some of these RBOs that
23 continue to be on a corrective action plan.
24 But the more aggressive approach is really to take an enforcement
25 action directing the contracted health plans to freeze enrollment or to de-

1 delegate, which means they no longer can assign health plan enrollees to that
2 RBO or move enrollees into other RBOs. That is not an action we take lightly.
3 Many of these groups are part of our safety net, they are serving a very
4 vulnerable population.
5 So I hope that provides a little more clarity. And we have made,
6 again, some changes to both the corrective action report and the overall report,
7 welcome your feedback, but I thought it was important for us to really kind of talk
8 about our role in our oversight of RBOs, the role of the health plans and what our
9 tools are in our tool kit. So I'll let Michelle take over from there, but I wanted to
10 start us off with those remarks. Thank you, Michelle.
11 MS. YAMANAKA: Thank you, Mary.
12 So yes, there have been some changes to the presentation when
13 comparing to previous presentations so we will go through those. One of the
14 questions from the last FSSB meeting was the number of insolvencies since the
15 DMHC began financial monitoring of the risk bearing organizations or RBOs. In
16 order to do this we captured the RBOs that previously filed financial information
17 to the Department and were inactive in our system. Then we determined if the
18 inactive reason was due to financial concerns, which includes insolvency. This
19 slide represents 111 RBOs that have been inactivated for various reasons for the
20 period December 2005 through June of 2020.
21 And so for the Board Members, we made a minor adjustment to the
22 slide after the packets were sent to you. The changes were in the row
23 Department Issued C&D, that number in your slide was 3 and it increased to 5.
24 And then the row Financial Concerns - Purchased was 12 in your packet, it was
25 reduced to 10. So it was just the difference of two in those two columns.

1 Okay, so back to where we compiled the information. The RBOs
2 were either classified as having financial concerns or no financial concerns at the
3 time the RBO was inactivated.
4 As you can see there are 39 RBOs that had financial concerns,
5 which are represented in the first four rows of this table. Let's go over those and
6 I will give a little bit more of a description on what is involved in each row.
7 So RBO Filed Bankruptcy. This is the RBO or its parent that filed
8 bankruptcy and with that the enrollment was moved.
9 Department Issued C&D. That's for a cease and desist order. The
10 Department issued a cease and desist order on these RBOs or to the health
11 plans that contract with the RBOs for violations with the regulations; and there
12 were five RBOs in this category.
13 For Financial Concerns - Purchased, these RBOs were on a
14 corrective action plan when purchased. It was likely that these RBOs would have
15 gone out of business because we worked with them in the corrective action
16 process and the RBOs were not improving.
17 For Financial Concerns - Enrollment Reassigned, 21 in this
18 category. These RBOs had financial concerns and the contracting health plans
19 took steps to reassign the enrollment to other organizations.
20 Then the remaining 72 RBOs had no financial concerns at the time
21 the account was inactive and those are the bottom three reasons.
22 So no financial concerns and there was a purchase, these RBOs
23 were purchased. And again, no financial concerns at the time of purchase.
24 For the row, No Financial Concerns - Enrollment Reassigned,
25 health plans reassigned these enrollees for 25 of the RBOs.

1 And then we have a catchall Other category which includes RBOs
2 combining with other RBOs, duplicate numbers issued, or the entity no longer
3 met the definition of an RBO. So there are 30 (sic) in that category.
4 So looking at the past couple of years to see what happened. In
5 2019 there were 9 RBOs that were inactivated, 1 RBO or its parent filed for
6 bankruptcy, 2 RBOs had financial concerns and were purchased, 1 RBO had
7 financial concerns and the enrollment was reassigned, 1 RBO had no financial
8 concerns when it was purchased, and four RBOs had no financial concerns and
9 the enrollment was reassigned. So that is pretty much our analysis since
10 inception of obtaining the financial reports, kind of showing where possible
11 insolvency was, what the financial concerns, RBOs that had financial concerns.
12 So I just want to pause here because this is a lot of information, to
13 see if there's any questions, and then we can move on to the financial reporting
14 for the quarter ended June 30.
15 CHAIR GRGURINA: Comments or questions from the Board
16 Members?
17 MEMBER YAO: John, it's Amy.
18 CHAIR GRGURINA: Go ahead, Amy.
19 MEMBER YAO: I have a quick question for Michelle.
20 MS. YAMANAKA: Yes.
21 MEMBER YAO: For RBOs without any financial concerns why their
22 enrollment got reassigned, for what reason?
23 MS. YAMANAKA: You know, in some of these -- and a lot of them
24 are smaller RBOs and they just found -- they just found that it wasn't working for
25 them, this model wasn't working for them, so then they no longer wanted to be

1 and take this -- continue to take the risk.

