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, FEBRUARY 23, 2022

10:00 A.M.

Reported by: Ramona Cota

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APPEARANCES

BOARD MEMBERS

Larry deGhetaldi, MD, Chair

Scott Coffin

Abbi Coursolle

Paul Durr

Theodore Mazer, MD

Jeff Rideout, MD

Mary Watanabe

DMHC STAFF

Pritika Dutt, Deputy Director, Office of Financial Review

Scott Ostermiller, Attorney III

Sarah Ream, Chief Counsel

Daniel Rubinstein, Associate Governmental Program Analyst

Jordan Stout, Staff Services Manager I

Michelle Yamanaka, Supervising Examiner, Office of Financial Review

ALSO PRESENTING/COMMENTING

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

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1 PROCEEDINGS

2 10:00 a.m.

3 CHAIR DEGHETALDI: Welcome, everybody. On behalf of Mary
4 and the Department and the Board, welcome to the first FSSB meeting of the
5 year. It is a great meeting because we have two new Board Members. I am
6 excited to meet them and see their contributions going forward.

7 But we usually start here, before we introduce the Board Members,
8 with some housekeeping notes. They will be a little bit abbreviated today, and I
9 will explain why. For our Board Members, please remember to unmute
10 yourselves when making a comment and mute yourselves not speaking. For our
11 Board Members and the public, as a reminder, you can join the Zoom meeting on
12 your phone should you experience a connection issue.

13 Questions and comments will be taken after each agenda item. For
14 the attendees on the phone, if you would like to ask a question or make a
15 comment please dial *9 --

16 MEMBER COURSOLLE: Good morning.

17 CHAIR DEGHETALDI: -- and state --

18 Good morning. Hi, Abbi, hi. Welcome. I am kicking off with some
19 housekeeping notes.

20 And state your name and your organization that you are
21 representing for the record.

22 MEMBER COURSOLLE: Thank you.

23 CHAIR DEGHETALDI: For attendees participating online with
24 microphone capabilities, you may use the Raise Hand feature and you will be
25 unmuted to ask your question or comment. To raise your hand, click on the icon

1 labeled Participants on the bottom of your screen, then click the button labeled
2 Raise Hand. Once you have asked your question or provided a comment,
3 please click the Lower Hand. All questions and comments will be taken in order
4 of when the raised hands appear.
5 And here is where I will stop on our usual comments. Typically,
6 here we will comment on some of the rules and obligations of the Board under
7 the Bagley-Keene Open Meeting Act. But because we are going to have a
8 special agenda item talking about that Act, I will hold off on that and we will hear
9 directly from Scott in the fourth agenda item.
10 Mary, any comments or items that I missed in that intro?
11 MEMBER WATANABE: No, you did great. Thank you, Larry.
12 CHAIR DEGHETALDI: Okay, great. Boy, a lot of pressure. Okay.
13 So, the second agenda item would be -- I'm sorry, let's now introduce our two
14 new members. I am going to ask Scott to go first because, Abbi, I did let him
15 know that we want to hear a little bit of detail about our two new Board Members.
16 So Scott, why don't you go first and put the pressure on the rest of us.
17 MEMBER COFFIN: Okay, thank you, Larry. Good morning. My
18 name is Scott Coffin; I am the Chief Executive Officer for Alameda Alliance for
19 Health. I have served at the Alliance for the last seven years and I am just very
20 honored to be part of the FSSB and thank you.
21 CHAIR DEGHETALDI: So welcome, thank you. And Abbi?
22 MEMBER COURSOLLE: Thank you. My name is Abbi Coursolle.
23 I am a senior attorney with the National Health Law Program where I have
24 worked for a little over ten years now. We are also part of the Health Consumer
25 Alliance so here to represent the consumer advocate perspective and really glad

1 to be joining the Board.

2 CHAIR DEGHETALDI: So welcome, Abbi, it is great to have you.

3 So I am Larry deGhetaldi, I am a family physician. Practiced my

4 entire 40 year career in Santa Cruz. I am part of the Sutter Health PAMF system

5 and I think I have been on this board circa eight years. It is a wonderful

6 experience working for, trying to support a wonderful department.

7 Let's go to our rainy San Diego colleagues next.

8 MEMBER MAZER: I'll take it first, Paul. Ted Mazer, ENT physician

9 in San Diego, here as an independent physician, Past President of the California

10 Medical Association.

11 MEMBER DURR: Paul Durr with Sharp Community Medical

12 Group, it is a large independent provider group in San Diego, I serve as the CEO

13 of that organization. Glad to be here.

14 CHAIR DEGHETALDI: Jeff?

15 MEMBER RIDEOUT: Hi, Jeff Rideout, I am the CEO of the

16 Integrated Health Care Association.

17 CHAIR DEGHETALDI: Great. And we are missing Amy Yao,

18 excused absence, from Blue Shield. You will love her, her comments are

19 fabulous.

20 Okay, let's move to the second agenda item, which is a review and

21 asking for comments from any Board Members that were at the last FSSB

22 meeting, review of the transcript, and ask for any comments or corrections. And

23 if there are none we will just proceed with approval of that so I am looking for any

24 comments from Board Members who were here three months ago.

25 (No audible response.)

1 CHAIR DEGHETALDI: Okay, let's move on. Mary, now it is your
2 turn --
3 MEMBER DURR: Larry.
4 CHAIR DEGHETALDI: Yes, Paul.
5 MEMBER DURR: I would make a motion to approve those
6 minutes.
7 CHAIR DEGHETALDI: I will accept that. A second?
8 MEMBER MAZER: Second.
9 CHAIR DEGHETALDI: All those in favor?
10 (Show of hands.)
11 CHAIR DEGHETALDI: Great, it looks unanimous so thank you.
12 Now we go to Mary and Director's comments.
13 MEMBER WATANABE: Great, thank you. And thank you, Larry,
14 for taking on the role as our Chair. I know this is a lot of pressure for your first
15 meeting but it will just become routine and no big deal going forward.
16 Scott and Abbi, welcome to the Board. We are really excited to
17 have you and continue to have a Medi-Cal managed care and consumer voice
18 on the Board.
19 I think for anybody that doesn't know me, I am Mary Watanabe, the
20 Director of the Department of Managed Health Care. I will take just a moment to
21 introduce the DMHC team. We have Pritika Dutt, our Deputy Director for the
22 Office of Financial Review with us, Michelle Yamanaka, also from the Office of
23 Financial Review, Scott Ostermiller is here to talk about our Bagley-Keene
24 requirements, Sarah Ream will be joining us to do a federal and reg update, and
25 then as always we have Jordan Stout and Daniel Rubinstein providing amazing

1 technical support. Hopefully I think I caught everybody.

2 So, I will move on to just a few quick updates. I will start with the

3 Governor's 2022-23 proposed budget. We are in a very fortunate position again

4 this year. The budget is $286 billion and it includes an almost $46 billion surplus.

5 The proposed budget focuses on five priorities, COVID, the climate,

6 homelessness, cost of living and safety. So, I am going to hit just a couple of the

7 high points for our Health and Human Services agency and some exciting

8 proposals. The DMHC doesn't have any specific proposals this year but thought

9 it would be helpful just to walk through a few of these. And I know Lindy will

10 share a couple more of the DHCS budget items under her proposal -- under her

11 presentation.