2 MEMBER YAO: Okay, thank you.

3 MS. YAMANAKA: Thank you. Paul, do you have your hand up?

4 MEMBER DURR: I do, thank you, John. I think this is great,

5 Michelle. This is great information and I appreciate you and Mary and the

6 Department listening and providing more information because I think it's helpful.

7 You know, one of the things that I thought of is really having this information is

8 wonderful, but also looking at it by how much enrollment was assigned to these

9 plans during that time so that we can balance that, or to these RBOs I should

10 say. It does make me think about the health plan as well and knowing which

11 health plans were involved would be helpful as well. Because to your point,

12 Mary, at the beginning, it is really the health plan's responsibility to monitor the

13 RBOs because that is where the contract is.

14 So it might be good to kind of keep in mind, are health plans doing

15 their jobs? And I think balancing that with knowing how much enrollment was

16 affiliated with those plans that wound up being more where they filed for

17 bankruptcy or had a cease and desist or there were financial concerns. I think

18 those that moved because there's no financial concerns would be something

19 different but I think it speaks to the stability of the other groups. So, you know,

20 kind of looking at this time period, well, how many new groups also came in

21 during this time period would be another factor to say, okay, you know, and the

22 enrollment therewith.

23 CHAIR GRGURINA: Any other comments or questions from the

24 Board Members?

25 MEMBER RIDEOUT: Michelle?

1 MS. YAMANAKA: Yes.

2 MEMBER RIDEOUT: I know the RBO number actually can cover

3 multiple groups of the same parent. Do you have a way to track the subgroups,

4 geographic distinctions?

5 MS. YAMANAKA: We have that information, yes.

6 MEMBER RIDEOUT: Okay.

7 MS. YAMANAKA: And with those, if they're combining, we do

8 receive a combining schedule from the RBO that is reporting. Is that your

9 question?

10 MEMBER RIDEOUT: Yes. Is that available publicly or is it just an

11 internal document? Either way it's fine.

12 MS. YAMANAKA: That's an internal document.

13 MEMBER RIDEOUT: Okay, thank you.

14 CHAIR GRGURINA: Any other questions?

15 Michelle, why don't you go ahead and continue with the

16 presentation.

17 MS. YAMANAKA: Okay. And then one other note I just wanted to

18 make, in 2020 as of the quarter ended June 30th there were no RBOs that were

19 inactivated.

20 Okay, so moving on with the quarter ended financial reporting for

21 the quarter ended June 30th, 2020. We have 198 RBOs or risk bearing

22 organizations that are required to file survey reports. This is an increase of 6

23 RBOs for the period.

24 For annual reports we received 2 annual survey reports for the

25 quarter ended March 31st, 2020. Again, a majority of the RBOs have a fiscal

1 year end of December 31st and the financial survey reports are due 150 days
2 after the RBO's fiscal year end.
3 Quarterly reports, we have 198 RBOs filing quarterly reports.
4 Compliance statements are no longer allowed with the revised regulation.
5 And we have 12 RBOs filing monthly financial statements with the
6 Department. Next slide, please.
7 With the new reporting requirements the RBOs file additional
8 supplemental information with their reports and part of that information is
9 enrollment, so now we can provide some enrollment figures to you. So as of
10 June 30th there's approximately 8.5 million enrollees assigned to the RBOs and
11 this is a 2% increase from the prior period. Next slide, please.
12 For the financial survey reports, the status of the RBOs, we made
13 some changes to the slide. We had four categories which were Superior,
14 Compliant, Monitor Closely and Non-Compliant. We changed it up; now we have
15 two categories Compliant or Non-Compliant. In addition, we did receive
16 compliance statements for the period quarter ended September 30th, 2019.
17 Those compliance statements are included in the Compliant category in the
18 column labeled September 30th, 2019.
19 So for the quarter ended June 30th, the far column to the right,
20 again, we have 198 RBOs reporting; 177 RBOs are reporting compliance, that's
21 89% of the RBOs. Within this category we do still keep track of the Monitor
22 Closely. There are 16 RBOs reporting compliance but are in the Monitor Closely
23 category. And we have 21 RBOs reporting non-compliance and are on
24 corrective action plans.
25 So moving on to corrective action plans. There are 27 CAPs,

1 active CAPs as of June 30th, again in the far right column titled June 30th, 2020.
2 Twenty-three CAPs are continuing from the previous period, 4 are new as of
3 quarter ended 6/30. Of those 23 continuing CAPs 21 RBOs are improving. I
4 wanted to also mention there are 6 RBOs that have two CAPs. So, going to the
5 23 continuing CAPs. Again, 21 are improving and 2 did not meet their quarterly
6 projections, so we have been working with those RBOs receiving monthly
7 financial statements and monitoring them on a monthly basis and working with
8 them. Regarding the 27 CAPs, 24 are approved and 3 are in review. And as of
9 October 7th of 2020, after our Quarter 2 review, 6 of these 27 CAPs have been
10 completed. RBOs have met, are currently meeting all the solvency criteria so
11 they are no longer required to submit progress reports.
12 And then we also have our attachment regarding the details
13 regarding the CAPs in our CAP Review Summary and we also made changes to
14 this attachment. Previously we had several RBOs on here but we listed just the
15 27 CAPs that we have. So it has the RBOs, its MSO if they contract with an
16 MSO, the enrollment ranges, the quarter the CAP was initiated. When we
17 receive the CAP, when we first receive the CAP, that is the date in that column.
18 For the column Compliant with Final CAP, this is if the RBO is meeting its
19 projections. So again, there will be 21 yeses or Ys showing those RBOs that are
20 meeting their approved projections. There were 2 that were not, you will see it as
21 an N in that column. And for those that have a Not Applicable, N/A, those CAPs
22 have not been approved yet. And then it also gives the deficiencies that the
23 RBOs are reporting non-compliance with. Next slide, please.
24 So for the revised regulations effective October 1st, 2019 there is a
25 new TNE requirement. The previous requirement was positive or $1; the new

1 requirement is the greater of 1% of annualized health care revenues or 4% of
2 annualized healthcare expenditures. There is a phase-in period for this
3 requirement, which expired on October 2nd of 2020, and so now currently all
4 RBOs are required to meet this new requirement.
5 So the Department reviewed the quarter ended June 30th financial
6 data to determine compliance with the new TNE requirement. And in this chart in
7 the column <100% it shows 17 RBOs that are not meeting the new TNE
8 requirement; so of those 17, 8 are currently on corrective action plans. So in the
9 event that -- the RBOs have two additional quarters before they have to report
10 showing their compliance with the new TNE requirement but we are continually
11 monitoring them. Hopefully they will be able to meet the compliance date of
12 October 2nd, 2020.
13 And then for those RBOs that do not meet in the event when we
14 receive the December financials, those will be received in February of 2021. For
15 those that do not meet the new TNE requirement they will be required to file a
16 corrective action plan and to go through the corrective action plan process.
17 Okay, so next slide please.
18 So again, with the revised regulation there was a change to the
19 cash-to-claims ratio. It would allow specific assets that could be used in this
20 calculation and that's limited to cash, short term investments and HMO capitation
21 receivables collectable within 30 days. So again, a phase-in period of October
22 2nd, 2020 for this requirement. And as of June 30, as you can see in the column
23 titled <.75, there is one RBO that is not meeting the new cash-to-claim ratio and
24 that RBO is on a corrective action plan. Next slide, please.
25 We do want to note the Office of Financial Review does an analysis

1 of RBOs that have Medi-Cal lives assigned to them. There were approximately
2 4.7 million lives assigned to 88 RBOs as of quarter ended June 30th, 2020. We
3 took the top 20 RBOs which had approximately 3.6 million lives assigned to
4 them, which is approximately 77%, an average of 181,000 enrollees per RBO;
5 and the remaining 1.1 million Medi-Cal lives was assigned to 68 RBOs, which is
6 an average of 16,000 enrollees per RBO.
7 So for the top 20 that had approximately 3.6 million lives assigned
8 to them, 5 of the RBOs were on a CAP, 3 RBOs on our Monitor Closely list and
9 12 RBOs had No Financial Concerns.
10 Looking at the 1.1 million Medi-Cal lives assigned to 68 RBOs, next
11 slide, please. There were 8 RBOs on a CAP, 6 RBOs on our Monitor Closely list
12 and 54 RBOs had No Financial Concerns. Sorry, I did that backwards.
13 Okay. And with that, that concludes my presentation so are there
14 any questions or comments?
15 CHAIR GRGURINA: Yes. So Michelle, first of all, Dr. Ted Mazer is
16 having some difficulty getting on to our piece but has sent me some questions for
17 you for this presentation. The first one is, early on you were showing there's a
18 real increase, in fact, as Ted says, quite dramatic in the number of non-compliant
19 RBOs and that the report was new. I think you described but can you describe
20 again why you have the new report and do you have concerns with the real
21 increase in the number of RBOs that are non-compliant?
22 MS. YAMANAKA: So are we talking about the attachment?
23 CHAIR GRGURINA: I think you were talking about early on there
24 was a report where it showed back in '19 I think there were 3 non-compliant, then
25 I think it went to 14, 17. So just a question of, do we have concerns that it has

1 really increased dramatically?

2 MS. YAMANAKA: I am just trying to -- I just want to make sure I

3 am looking at his -- oh, I see, the status of risk bearing organizations. Can we

4 can we go back to slide 5? And I think this is the --

5 MEMBER WATANABE: I think it is slide 54 in our master power

6 PowerPoint, Jordan, it's towards the beginning. There you go. There you go,

7 that's the one.

8 MS. YAMANAKA: My assumption is that this is the slide that he is

9 talking about.

10 CHAIR GRGURINA: Yes. Michelle, if you look there in the middle,

11 the Non-Compliant category.