12 The budget includes $2.7 billion to ramp up vaccine, boosters and

13 statewide testing and increase medical personnel to meet potential surges. You

14 probably heard the Governor's announcement, I think it was last week or the

15 week before, on the SMARTER Plan as we move forward living with COVID and

16 to prepare for future variants, so lots of exciting work happening on the response

17 to COVID.

18 The Health and Human Services budget also includes items to

19 build a 21st Century public health system. The COVID pandemic has

20 underscored the need for investments in our Department of Public Health and

21 local health jurisdictions to respond to the needs of Californians during public

22 health emergencies. So there is a, the budget proposal is a $300 million

23 investment in public health infrastructure.

24 There are several initiatives targeted at addressing childhood

25 poverty including a 7.1% increase to CalWORKS grants, expanding voluntary

1 home visiting programs for children age 0-3 to provide a range of supportive
2 services to pregnant and new parenting families. It also provides additional
3 funding to expand the California Home Visiting Program and California Black
4 Infant Health Program.
5 The budget also includes additional funding to extend adverse
6 childhood experiences or ACEs training for Medi-Cal providers. We were
7 disappointed to hear our Surgeon General Nadine Burke Harris recently has left
8 but excited to see the great work that she has done on ACEs continuing.
9 There's a number of initiatives related to making health care
10 affordable and expanding the availability of services to all Californians. Most
11 notably and the one that we have been talking about quite a bit is the expansion
12 of Medi-Cal to all income-eligible Californians, so exciting work there, I am sure
13 Lindy will talk about as well.
14 The administration will move forward with its proposal for an Office
15 of Health Care Affordability within the Department of Health Care Access and
16 Information. This office will address underlying cost drivers to improve the
17 affordability of health coverage. The office will be charged with increasing
18 transparency on cost and quality, developing cost targets for the health care
19 industry and forcing compliance through financial penalties and approving market
20 oversight of transactions.
21 Let's see here. There's a number of initiatives to further support
22 behavioral health through housing and community-based services, so a lot of
23 exciting work that is continuing from last year's investments on the behavioral
24 health side.
25 And there is also a one-time $1.7 billion investment over three

1 years to support workforce development and this is really a partnership between
2 the Labor and Workforce Development Agency and our California Health and
3 Human Services Agency, with the goal of creating opportunities to recruit, train,
4 hire and advance an ethnically and culturally inclusive workforce. So recognition
5 that I think there is a lot of, a lot of work needed to expand our workforce
6 capacity.
7 And finally, there's a number of proposals related to CalAIM but I'll
8 leave that to Lindy to talk about.
9 So a quick update on the Centene-Magellan merger. We have
10 been talking about this I think all of last year. But on December 30th of last year,
11 we announced our approval of Centene's acquisition of Magellan, with conditions
12 to ensure the merger did not adversely impact enrollees or the stability of
13 California's health care delivery system. We conducted a comprehensive review
14 of the merger, including obtaining an independent impact analysis that evaluated
15 the impact of the merger on enrollees and the stability of the health care delivery
16 system. We also held a public meeting on the merger to solicit input from the
17 public.
18 We imposed several conditions or undertakings on the plan as part
19 of our approval. This included requiring the plans to continue with Magellan's
20 market presence in California and Human Affairs International to continue its
21 existing contracts to provide behavioral health services at the same rates for at
22 least two years.
23 The plans will also work to help control health care costs and keep
24 premium rate increases to a minimum, including no increases as a result of the
25 acquisition.

1 We also are requiring a third-party monitor to oversee the plan's
2 compliance with competition-related conditions including holding the Magellan
3 and Centene plans separate to ensure the Magellan health plans are run as a
4 separate business.
5 And then finally, Centene is required to contribute $10 million over
6 five years to the Purchaser Business Group on Health, PBGH, a nonprofit
7 501(c)(3) foundation, to support their California Quality Collaborative initiative to
8 accelerate behavioral health integration into primary care practices.
9 And then finally here I am going to talk a little bit about the findings
10 of our Prescription Drug Cost Transparency Report. We released this at the end
11 of last year. We have a lot on our agenda so we are not going to do a whole
12 presentation today but I did just want to hit a couple of the highlights of this
13 report. Let's see.
14 The report provides greater transparency into prescription drug
15 costs and provides important information about the impact of prescription drug
16 costs on health plan premiums.
17 We looked at the total volume of prescription drugs covered by
18 plans and the total cost paid by health plans for those drugs.
19 Additionally, you may remember we look at the 25 most frequently
20 prescribed drugs, the 25 most costly drugs, and the 25 drugs with the highest
21 year-over-year increase in total annual spending and how that impacted the
22 health plan premiums.
23 I will hit just a couple of the key findings from the report.
24 Health plans paid more than $10.1 billion for prescription drugs in
25 2020. This was an increase of almost $500 million or 5% from the previous year

1 in 2019. And since 2017, prescription drug costs paid by health plans increased
2 by $1.5 billion.
3 Prescription drugs accounted for 12.7% of total health plan
4 premiums in 2020, this is a slight decrease from 12.8% in 2019.
5 And health plans' prescription drug costs increased by 5% in 2020,
6 whereas medical expenses increased by 3.7%.
7 Manufacturer drug rebates totaled approximately $1.4 billion, this
8 was up from $1.2 in 2019 and a little over $1 billion in 2018, so we are continuing
9 to see that grow.
10 While specialty drugs accounted for only 1.6% of all prescription
11 drugs dispensed, they accounted for 60.2% of total annual spending.
12 And let's see. I think I'll stop there on the highlights. I will just point
13 out that the report is published on our public website at healthhelp.ca.gov. You
14 can find it, there is a little hyperlink on the right side to DMHC Reports, so we will
15 let you look at that report.
16 We will be having a public meeting on individual, small group, large
17 group premiums and prescription drug costs next month and so at our next
18 meeting we will have more information to share with you on both of those.
19 And then finally just a quick COVID update. Obviously, COVID
20 continues to be at the forefront of all of our minds and is keeping us busy. The
21 federal government issued guidance on at-home tests, which you probably saw
22 that, I think it was towards the end of the year with more guidance in January,
23 Sarah is going to talk about that shortly. But we are continuing to work on our
24 guidance on SB 510, which also took effect on January 1st of this year and
25 requires health plans to cover the costs of diagnostic and screening testing and

1 immunizations without cost-sharing, prior authorization or utilization
2 management. I know there were questions at our last meeting about that. We
3 have been working with stakeholders on our guidance and should have
4 something more to share soon.
5 And with that I will pause and see if there's any questions.
6 CHAIR DEGHETALDI: Mary, thank you for that report. Just a
7 reminder to Abbi and Scott, with each agenda item we then go to the Board to
8 ask for comments or questions. And just keep in mind also that at the end of the
9 meeting we ask the Board to share any general comments about the meeting
10 and possible future agenda items, so keep that in the back of your mind. So
11 now, any questions or comments from the Board to Mary?
12 Okay. And then we go to the public. Jordan, are there any
13 questions or comments for Mary?
14 MR. STOUT: There are none at this time.
15 CHAIR DEGHETALDI: Excellent. I see our next two speakers are
16 teed up and ready. Scott, you are up first, so welcome.
17 MR. OSTERMILLER: Good morning, everyone. My name is Scott
18 Ostermiller, attorney with the DMHC's Office of Legal Services; and this morning
19 I will be providing a brief overview of the Bagley-Keene Open Meeting Act.
20 The purpose of Bagley-Keene is to allow the public to participate in
21 government and have an opportunity to participate in the decision-making
22 process of state bodies.
23 The public is allowed to monitor and participate in all meetings of
24 state bodies, unless there is a specific reason to exclude the public. There are
25 three general requirements: public notice, opportunity to comment and public

1 access.