12 MS. YAMANAKA: Right, yes, yes. So you know, each of the

13 RBOs they -- everybody is non-compliant for one reason or another and there's

14 just -- there isn't a common pattern with the RBOs, it really depends on their

15 finances and their claims shops if they're experiencing difficulties. So again, of

16 198 RBOs, 89% currently at June 30th are reporting compliance. With those that

17 are on corrective action plans as of October 7th that number has gone down to

18 21 CAPs. The number is less on this slide because this represents the RBOs;

19 the second slide or the CAP slide represents the number of CAPs. So we do not

20 see a concern at this point. Looking at the, monitoring the RBOs that are on

21 corrective action plans. As I mentioned, 21 are meeting their CAPs and are on

22 their way to compliance. And for those 2 that did not meet their corrective action

23 plan projections, we are working with them.

24 CHAIR GRGURINA: All right, thank you, Michelle. Maybe I

25 wonder if in the future that slide might have a row for non-compliant and a

1 separate one for under a corrective action plan but are positively moving forward.
2 Just something to think about.
3 MS. YAMANAKA: Okay, thank you for the comment.
4 CHAIR GRGURINA: The second question that Ted had was, many
5 of the RBOs in the CAPs appear clustered in specific medical service
6 organizations. Are we looking at those MSOs and the increased problems? Are
7 they related to COVID or other factors? What do we know about that?
8 MS. YAMANAKA: So again, you know, if you are going to look at
9 the MSOs the one area that may be a factor is if that claim shop that processes
10 claims for several different RBOs, the claim shop had a system conversion of
11 some sort and it is affecting all the RBOs, that is where it may come into
12 consideration. But as for the MSOs for the financial solvency area, it really
13 depends on each RBO, their books of business, because they all operate
14 separately. So right now we are focused on the RBOs at this point with the
15 solvency metrics; and for the MSOs if there are claims issues then yes it would
16 be at the MSO level. But we work through the RBOs because that is who is on
17 the corrective action plan to ensure that they will be able to meet compliance.
18 CHAIR GRGURINA: All right, thank you, Michelle.
19 Comments or questions from other Board Members? Amy?
20 MEMBER YAO: Yes. Michelle, I like your new table about the
21 cash-to-claims ratio as another early indicator for potential issues. But what is
22 your cutoff point when you put the plan onto the CAP? I think you mentioned
23 something about like, if the cash-to-claims ratio is less than .75; is that correct?
24 MS. YAMANAKA: Yes.
25 MEMBER YAO: Okay. That seems to me is a really low bar.

1 Because for claims, you always know they incur claims that haven't come in yet.
2 So if you don't have enough cash even to pay the current claims, let alone about
3 the claims outstanding, that seems like a really low bar for the cutoff. Typically
4 we will try to keep a cash-to-claims ratio at like 2.0. It's just a comment.
5 MS. YAMANAKA: Okay. So the regulations state that the cash-to-
6 claims ratio, the minimum is .75, so that is by regulation. So anything --
7 MEMBER YAO: Okay.
8 MS. YAMANAKA: Yes, less than --
9 MS. DUTT: Amy, to add to your question. Sorry, Michelle. So
10 Amy, it does include IBNR in that calculation.
11 MS. YAMANAKA: Yes.
12 MS. DUTT: So it does include IBNR.
13 MEMBER YAO: Okay.
14 MS. YAMANAKA: It is the cash, short term investments and
15 capitation receivables collectable from health plans within 30 days, and then as
16 Pritika mentioned, the claims payable and the IBNR. So we do take the IBNR
17 into consideration, yes.
18 MEMBER YAO: Okay.
19 CHAIR GRGURINA: Other questions, comments from Board
20 Members?
21 I see, Paul, you have your hand up.
22 MEMBER DURR: Yes, I just had to two questions, maybe quickly.
23 One is on the slide. Michelle, by the way, this is great information, so thank you
24 for listening and more information is better. On the slide that does talk about, I
25 think it was maybe the slide before this that we got to the TNE. There was -- yes,

1 this slide, thank you. You mentioned out of the 17 in the first column there that
2 are less than 100%. I think you mentioned, if I remember right, that 6 or so were
3 on a CAP. My concern would be is the one plan that is less than 100% that has
4 200,000 plus enrollment, should we be concerned about that RBO because of
5 that large size of enrollment?
6 MS. YAMANAKA: So let me just take a look at -- let just -- if you
7 would just bear with me just for one second, I just want to see if that RBO
8 attained compliance with their CAP, if they were on a CAP. Or maybe what I can
9 do is let me take a look but that RBO may have attained compliance with their
10 CAP and completed their CAP.
11 MEMBER DURR: Okay. Just a concern.
12 MS. YAMANAKA: Yes.
13 MEMBER DURR: My other observation is on the separate handout
14 that was provided that does list the RBO by name and the MSO. This is a
15 clarifying question. So I am looking at it and, you know, there's the first RBO that
16 is listed there, it has two lines because Quarter CAP Initiated for the first line is
17 March of 2019, they are compliant with the CAP and the deficiency is Working
18 Capital; and the second line is related to the CAP being initiated in December of
19 2018, they are compliant with the CAP and their deficiency was TNE. Am I to
20 assume that deficiency for TNE and Working Capital is ongoing from that
21 initiation CAP date? Meaning that, so for the first one that they have been
22 deficient in working capital from March of 2019 going forward but they have also
23 been deficient in TNE going back to December of 2018, every quarter from
24 December of '18?
25 MS. YAMANAKA: Okay, so let me just clarify our CAP process a