2 What bodies are covered under Bagley-Keene? Any multi-member

3 body created by statute. As such, the Financial Solvency Standards Board

4 meetings are subject to the requirements of the Bagley-Keene Open Meeting

5 Act.

6 What constitutes a meeting? "Any congregation of a majority of the

7 members of a state body at the same time and place to hear, discuss, or

8 deliberate upon any item that is within the subject matter jurisdiction of the state

9 body to which it pertains."

10 A quorum of members may not discuss any matter within the

11 board's subject matter jurisdiction through a series of meetings. For example, if

12 Board Member A talks to Board Member B and then Board Member B talks to

13 Board Member C.

14 A quorum of members many not discuss a matter within the

15 committee's -- I'm sorry -- the board's subject matter jurisdiction through

16 representatives. For example, Board Members A, B and C each talk to a third,

17 non-member party.

18 What a quorum may not do as a group it may not do through a

19 series of meetings or through representatives.

20 There are exceptions to the meeting rule. Separate

21 communications with a member of a legislative body, such as the legislature or a

22 committee, are permitted as long as there is no communication about another

23 board member's position.

24 Individual contacts between committee members and members of

25 the public are permitted.

1 Conferences that are open to the public and involve discussion of
2 issues of general interest to the public are permitted as long as there are no
3 private communications between a quorum of board members.
4 Social gatherings are also permitted, but again, there may not be
5 discussion of matters within the board's subject matter jurisdiction during these
6 gatherings.
7 Open meetings of standing committees and open meetings of other
8 state bodies or of local agencies are also permitted.
9 Meetings by teleconference are permissible.
10 The primary physical location must be designated in the meeting
11 notice, and members of the public must be permitted to attend and participate in
12 the meeting at the primary location.
13 All votes must be made roll call and all other Bagley-Keene
14 provisions apply to teleconference meetings.
15 Notice of upcoming meetings must be provided to people who
16 request it and post it on the agency website at least 10 calendar days before the
17 meeting.
18 The time and place of the meeting, as well as the name and contact
19 information of a person who can provide information must be included in the
20 notice.
21 The notice must also include a specific agenda with a brief 20 word
22 or less description of each item.
23 The agenda must include any closed session items and the
24 statutory basis for holding a closed session, if any.
25 And the notice and agenda must be made available in alternative

1 formats under the Americans with Disabilities Act.
2 Public access and participation:
3 The board may not impose conditions on public attendance at a
4 meeting.
5 Any sign-in sheet at meetings must be accompanied with a notice
6 that it is voluntary.
7 Members of the public may record and broadcast meetings unless
8 doing so would constitute a persistent disruption.
9 The public must have the opportunity to speak either before or
10 during consideration of each agenda item.
11 There may not be discrimination of attendance based on race,
12 national origin, et cetera; and entrance fees are not permitted.
13 Meeting facilities must be accessible to the disabled.
14 Access to records:
15 Any written materials provided to a majority of board are
16 disclosable public records.
17 These records must be made available in alternative formats to
18 disabled individuals who request them.
19 However, these records are subject to exemptions under the Public
20 Records Act. For example, attorney-client privileged documents are not public
21 records subject to disclosure.
22 And finally, remedies for violations:
23 Invalidation of any action taken by the board in violation of Bagley-
24 Keene.
25 Costs and attorneys' fees may be recovered from the body.

1 And there are misdemeanor penalties if a board member attends a
2 meeting with the intent to deprive the public of information he or she knows, or
3 should know, the public is entitled to.
4 I will now open the floor to questions, if any.
5 CHAIR DEGHETALDI: So let's start with the Board. Any
6 questions? Scott, thank you for that.
7 MEMBER WATANABE: Larry, maybe I will just add a little note
8 here. Some of you may be wondering why we went through this entire
9 presentation. Part of it is that we have two Board Members, but we also will
10 likely be looking at returning to in-person meetings for our next meeting in May,
11 so I think there's a couple of reminders and things that we will be considering as
12 we return to in-person meetings. Also, as we consider returning to conferences
13 and we all may be at a conference together. Part of this is just a reminder about
14 the importance of FSSB content being discussed in a public forum consistent
15 with the Bagley-Keene Act requirements.
16 One of the other issues that came up over the last two years as we
17 moved to virtual meetings is to be careful that we are not using either chat or
18 email or a text message during these meetings amongst the Board Members to
19 have conversations. That was a little tempting in the beginning and we had to
20 consult with our legal counsel to see if that was permitted and it is not, so that will
21 be part of our ongoing housekeeping reminders going forward.
22 But Scott, appreciate just the reminders of the importance of having
23 public discussions.
24 CHAIR DEGHETALDI: Ted.
25 MEMBER MAZER: Yes, thanks, Larry. I think I understand the

1 concept of individual members but much of what you presented talked about a
2 quorum cannot do certain things. Does it apply to two individuals that do not
3 make a quorum? Just to clarify.
4 MR. OSTERMILLER: It does not, it applies to a quorum of the
5 Board.
6 MEMBER MAZER: So A being an individual, B being an individual,
7 can talk to each other, but three people can't talk to two people, if I understand
8 correctly?
9 MR. OSTERMILLER: Correct, if it creates a quorum then it does
10 fall under Bagley-Keene.
11 MEMBER MAZER: Thank you. And last question is, hopefully this
12 never comes about, but is there indemnification for the Board Members if the
13 body gets attacked for having improper communications?
14 MR. OSTERMILLER: I might see if Sarah Ream happens to know
15 the answer to that?
16 CHAIR DEGHETALDI: Sarah's hand is up.
17 MS. REAM: Hi, this is Sarah. I am going to have to take that back.
18 I do not believe that there is indemnification under the Bagley-Keene Act. I do
19 believe it is a personal liability on that so it is important that you do not -- I would
20 not expect anybody would be violating the Bagley-Keene Act but it is important
21 that you not do that.
22 Also, I wanted to just -- to the question about one member talking to
23 another. It is important to -- I would recommend you avoid actually doing that
24 because what can happen is you can be considered to have had a serial
25 meeting. So, if Board Member A talks to Board Member B who then talks to

1 Board Members C and D, even though they are not all together talking at once in
2 a quorum you essentially have a meeting, you just have it in a serial fashion. So
3 best to just avoid, avoid talk. Talk about the weather and sports and all the other
4 things but just don't talk about Board business if you happen to run into each
5 other at the grocery store.
6 MEMBER MAZER: So thank you, I think. But also, if we just
7 simply want to put something up for discussion for an agenda item, that doesn't
8 constitute a violation if I were to contact, maybe I contact two people and say,
9 would you like to discuss this at a future meeting. That is not discussing an item
10 yet, correct?
11 MS. REAM: Again, I would avoid that as well. I don't, I know it
12 seems overly prescriptive but the Bagley-Keene is very -- it is meant to shine
13 complete sunlight on everything that the Board does. So, if you want to propose
14 an agenda item I suggest you send it in to Jordan, suggest that, and then he can
15 share that out with the group and talk more with you about that. But again, you
16 really do want to avoid any possibility of having a serial meeting. You could
17 actually inadvertently have a serial meeting because if one member, again, talks
18 to another member and then doesn't know that that second member goes and
19 talks to three other members, well, now you have got, you have a problem.
20 MEMBER MAZER: Okay, I'll put my handcuffs back on, thank you.
21 MS. REAM: Yes, that's exactly what I was going to say. It is, I
22 think a lot of people chafe under it because it is not the way we ordinarily do
23 business, you know, in the world, and it can work to be a little bit inefficient
24 sometimes, but it really is there to keep everything totally out in the open.
25 CHAIR DEGHETALDI: Any other Board questions or comments? I

1 think this was helpful.

2 And then, any comments from the public, Jordan?

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

4 CHAIR DEGHETALDI: Well, excellent. Okay.

5 Now it is, Lindy, I see you are ready to go with the DHCS update.

6 Good morning.

7 MS. HARRINGTON: Good morning to everyone. Yes, Lindy

8 Harrington, Deputy Director for Health Care Financing, representing the

9 Department of Health Care Services. I will do my standard caution that I am

10 providing the updates for the entire department, so when we get to questions

11 there may be some items that I will have to take back to my colleagues as I may

12 not know all of the in-and-out details of some of the items that I am presenting to

13 you today as it falls outside my purview.

14 So starting, if we can go to the next slide. We will do a budget

15 update. I think everyone is always really interested in what we have proposed.

16 So the Governor's budget does propose $138 billion in total funds

17 for the Department of Health Care Services.

18 And we are expanding health care access to all Californians as a

19 key focus of this administration. And to that end we have proposed expansion to

20 provide full-scope Medi-Cal to 700,000 undocumented adults ages 26 through

21 49, regardless of immigration status, beginning in 2024. And then with this

22 expansion full-scope Medi-Cal coverage will be available to all otherwise eligible

23 Californians regardless of immigration status.

24 We have new major budget issues and proposals that include

25 under our CalAIM initiatives capacity-building and implementation funding for

1 justice-involved initiatives; expanded funds to support Providing Access and
2 Transforming Health or our PATH initiatives, including Enhanced Care
3 Management and Community Supports; and continued work with stakeholders
4 on the Foster Care Model of Care effort.
5 We are also proposing to do certain Proposition 56 payments, to
6 transition those to ongoing General Fund support instead of being funded with
7 the declining revenue source. We have a proposal to do equity and practice
8 transformation payments as well as elimination of certain AB 97 payment
9 reductions.
10 We are proposing to reduce Medi-Cal premiums to zero for
11 programs under the Children's Health Insurance Program and the 250 percent
12 Working Disabled Program.
13 We have a proposal for telehealth changes to continue to allow
14 Medi-Cal covered benefits and services to be provided via telehealth across
15 delivery systems when that is clinically appropriate.
16 We have a placeholder funding for skilled nursing facility payment
17 reform and this would extend and reform the funding framework to move from a
18 primarily cost-based methodology to one that incentivizes value and quality.
19 We have included behavioral health bridge housing funding totaling
20 $1.5 billion General Fund to address the immediate housing and treatment needs
21 of people experiencing unsheltered homelessness with serious behavioral health
22 conditions.
23 As well as mobile crisis services funding totaling $108 million to add
24 qualifying 24 hours a day, 7 days a week, community-based mobile crisis
25 intervention services as soon as January 1, 2023, as a mandatory, Medi-Cal

1 benefit to eligible beneficiaries statewide.

2 And again, this was just kind of a brief highlight of our budget but

3 did provide some additional information on resources where you can find more

4 information about the DHCS budget, including our highlights document, the

5 Governor's proposed budget and our Medi-Cal estimate if anyone is ever bored

6 and wants to read the over 1,000 pages of detailed information about how we are

7 proposing to spend funding in the Medi-Cal program.

8 The next topic that we wanted to give you an update on was the

9 managed care procurement.

10 On February 9th we released the Medi-Cal managed care plan

11 Request for Proposal.

12 On February 15th we hosted a webinar for members, advocates,

13 providers, health plans and other stakeholders to share how DHCS will leverage

14 the managed care plan RFP and managed care contracts to further DHCS' goals

15 to enhance how care is delivered to Medi-Cal members.

16 And then tomorrow we are hosting a pre-proposal web conference.

17 Details were included in the RFP as well as they are available on the DHCS

18 website.

19 And then information for proposers regarding the RFP is also

20 posted on the DHCS website.

21 And really as we look at the procurement and the updated contract

22 we are really looking at redefining how care is delivered to more than 12 million

23 Californians through the commercial RFP and the restructured and more robust

24 managed care contract.

25 So these efforts will enable DHCS to hold all plan partners and their

1 subcontractors more accountable for high quality, accessible, and
2 comprehensive care across all settings and levels of care; reducing health
3 disparities; and improving health outcomes.
4 Members can expect to receive more holistic health care that takes
5 into account social drivers of health, cultural and linguistic differences, and
6 physical and behavioral needs throughout their life span.
7 And so for the managed care procurement process and timeline.
8 So again, the RFP was released on the 9th. We have the voluntary pre-proposal
9 web conference tomorrow. Proposals are due on April 4th at 4:00 p.m. We
10 anticipate putting out the Notice of Intent of Award in August of 2022. And then
11 the Managed Care Plan Operational Readiness will take, will happen during mid-
12 2022 through late 2023. With an implementation of the new contracts January of
13 2024.
14 Moving into the next big thing. DHCS is very excited that we were
15 able to gain approval of our CalAIM Section 1115 waiver as well as our 1915(b)
16 waivers.
17 We do have a lot of resources out on our website as well as
18 through Twitter and Facebook if anyone is interested in staying up to date on
19 what is happening with CalAIM. I wanted to be sure we provided those
20 resources to you all today.
21 So on the approved CalAIM waivers. So we did receive formal
22 approval in December and that authorized both our CalAIM 1115 as well as our
23 1915(b) waivers through December 31st of 2026. We also provided resource
24 links to where you can see those approved, those approved waivers. And one of
25 the things that it is always important to be sure that we are discussing as we talk