1 little bit. So one of the things that we do is an RBO needs to be compliant for
2 one entire quarter before they will be released from the corrective action. In
3 addition to that we also work with the health plans to ensure that they don't have
4 any concerns before completing the CAP. So let's just say at March 31st the
5 RBO was not compliant with the solvency criteria but on June 30th they were
6 compliant. They were not compliant at all times because the assumption most
7 likely as of April 1st they would not be compliant unless they put in the money on
8 March 31st to get compliant April 1st. So in a sense they were not compliant at
9 all times even though at the end of the quarter they were compliant, so they
10 would need to stay on a corrective action plan for another quarter. So within that
11 there could be -- in certain situations they could be compliant at June 30th but
12 then come September 30th they were not compliant at all times, so then you go
13 backwards and such.
14 With our CAP process, and as Mary mentioned, the options
15 available to the Department, which is work with them, extend or take
16 administrative action, which is to freeze or to possibly de-delegate. We really try
17 to work with the RBOs to determine, are there severe financial concerns that we
18 need to take action or does the RBO, are they going to be able to come out of
19 this, to extend it? For those that are longer the option probably was they would
20 be able to come out of it and therefore we allow them to extend the corrective
21 action plan. So a combination of those things where it is an on/off, on/off
22 situation, which kind of kick the can down the road.
23 CHAIR GRGURINA: All right, thank you, Michelle.
24 Mary, I think you wanted to say something.
25 MEMBER WATANABE: Yes. No, I just wanted to circle back to Dr.

1 Mazer's question about the MSOs. I am reminded of how much this chart has
2 evolved over the last few years. So we actually added MSOs in response to
3 some of the presentations we had, it is probably going back two or three years
4 ago, from MSOs, just trying to understand their role in the work that they do with
5 RBOs. We added it really trying to see if there were trends or patterns.
6 But the piece I think I would caution about is what you are not
7 seeing is the universe of RBOs that work with all of the MSOs that are out there.
8 And so just a caution about assuming causation of it is an issue with the MSO
9 versus an issue with the RBO. Because we are not looking at the universe, we
10 are really just looking at for those RBOs that are on CAP and who their MSO is. I
11 know, Michelle and Pritika, this is something that I always look for when I get this
12 report is are there trends or patterns? Do we see a significant of RBOs on CAP
13 that are affiliated with an MSO? But it's just, again, one piece of the puzzle.
14 CHAIR GRGURINA: Thank you, Mary.
15 Paul, do you have your hand up again?
16 MEMBER DURR: I do. It just prompted me for another thought
17 that I had so I apologize. Thank you, Mary, for that. You know, it made me think
18 about the fact that what you said at the beginning, Mary, is the enforcement
19 action is really limited to what the Department can do. So it really speaks to the
20 health plan responsibility to be overseeing the groups because we do get audited
21 by the health plans as a provider group but we don't have routine audits, I think,
22 from all the plans. And I remember this going back is that they weren't really
23 doing their job. So it made me think about, or makes me think about, the fact is,
24 should we identify if there's one plan or two that are in each RBO that really has
25 the majority of the members for that RBO that really should be called out?

1 Somehow how do we track that? Because if you are well diverse in an RBO and
2 you have, you know, 5,000 members with each plan it may not be as big of an
3 issue, but if all that membership happens to be in one plan, you know, kind of
4 looking at where is the plan accountability for that? And knowing that that's a big
5 issue if it is one plan because the plan could move the members, but if it is
6 spread amongst multiple plans it gives maybe more concern. And then an
7 insight into are the plans doing what they are supposed to be doing?
8 CHAIR GRGURINA: Then, Paul, I'll add to your comment. Like I
9 know our plan is now out there doing more audits than we have done before. It
10 also leads to the question of if a medical group has multiple contracts with
11 multiple plans are they getting audits from every single one of them? Versus the
12 question you were kind of leaning towards which is, well, what if it's the one that
13 has the majority of the membership? But things for us to figure out as we can
14 continue to move along. I think that we are all aware given the circumstances
15 from a couple of years ago that there is much more oversight that is coming from
16 the plans on delegated groups. And then you also saw in the DHCS presentation
17 where they are making their future selection of which plans will be participating in
18 the two plan model. That is one of the criteria they are looking at is the oversight
19 from the health plan of the delegated groups.
20 MEMBER DURR: And to that point, John, just to add on that, and
21 not -- I know we are getting short on time. But just being mindful of all of those
22 plans coming in is a burden to the groups, right? And to your point, I mean, if it
23 could be streamlined, which is really audited financials does make it easier.
24 Because I think one of the other things that I think Bill might have raised is the
25 increased regulatory burden that is being absorbed by the groups, the RBOs.

1 That does get frustrating when -- you know, if we have audited financial
2 statements that should be good enough for each plan. So something to be
3 mindful of to your point, thanks.
4 CHAIR GRGURINA: I appreciate it, Paul. We have a room that we
5 refer to as the auditor's room for our friends from DHCS and our friends from
6 DMHC and from others who come by and visit us, NCQA, so good comments.
7 Other comments or questions from Members of the Board?
8 Not seeing any, Lezlie, do we have any comments or questions
9 from members of the public?
10 MS. MICHELETTI: We do, we have three. The first one, Kimberly,
11 you can unmute yourself and introduce yourself.
12 MS. CAREY: Thank you. This is Kimberly Carey, I am the
13 President of MedPOINT Management. I just wanted to make a couple of
14 comments on the actual extra handout, Michelle, and the fact that I believe Ted
15 was mentioning the numerous, some MSOs mentioned numerous times. I just
16 wanted to give both the Board - and thank you, Mary, because I think you
17 mentioned this a little bit - some perspective when you talk about MSOs.
18 We are an MSO that manages 1.4 million patients in the state of
19 California. And of those 1.4 million patients 93% of our patient population is
20 Medi-Cal, so there is a significant difference in an MSO when you look at what
21 their percentage of Medi-Cal population is.
22 And then I also want to make a comment on the four groups that
23 are there represent about 5% of our overall membership. So I think it's important
24 to -- I'm sorry, 20% of our overall membership. So I think it is important to
25 understand that there is a significant number of patients out there and groups out

1 there that are managed that are also heavily weighted in Medi-Cal that are doing
2 okay.
3 A lot of what I think is important, as Michelle and I have talked
4 about and Mary and I have talked about, is looking at the geography and health
5 disparities and health plans that are with these groups. Because only, I think
6 only two are really going to be on an ongoing CAP and the other two had a one-
7 time event. So I just think it is really important that we look at this and we have
8 long, long discussions with Michelle and her team on these issues.
9 So I just wanted to point that out that some MSOs are very heavily
10 weighted in the Medi-Cal marketplace and that is why our name is loud and
11 proud. Not necessarily proud but loud on these reports but we do work hard. All
12 right, thank you.
13 CHAIR GRGURINA: Thank you, Kimberly.
14 All right, Lezlie, the next one.
15 MS. MICHELETTI: Okay. The next one, Melissa, you can unmute
16 yourself and introduce yourself, please.
17 MS. BORRELLI: Hi, my name is Melissa Borrelli, I am from
18 Mazars, which is a consulting firm. The audio kind of goes in and out so you may
19 have said this earlier but I didn't hear it. If we do have thoughts, feedback on the
20 report how would you like to receive that? Via email or now or what would you
21 prefer?
22 MS. DUTT: Melissa, this is Pritika. You can email it, email your
23 feedback to Michelle and I.
24 CHAIR GRGURINA: Did you hear that, Melissa?
25 MS. BORRELLI: I did, yes. Sorry, the mute seems to be going on

1 and off. But yes, I did, thank you.
2 MS. DUTT: Thank you.
3 CHAIR GRGURINA: All right, thank you, Melissa.
4 All right, Lezlie, next up?
5 MS. MICHELETTI: Okay. Bill, go ahead, you should be able to
6 speak.
7 MR. BARCELLONA: Thank you, Lezlie. Bill Barcellona, APG. I
8 know the hour is getting late so I am going to avoid 20 of my comments and just
9 say a big thank you to the staff for doing all this work and for your constant calls
10 back and forth with me over the past two months to get this ready. I really like
11 the results, I think the new format is excellent, so a big round of snaps. Thanks.
12 CHAIR GRGURINA: All right, thank you, Bill. I will double down on
13 the thanks, Michelle and staff, for the change in the report and addressing the
14 issues that folks have raised in the past. Mary and Pritika and Michelle
15 mentioned this earlier but they are listening to us and making changes so we
16 appreciate that. I will thank you very much, Michelle, and we will move on to the
17 health plan quarterly update.
18 MS. YAMANAKA: Thank you.
19 MS. MICHELETTI: John? John, I do have one more that has
20 raised a hand.
21 CHAIR GRGURINA: I apologize, Lezlie. One more.
22 MS. MICHELETTI: That's okay. Diana, go ahead.
23 MS. DOUGLAS: Hi, sorry about that. Diana Douglas with Health
24 Access here. I just wanted to say thank you to Michelle for the detailed
25 presentation in this report, we appreciated it. I do want to just flag that from a