1 about this is, you know, the 1115 waiver is more than just one thing. So you will
2 see those waiver approvals as well as state plan amendments. So we have
3 multiple authorities that are coming together to authorize CalAIM.
4 As we look at the approved CalAIM initiatives, so we are aligning
5 our delivery systems, Enhanced Care Management was approved. All 14 of our
6 proposed community supports were approved. We received approval of our
7 PATH proposal with the caveat that there is still a portion of PATH associated
8 with our justice-involved that is still pending formal approval. Contingency
9 management in our Drug Medi-Cal Organized Delivery System Counties.
10 Approval of peer support specialists. Aligned enrollment for our dual eligibles. A
11 continuation of our global payment program for a select group of our designated
12 public hospitals. Our community-based adult services continues to be approved.
13 DMC-ODS services for short-term residents of IMDs. Chiropractic services for
14 Indian Health Service and tribal facilities. Coverage for low-income pregnant
15 individuals and out-of-state former foster care youth. As well as preventive
16 dental benefits and pay-for-performance initiatives for our dental providers.
17 So as you can see, there was a lot going on throughout the end of
18 last year to work with CMS to gain all of these approvals. And as I mentioned,
19 there's really multiple federal authorities to support that CalAIM vision. So we
20 have our Medi-Cal state plan, we have our Section 1115 waiver, our Section
21 1915(b) waiver as well as the managed care contract. And additional details for
22 certain CalAIM initiatives will come from our guidance. For example, our All Plan
23 Letters that we issue.
24 So really as we look at kind of the delivery system changes that
25 come under CalAIM. So first and foremost, all four delivery systems are now

1 authorized via a single Section 1915(b) waiver. And this, you know, was done to
2 standardize and streamline what we were doing. So it standardized enrollment,
3 benefits and payment in managed care delivery systems by eliminating variation
4 in managed care enrollment and benefits based a Medi-Cal enrollee's eligibility
5 category or their county of residence. So where they live to determine to what
6 benefits they received under managed care.
7 It allows us to provide services available in the managed care
8 benefit package statewide such as major organ transplants and institutional long-
9 term care services.
10 We streamlined our specialty mental health services and DMC-
11 ODS policies and access by we are implementing payment reform for specialty
12 mental health services and drug Medi-Cal.
13 We are transitioning to a new coding system that will allow for more
14 granular claiming and reporting of services provided and allow for enhanced
15 monitoring of plan performance.
16 And as we think about that oversight and accountability, we will be
17 implementing robust monitoring and oversight focused on access to and
18 availability of services, quality of care, and financial accountability within and
19 across our managed care delivery systems.
20 So we are looking to improve the consumer experience by
21 continuing to meet quarterly with advocates and stakeholders; We will be
22 establishing a Member Advisory Committee; and conducting annual consumer
23 satisfaction surveys across all four delivery systems, starting in 2023.
24 And we will be submitting a work plan detailing the approach to
25 strengthen monitoring and oversight of plans to improve member access to care

1 for Medi-Cal managed care, dental managed care, specialty mental health
2 services, and drug Medi-Cal organized delivery systems by June 29 of 2022.
3 Continuing that discussion of oversight and accountability.
4 We will be supporting independent assessments on access to care
5 for those delivery systems, including an independent assessment comparing the
6 Medi-Cal managed care networks with those in Medicare Advantage and private
7 California commercial plans.
8 And we will collect and report on data to create a comprehensive
9 and transparent view of access to care, provider network capacity, appeals and
10 grievances, quality, and consumer experience.
11 And also consistent with CMS-imposed requirements in the 1915(b)
12 special terms and conditions: We will be ensuring full and partially delegated
13 plans and other subcontractors that assume delegated risk meet the standards
14 outlined for Medi-Cal managed care plans.
15 We will be strengthening the medical loss ratio oversight: So for
16 our current practice, all Medi-Cal managed care prime plans and dental managed
17 care plans report MLR and the dental managed care plans provide remittance if
18 they do not meet the minimum MLR.
19 By July of 2022 we will develop a plan with stakeholders outlining
20 key deliverables and timelines to meet the new MLR requirements.
21 And so we will be strengthening that MLR oversight by the rating
22 period beginning in January of 2023. All Medi-Cal managed care fully and
23 partially delegated plans and subcontractors will be required to report their MLR.
24 And by the rating period beginning in January 2024 all Medi-Cal
25 managed care prime plans will provide a remittance if they do not meet that

1 minimum MLR. As a reminder, that was already in statute and scheduled to go
2 live so that is not new.
3 What is new is that beginning with rating periods for January 2025,
4 all Medi-Cal managed care fully and partially delegated plans as well as
5 subcontractors will be required to provide a remittance if they do not meet the
6 minimum MLR.
7 And then the final requirement under the STCs is that we will in
8 2028 conduct a five-year retrospective audit of the five year period for those MLR
9 components.
10 As we look at the big components approved under CalAIM that
11 most directly impact managed care plans we look at enhanced care management
12 and this is really leveraging our managed care authority. We began
13 implementing ECM for populations with complex health and social needs via our
14 Medi-Cal managed care contract in January of 2022 and we will continue to
15 phase that in through 2023.
16 It is a new, statewide Medi-Cal benefit providing intensive care
17 management to address both clinical and non-clinical needs of Medi-Cal's
18 highest need beneficiaries, primarily through in-person engagement where
19 enrollees live, seek care and choose to access services.
20 It builds off the successful community-based care management
21 programs that we piloted in the Medi-Cal 2020 waiver Whole Person Care pilots
22 as well as the Health Homes Program.
23 And in addition to enhance care management, beneficiaries may
24 have connections to community supports to address social drivers of health to
25 the extent their plan elects to provide those.

1 And we have more information and the full populations of focus can
2 be located on the enhanced care management web page as well as in the fact
3 sheet that we have developed.
4 And as we move on, so talking about community supports. We
5 received federal approval to provide 14 state-proposed community supports
6 beginning in January of 2022.
7 It's 14 new services proposed by DHCS and approved by CMS
8 designed to address the social drivers of health and advance health equity.
9 The benefits will be offered by a local community provider as a
10 medically appropriate, cost-effective alternative to traditional medical services or
11 settings.
12 Medi-Cal managed care plans are encouraged to offer as many of
13 the community supports as possible, which are voluntary for Medi-Cal managed
14 care plans to offer and for members to use.
15 And again, provided resources where more information can be, can
16 be accessed, including the managed care plans that have opted to provide and
17 when for each of the community supports.
18 The next area where we received approval was for our PATH
19 supports.
20 And PATH provides kind of a flexible source of new funding that is
21 intended to maintain, build and scale the capacity necessary to ensure
22 successful implementation of CalAIM.
23 Ensure a smooth transition from the Whole Person Care Pilot
24 Program as ECM and community support services are scaled up and
25 implemented statewide.

1 Support a diverse array of stakeholders participating in CalAIM,
2 including community-based organizations, counties, tribal organizations,
3 providers, and justice-involved stakeholders as they prepare for implementation
4 of CalAIM.
5 And finally, to advance health equity by investing in providers,
6 counties, community-based organizations and other entities that support
7 historically underserved and under-resourced populations.
8 And finally, effect for our dual eligibles:
9 Effective January of 2022 it will provide a more integrated
10 experience for dual eligibles by permitting Medicare plan choice to drive Medi-Cal
11 plan choice.
12 In certain counties a member's Medi-Cal plan choice will align with
13 their Medi-Cal Advantage or dual Special Needs Plan to the extent the Medicare
14 plan has an affiliated Medi-Cal plan.
15 And then effective January of 2023 we will transition the Cal
16 MediConnect demonstration to a D-SNP exclusively aligned enrollment model,
17 with plans that coordinate all Medicare and Medi-Cal benefits for dual eligibles.
18 And in future years we will expand the D-SNP exclusively aligned
19 enrollment model to additional counties.
20 The federal authority is subject to improved care coordination
21 across Medicare and Medi-Cal, integrated appeals and grievances, and
22 integrated member materials for D-SNPs.
23 And with that, I have thrown a lot of information at all of you but
24 happy to take questions.
25 CHAIR DEGHETALDI: Lindy, as usual, the pace of change is