1 consumer perspective We are concerned about the sort of increasing percentage
2 of RBOs on CAPs on I believe it was slide 5 or page 5 of the slide. Over time it
3 has, you know, gone from it looks like just over 1% now to about 10% are on
4 corrective action plans. So it's just something that, you know, from our
5 perspective, we want to keep a close eye on the trend, even though I appreciate
6 the context that there does not seem to be a specific common pattern. But we
7 are also pleased to see that 21 are improving on their CAPs as well. Thank you.
8 CHAIR GRGURINA: All right, thank you, Diana, and I apologize for
9 cutting you off.
10 Okay, let's go ahead and move on, Pritika, to the health plan
11 quarterly update.
12 MS. DUTT: Thank you, John. Hi, this is -- good afternoon, this is
13 Pritika Dutt, Deputy Director for the Office of Financial Review again. I will
14 provide you an update of the financial status of health plans at quarter ended
15 June 30th, 2020.
16 For the health plan financial information presented in the
17 subsequent slides and charts we changed the format from making comparison of
18 the financial and enrollment data from year to year to comparing the data from
19 quarter to quarter to show any immediate changes as a result of the pandemic.
20 We have been tracking the health plan financials, financials and enrollment
21 trends very closely and working with the plans if we see any unusual trends that
22 would raise concerns.
23 At October 2nd, 2020 we had 132 licensed health plans. Since the
24 last FSSB meeting we licensed 2 additional full service plans; those were
25 Medicare Advantage plans. One dental plan surrendered its license. We are

1 currently reviewing 11 applications for licensure, 7 full service and 4 specialized.
2 Of the 7 full service, 2 are seeking licensure to be Medicare Advantage plans, 5
3 are seeking licensure for restricted Medicare advantage plans and 1 for restricted
4 Medi-Cal. For the 4 specialized applications we are working on, 2 are looking to
5 get licensed for dental and 2 are looking to get licensed to offer behavioral health
6 services, especially employee assistance programs. Next slide.
7 At June 30th, 2020 there were 27 million enrollees in full service
8 plans licensed with the DMHC. Total commercial enrollment includes HMO,
9 PPO/EPO and Medicare supplement. As you can see on the table, compared to
10 previous quarters, total full service enrollment increased by 330,000 enrollees,
11 and this was driven by an increase in Medi-Cal enrollment. Next slide.
12 This slide shows the makeup of HMO enrollment by market type.
13 All markets saw a slight decrease in HMO enrollment. Overall HMO enrollment
14 decreased slightly when compared to the previous quarter. The decrease was
15 about 50,000 lives for the quarter ended 6/30/2020. Next slide.
16 This slide shows the makeup of PPO/EPO enrollment. We do not
17 separately get the PPO and EPO enrollment broken out. Right now the health
18 plans are reporting combined PPO/EPO enrollment so that is something like we
19 would be capturing in the future when we make changes to our financial reporting
20 form and enrollment tables. As you can see on the table, the Large Group, Small
21 Group and Individual PPO enrollment remained stable when compared to the
22 previous quarter.
23 This table shows government enrollment which is Medi-Cal and
24 Medicare. Overall, the government enrollment increased. As I previously stated,
25 the increase was driven by Medi-Cal enrollment of 370,000 lives.

1 We are currently monitoring 28 health plans closely due to various
2 reasons, including but not limited to declining financial health, issues with claims
3 processing or plans going through claims system conversions, issues identified
4 during our financial audits, newly licensed plans, concerns with parent entity and
5 low enrollment, amongst other things.
6 There were 4.3 million enrollees enrolled in the closely monitored
7 full service plans. Of the 24 closely monitored full service plans 11 are restricted
8 licensees and had less than 1 million enrollees. For those restricted licensees, 4
9 are restricted for Medi-Cal, 5 are restricted for Medicare and 2 Commercial.
10 We have 6 Medicare Advantage health plans that are being closely
11 monitored as well.
12 The total enrollment for the 4 specialized plans is 280,000 lives.
13 For the 4 specialized plans, 2 are behavioral health plans, 1 vision and 1 dental.
14 One health plan did not meet the Department's minimum financial
15 reserve or TNE requirement. Vitality remains TNE-deficient and we continue to
16 work with CMS and the DMHC's Office of Enforcement on this matter. The
17 DMHC issued a cease and desist order on June 30th that prohibits Vitality from
18 accepting new members effective July 2nd, 2020. Due to the severity of Vitality's
19 TNE deficiency and financial viability concerns the DMHC issued an Accusation
20 on July 31st, 2020 to revoke Vitality's license. Vitality had 15 days to request a
21 hearing, which it did. The Office of Administrative Hearings has scheduled a
22 hearing date for April 26th, 2021.
23 Additionally, CMS issued a special enrollment period for Vitality
24 members due to a significant change in provider network for Vitality's members.
25 Vitality enrollees have a special one-time opportunity to choose a different

1 Medicare health or drug plan or change to Original Medi-Cal. The special
2 enrollment period runs from the beginning of September to November 30th.
3 This chart shows the TNE of health plans by line of business. A
4 majority of the health plans with over 500% of TNE are specialized health plans.
5 This is because the required TNE for full service plans is higher because the
6 medical expense or the risks for the full service plans are higher. For most plans
7 the required TNE is driven by medical expenses. The higher the plan's medical
8 expenses, the higher the reserve requirement for these plans are. Next slide,
9 Jordan.
10 This chart shows the TNE of full service plans by enrollment
11 category. Fifty-seven health plans, or over half of the full service health plans,
12 reported TNE of over 250% of required TNE.
13 This chart shows a breakdown of 22 full service health plans in the
14 130% to 250% range of the required TNE. If a health plan's TNE falls below
15 130% the plan is placed on monthly reporting. We also monitor the plans closely
16 if we observe a declining trend in their financial performance, which includes
17 TNE, net income, enrollment, amongst other financial ratios that we track.
18 This chart shows the TNE by line of business for plans that are
19 being monitored closely. As you can see, 6 plans with over 500% of TNE are
20 being monitored closely. This is because we may have claims processing
21 concerns with these entities or declining financial performance. Although they
22 are at 500% of required TNE we still have observed declining trends like net
23 losses and the reserves continue to decline so we have them on, we have been
24 monitoring those plans closely.
25 Okay. That brings me to the end of my presentation. Any

1 questions?

2 CHAIR GRGURINA: All right, questions and comments from the

3 Board Members? Remember, we are seven minutes from closing so your most

4 important comments or questions for Pritika.

5 I am not seeing any hands up. No, Amy says, no.

6 All right, Lezlie, any comments or questions from members of the

7 public?

8 MS. MICHELETTI: No questions or requests to speak from the

9 public.

10 CHAIR GRGURINA: All right, thank you, Lezlie.

11 All right, thank you, Pritika, we appreciate it.

12 Let's go ahead and move on and it is the 2021 meeting schedule.

13 So if we could turn the slide, show our dates.

14 MEMBER WATANABE: We may not have a slide with the dates,

15 John, I will just quickly read. I think we have February 24th, May 12th, August

16 11th and November 17th. I know we have got a little bit of uncertainty about who

17 will be on the Board next year and what potential conferences and meetings will

18 happen. If anybody has a known conflict with any of the dates that are posted on

19 our website or that we sent out you can email Lezlie or myself or any of our other

20 admin support people, but we'd like to at least lock those down for our next

21 February meeting.

22 CHAIR GRGURINA: All right. As you said, Mary, those are

23 available on the website and for the Board Members it was sent to all of us as

24 well. All right, thank you.

25 Okay, we have next on the agenda the public comments on matters

1 not on the agenda.

2 Lezlie, do we have any members of the public who have a

3 comment to make?

4 MS. MICHELETTI: There are no comments or raised hands at this

5 time.

6 CHAIR GRGURINA: Okay, great, thank you, Lezlie.

7 All right, the next agenda item is for the Board Members, which is

8 any future items that you would like to raise for DMHC to bring back to us at

9 future meetings. Any requests? I am not seeing any hands up?

10 MEMBER DEGHETALDI: You know, John, I think it's obvious, it is

11 the COVID vaccine. We are looking at, you know, a seismic change coming the

12 first quarter of next year and we want to be able to, you know, have adequate

13 reimbursement and protect consumers. Because, you know, I am looking at,

14 what are we going to have, 80 million Californians at 40 times 2? Right.

15 CHAIR GRGURINA: Okay, so we will mark that one down.

16 Any other requests from Board Members?

17 MEMBER DURR: John, this is Paul. I would just say that

18 continued focus on the high-cost drugs. Vaccines are one with regards to

19 COVID but I am still very concerned about the alarming increase in the drug self-

20 injectables and other things that Larry would be able to further go into detail, but

21 that is something I am so mindful of on the impact to the healthcare system.

22 CHAIR GRGURINA: Thank you, Paul.

23 Mary, I will add, we would like to have our friends from DHCS come

24 back, particularly in January. We will hear where we are with the Rx transition as

25 well as, I believe -- did you say January or February, Mary?

1 MEMBER WATANABE: February 24th, so we'll have some budget
2 --
3 CHAIR GRGURINA: Perfect. It will be after the February budget
4 comes out, that will be a good time to have our friends from DHCS with us.
5 All right. Are there any last comments or additions from the Board
6 Members?
7 If not, thank you to the Board Members. Thank you, Mary, to you
8 and Pritika and Michelle. Thank you to Lindy. And big thanks to Lezlie and
9 Jordan behind the scenes making this work and to all the members of the public
10 who attended.
11 I wish everyone as best as we can a Happy Thanksgiving, Happy
12 Holidays and a safe and positive new year. We will look to turn the clock and
13 look for a time when we could actually be together and see each other in person.
14 With that, thank you very much, folks, have a good day.
15 MEMBER WATANABE: Thank you. Thank you, John.
16 (The meeting was adjourned at 12:57 p.m.)
17 --o0o--
18
19 .
20 CERTIFICATE OF REPORTER
21
22 I, RAMONA COTA, an Electronic Reporter and Transcriber, do
23 hereby certify:
24 That I am a disinterested person herein; that the foregoing
25 Department of Managed Health Care, Financial Solvency Standards Board

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

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

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

4 IN WITNESS WHEREOF, I have hereunto set my hand this 8th day

5 of December, 2020.

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10 RAMONA COTA, CERT*478

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