1 startling the Department is looking at and this is fascinating. Let me turn it over
2 starting with Dr. Mazer; I'm sure we all have questions. Thank you so much.
3 MEMBER MAZER: I have a few, thanks. Thanks for your
4 presentation, Lindy, it's a mouthful.
5 The AB 97 reduction reversals, you said some. Just if you could
6 give us a quick overview of which ones are being reversed. That's one question.
7 One comment on the telehealth issue. Some of the concerns that
8 we are hearing is that I think by January of '24 there is a mandate in this proposal
9 that if you provide audio services you have to provide audio/video services. And
10 there are providers who, particularly in the rural areas, feel that that's an
11 imposition on them, both cost and just basically technology in their areas. So
12 maybe you can address those.
13 And a comment is, with all of these changes coming on, I just want
14 to highlight that there have been real issues with the transition to the Medi-Cal Rx
15 program with delays in services, delays in access, physicians receiving additional
16 phone calls from patients and pharmacies trying to deal with a system that was
17 not ready for prime time. I know the DHCS has taken some action on that, I am
18 not sure it is complete enough, but I am concerned that the same might happen
19 in all of these other implementations and that should be a lesson before moving
20 forward full force. Thank you.
21 MS. HARRINGTON: Appreciate the comments and I will take that,
22 take those back. I can -- Medi-Cal Rx, again, doesn't fall under my area but I can
23 tell you that the prior authorization backlog was cleared by end of day Friday,
24 February 11th and they have remained compliant with a 24 hour turnaround time
25 since that, since that time. So while we, you know, acknowledge there was some

1 challenge there we are back to that 24 hour turnaround time so hopefully folks
2 are seeing that improvement.
3 On the AB 97 I am bringing up the list. Give me one moment, my
4 computer is stalling on me and I don't have them completely memorized,
5 shocking, I know.
6 MEMBER MAZER: If not a list at least the categories that are
7 being reversed.
8 MS. HARRINGTON: Yes. There's about, there are several of
9 them. It is, so nurses of all types, durable medical equipment for oxygen and
10 respiratory services and respiratory care providers, audiologists and hearing aid
11 dispensers, chronic dialysis clinics, alternative birthing centers, as well as
12 emergency air transportation and non-emergency medical transportation. And
13 again, more information on all of those can be found in those budget resources
14 we provided.
15 MEMBER MAZER: Okay. But in that list, none of these are
16 reversals of the 1-in-10% cuts to physician services, correct?
17 MS. HARRINGTON: That is correct, physicians are not included.
18 MEMBER MAZER: Okay. And then the last one is the telehealth
19 and then I'll shut up.
20 MS. HARRINGTON: So on the telehealth I will have to take that
21 back, that feedback. As I understand it, we do include a requirement that in the
22 future, again, providing kind of some time for that to come up, but that folks want
23 to be ensured that we are offering full access.
24 CHAIR DEGHETALDI: Thanks, Ted. Abbi, you are up next.
25 MEMBER COURSOLLE: Thank you. I did want to thank Dr. Mazer

1 and echo his comments about the Medi-Cal Rx transition and I appreciate, Lindy,
2 your response. I understand that the wait time on the customer service line is
3 still approaching one hour so I think that is something that we remain concerned
4 about so just a comment on that.
5 I did have one specific question under the CalAIM, excuse me,
6 under the RFP. You talked a little bit about more monitoring and oversight for
7 plans that use delegated models and I was just wondering if there is, if you can
8 say a little bit more about what that will look like and who will be performing the
9 monitoring? Will DHCS be doing more monitoring itself or will it be leaning on
10 the plans to be monitoring their subcontractors or some combination? Thank
11 you.
12 MS. HARRINGTON: Sure. So there is -- Some requirements that
13 are coming in under the, our standard terms and conditions with our 1915(b).
14 And so the plan associated with that is due in June so we are actively working
15 through that so more information to come there. And I do anticipate that it will be
16 a combination of DHCS oversight as well as DHCS oversight over the plans
17 requiring additional oversight of their subdelegates and subcontractors.
18 CHAIR DEGHETALDI: Great. Paul.
19 MEMBER DURR: Lindy, fabulous overview as usual. I really learn
20 a lot when you do your presentation so thank you. A couple of comments that I
21 had.
22 One is that, you know, on the expansion for the Medi-Cal program
23 for the undocumented, what struck me is, has there ever been a thought about
24 doing an ROI analysis on the value of that expansion versus what it is already
25 costing the health system today to manage those patients when they come into

1 the EDs and things like that? As a public awareness campaign to say that, hey,
2 we are going to expand, it is going to cost us this amount of money; but on the
3 other hand, hospitals and health systems will be saving X dollars because they
4 are treating those patients when they come to the ED they have no choice. So
5 just a comment on that.
6 My other two things were around you mentioned about the SNF
7 transition to quality-based metrics, which I applaud. I applaud all quality metrics
8 and Jeff does a great job of leading us in that whole space. But making sure that
9 we are in alignment if there are existing quality metrics that SNF providers have
10 to abide by in any other forum. I am not aware of any but just making sure that
11 the metrics that we develop are in alignment with what they may already be
12 asked to provide.
13 And my last one was, this is a lot of work that we have to do. I
14 mean, the CalAIM is really wonderful and all of the waivers that we got on the
15 1115. How do we do all that work? Because it seems like there's a lot that ties
16 into what Ted was talking about is the Rx program. You know, it is great to have
17 all these opportunities for us to expand all these things but is the system at
18 DHCS ready for that, are the providers ready for that, are the managed care
19 plans ready for that? Just, you know, just the pace of change is my concern
20 overall. Thank you.
21 MS. HARRINGTON: I got it all down and will, and we will take, take
22 back those comments.
23 CHAIR DEGHETALDI: Scott or Jeff, any questions or concerns?
24 MEMBER RIDEOUT: I just had a general question. I think it was
25 on slide 39, Lindy, and thank you for the update, related to doing benchmarking

1 for Medi-Cal plans versus commercial and MA. If you could maybe detail that a
2 little bit more in terms of source of information. I am assuming that would come
3 through the HPD?
4 MS. HARRINGTON: Jeff, I am going to have to apologize and say
5 I will take that back. That actually falls under our health care delivery systems,
6 who is leading the charge on that. But I do believe that will be part of the
7 operational plan that they are developing for that submission in June of 2022.
8 CHAIR DEGHETALDI: And Scott?
9 MEMBER COFFIN: Yes. I don't have any questions at this point.
10 Thank you, Lindy, for the presentation.
11 CHAIR DEGHETALDI: So, Lindy, I have, I have a couple and they
12 both relate to health equity. In my 40 years in medicine, I have never seen as
13 much excitement as, you know, the COVID has clearly made visible health care
14 disparities and I see us moving forward. I just hope that the Department
15 understands a couple of things as we make visible the social determinants, the
16 clinical differences, you know, among populations, the homeless and non-
17 homeless, rural/urban. And I just hope that --
18 I have two concerns. First of all, we have a standard way of
19 defining at-risk populations so that we don't have multiple organizations defining
20 what a Latino patient is versus an Asian patient. And also that we are mindful of
21 the fact, and this affects financial solvency, that those organizations, those plans,
22 those risk bearing organizations that disproportionately care for the most socially
23 determinant burden populations receive adequate payment. And so I don't know
24 how we plan to risk adjust as we identify at-risk populations but that is a large
25 concern.

1 And the other, and I have a very simple way to follow-up on Jeff's
2 question about transparency across the different plan types. Those of us who
3 take care of patients look to the IHA P90 for clinical outcome. Whether that is
4 cervical cancer screening or breast cancer, we use the P90 as the reason we
5 work over the course of a year, to achieve the 90th percentile for a patient's
6 clinical outcome. I would like a P90 to be the same for every Californian, no
7 matter who. And this is just a very simple request, I have been saying it for a
8 long time. The P90 should be the same, no matter who pays for your health care
9 and no matter what your social determinants are. So that is just, as we do this
10 important work of cross-mapping between commercial and Medi-Cal population,
11 make the goals the same for outcomes and quality. So that is just an ask. Kind
12 of a big ask but nevertheless important.
13 Any other questions from the Board?
14 MEMBER WATANABE: Larry, this is Mary. I will maybe just jump
15 in there. I can't believe I forgot to mention in my remarks that we will be
16 convening our Health Equity and Quality Committee tomorrow to discuss many of
17 these issues that you just raised. And we are really excited to have a
18 representative from DHCS, Covered California, CalPERS, HCAI, I am probably
19 missing someone in there. But I think these are the types of issues we will be
20 talking about in that and really wanting to make sure that we are aligning with the
21 great work that DHCS is doing.
22 I will just acknowledge that DHCS has a tremendous amount of
23 work on their plate and I am sure at our future FSSB meetings we will continue to
24 have presentations and discussions to try to be responsive to the questions that
25 came up today but also just all of the great work that they are doing and how that

1 aligns with the work we are doing here on the Board. So thank you, Lindy.

2 CHAIR DEGHETALDI: Okay. Paul, I see your hand up.

3 MEMBER DURR: Larry, sorry. One more question, Lindy, is you

4 mentioned that these are all the things that got approved with the 1115 waiver.

5 Does everything get approved or does the federal government say no on some

6 things? More of an education moment for me.

7 MS. HARRINGTON: So when we are looking at our 1115, I mean,

8 they do have the ability to say, no. We have been pretty successful. This time

9 there are two components that are still pending CMS approval and we are

10 actively engaged with CMS and those were both things that were scheduled to

11 start later in, or were already proposed to start later, so we are continuing that

12 work with CMS. That is for our pre-release, in-reach services for our justice-

13 involved populations, having a subset of services that we are able to provide

14 prior to release to help with that reentry back into the system. And then services

15 associated with traditional healers for our Alaska Native and American Indian

16 populations. So those are two components that are continuing our discussion

17 with CMS as well as some financing mechanisms around designated state health

18 programs and being able to draw down additional funding, that is still pending

19 with CMS. And then as I mentioned, on our PATH components that were

20 approved there is a subset of those dollars that we had asked for that is

21 specifically associated with those justice-involved, so that pre-release and

22 reentry services. That is pending approval of that broader package.

23 CHAIR DEGHETALDI: Okay, Jordan, any questions or comments

24 from members of the public?

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

1 CHAIR DEGHETALDI: Lindy, fabulous and right on time. Thank
2 you so much.
3 MS. HARRINGTON: Thank you, everyone. Have a great rest of
4 your meeting.
5 CHAIR DEGHETALDI: Okay, now we turn to Sarah.
6 MS. REAM: Yes, good morning, hello, again. I am going to be
7 providing an update on our regulations and then also an update on some
8 happenings at the federal level and how those impact California law. So getting
9 right into these regulations.
10 So I am absolutely thrilled to report that we have had two
11 regulations recently approved by the Office of Administrative Law, or OAL, I
12 sometimes will shorten that to OAL.
13 First, on January 12th OAL approved our timely access/network
14 reporting regulation. This regulation specifies and includes requirements about
15 how plans must collect and report data regarding timely access to care and
16 provider networks. This reg, as I think you are probably aware, has been a long
17 time coming so we are absolutely thrilled and I want to thank my team here at the
18 DMHC for getting this one over the finish line.
19 The regulation will take effect on April 1st of this year, so just in
20 several weeks.
21 Additionally, on January 25th OAL approved our permanent
22 regulation regarding the transfer of enrollees per a public health order. This
23 regulation really only kicks in if we have a public health order requiring hospitals
24 to accept any patient via transfer, largely because of COVID impacts.
25 We initially adopted the regulation on an emergency basis in early

1 last year, it took effect on January 15th of 2021. The permanent regulation takes
2 effect January 26th, or took effect January 26th of this year. And I am hoping
3 that we never actually have to use this regulation, fingers crossed on that one.
4 We have -- in addition to the regulations that were recently
5 approved we have two regulations in formal rulemaking. The first is our
6 regulation regarding a summary of dental benefits and coverage disclosure
7 matrix. This regulation requires the dental plans to give enrollees and potential
8 enrollees a standard matrix so the enrollees have an idea of what benefits they
9 will be purchasing if they decide to buy coverage through that dental plan.
10 We initially adopted this regulation on an emergency basis as
11 directed in the authorizing statute and that emergency regulation took effect on
12 January 25th of last year and it is actually still in effect.
13 So the permanent regulation is substantially the same as the
14 emergency regulation. We have held two comment periods, the most recent
15 closed in December. Based on those comments that we received we made a
16 few, a few tweaks to the reg but in large part the final reg will be the same as the
17 one that was adopted on an emergency basis.
18 So in the next several weeks we will be submitting the dental matrix
19 regulation to the Office of Administrative Law for, hopefully for final approval.
20 The second regulation, we have in formal rulemaking concerns
21 requirements regarding health plan financial reporting to the DMHC. So we have
22 had two comment periods on this reg; the most recent comment period closed
23 about two weeks ago. And we are finalizing that regulation package and we will
24 be submitting it to the Office of Administrative Law in March for their final
25 approval as well.

1 So we have a lot of regulations in development. I am going to talk
2 about some of them here. I would be talking at you all morning if I talked about
3 all of them but I am going to hit the highlights here.
4 So first we have a regulation to implement SB 855, which concerns
5 mental health and substance use disorder coverage. This was a Senator Wiener
6 bill that was enacted in 2020. So among other requirements in this bill, when a
7 plan is conducting utilization management review the plan must follow criteria
8 and guidelines developed by the nonprofit association for the relevant clinical
9 specialty.
10 We drafted, we shared a draft of the regulation with stakeholders in
11 December and received some excellent feedback. We have made some edits to
12 the draft based on that feedback and we will be sharing the draft again shortly
13 with stakeholders and then we plan to start formal rulemaking in April on this
14 regulation. And obviously, during formal rulemaking stakeholders have yet
15 another opportunity to comment, just it is a more formalized process at that point.
16 We are also working on a regulation to implement Senate Bill 600
17 from 2019, which concerns iatrogenic fertility preservation. So this bill requires
18 plans to cover fertility preservation treatments when a covered health care
19 treatment the enrollee is receiving or is going to receive may directly or indirectly
20 cause infertility. We shared a draft of this regulation with stakeholders and plan
21 to start formal rulemaking in late March or early April.
22 Next we have regulation in the works regarding provider directories.
23 This regulation will put into a formal regulation many of the processes and
24 requirements the DMHC has required of plans for several years through
25 guidance. We plan to share a draft of this regulation with stakeholders by the

1 end of March and will go into formal rulemaking hopefully by May.

2 We also have a grievance and appeals regulation package. This

3 one will, we refer to this sort of colloquially as the Help Center reg. It revises

4 existing regulations concerning the IMR complaint processes here at the DMHC.

5 Primarily to bring those regulations into alignment with current practices, our

6 current practices. We are on track to share a draft of that regulation informally

7 with stakeholders by April and then we plan to start formal rulemaking this, later

8 this summer.

9 Rate review. So we have a number of reg packages in the works

10 regarding rate review. First, we have the large group rate review, which will

11 implement AB 731 from 2019 and SB 546 from way back in 2015. We shared a

12 draft with stakeholders some time ago and received some very helpful feedback

13 and then we plan to start formal rulemaking on this regulation by the second

14 quarter of this year.

15 Next we have individual and small group aggregate rate reporting.

16 So in 2020 the legislature passed AB 2118, which requires full service plans to

17 report annually information regarding premiums, cost-sharing, benefits,

18 enrollment and trend factors for their individual and small group market products.

19 AB 2118 includes a waiver that allows the DMHC to issue guidance through

20 2023. Technically it is a waiver from the Administrative Procedure Act

21 requirements to promulgate regulations.

22 So based on that waiver last summer we issued an All Plan Letter

23 that outlines information the plans must include in their annual aggregate rate

24 filings for their small and individual products. The filings were due October 1st of

25 last year. So now we are in the process of reviewing those filings and drafting

1 the regulation based on issues we have identified through those filings. The
2 waiver thankfully gives us some time to tweak our guidance so we can ensure
3 that we are getting meaningful and accurate data. We anticipate starting the
4 rulemaking process for this reg either in the later part of this year or early next
5 year.
6 Finally, regarding regs that we currently have in process in the
7 hopper. We have our general licensure regulation or also, we also refer to that
8 as our risk reg. So back in 2019, you may recall, the DMHC promulgated a
9 regulation defining various terms, including professional risk, global risk,
10 institutional risk. The regulation also requires that any entity that accepts any
11 amount of global risk has to either obtain a license of the health plan or receive
12 an exemption from the DMHC from licensure.
13 So we rolled out the reg and then we learned all the things that we
14 didn't know when we were doing the regulation itself and because of that we
15 instituted a phase-in period for entities to obtain an exemption or a license. That
16 phase-in period was initially to extend into July of 2020. Due to COVID and other
17 factors, obviously, we extended that phase-in period until we promulgate an
18 updated regulation. So currently, if an entity accepts some amount of global risk
19 but doesn't believe it needs a full license as a health plan we have an expedited
20 exemption request process that those entities can take, can take advantage of.
21 We are taking what we have learned during the phase-in process to
22 refine the filing requirements and to refine when an exemption would be
23 appropriate. Our revisions to the regulation will specify what types and level of
24 risk qualify an entity for receiving an exemption on an expedited basis, versus
25 what types and levels of risk may require a more thorough review or an

1 exemption request or even may require licensure as a health plan. So we are
2 planning to share a draft of this regulation by mid-March to early April and to start
3 the formal rulemaking process this spring.
4 And then finally, because we just don't have quite enough
5 regulations, I am being completely facetious, we have new legislation that will
6 require, likely require new regulations as well. So these bills, in no particular
7 order and this is not a completely comprehensive list, but some of these bills are
8 Assembly Bill 342, which regards colorectal cancer screening exams; Assembly
9 Bill 457, which concerns enrollees' access to telehealth services; and Senate Bill
10 255, which allows small employers in certain associations or multiple employer
11 welfare arrangements, also referred to as MEWAs, to purchase large group
12 coverage through the, through the association or MEWA. So we are still
13 analyzing these bills and another number of others that have passed last year
14 and I am sure I will have more to update you on at our next FSSB meeting as we
15 work through, work through those bills and decide what we need to do
16 regulations regarding. And with that, I will take your questions.
17 CHAIR DEGHETALDI: Board questions? Thank you, Sarah. Paul.
18 MEMBER DURR: Yes. Sarah, I just want to acknowledge and
19 compliment you for your openness of hearing feedback from us on the provider
20 side. Your warm embrace of hearing that is very welcomed by us and I think it
21 shows in the partnership that we can develop regs that meet the spirit of the law
22 and then help understand how we implement them on the provider side. And in
23 particular it certainly, to me, came to light with the whole risk regulation
24 requirements that you learned a lot, as the Department learned a lot, better
25 understanding how the provider side was. But it took that extra effort to say, no,

1 we want to listen more, and I want to compliment you and Mary and the
2 Department for taking that position, so thank you.
3 MS. REAM: Thank you for that, I appreciate it. And we really do
4 appreciate the feedback. We may not, we may not always agree with all the
5 feedback we get but we really do appreciate, we truly appreciate -- and I think
6 this goes -- and this is part of Mary's excellent leadership that she is, you know,
7 very much realizes that we are stronger and better when we get feedback from
8 the folks to whom this really, really applies so thank you for that.
9 CHAIR DEGHETALDI: Other questions or comments from the
10 Board?
11 CHAIR DEGHETALDI: Can we go to the public, Jordan.
12 MR. STOUT: There are none at this time.
13 CHAIR DEGHETALDI: Good job, Sarah. You get another topic,
14 though.
15 MS. REAM: I do, I do. All right, turning to federal updates. There
16 has been a lot of action at the federal level, as I am sure you know. So first I am
17 going to talk about coverage, health plan coverage of COVID-19 over-the-
18 counter tests. So per guidance that was issued by the federal Departments of
19 Labor, Health and Human Services and the Treasury in early January, beginning
20 January 15th of this year, all commercial health plans must cover at least 8 at-
21 home COVID tests per month, per enrollee, through the end of the federally
22 declared public health emergency. And plans must cover these tests without
23 cost-sharing; so even if an enrollee hasn't met their deductible they get the test at
24 no, no cost to them.
25 So plans can cover these tests in a number of ways. There is the

1 direct coverage model versus the reimbursement model. And this is, these are,
2 this is a system that was set up by the feds.
3 So first on the direct coverage model. This is really I think what we
4 think of in California as the delegated model. So the plan must contract with
5 retailers, with a sufficient number of retailers, to provide tests to the plan's
6 enrollees at no up-front cost to the enrollees. So the enrollee simply walks into
7 the drugstore or orders the tests online and gets the test and doesn't have to
8 reach into his or her pocket and pay anything. Now enrollees under the direct
9 coverage model can also buy tests from retailers that don't contract with the plan
10 and then seek reimbursement from their plan. But in that case the plan's
11 reimbursement amount, the plan can limit that amount to $12 per test. So it is
12 not, it is not an unlimited amount for which the enrollee can seek reimbursement.
13 The other model is what is called the reimbursement model. Under
14 this model, the plan doesn't contract with retailers or it contracts with an
15 insufficient number of retailers to provide over-the-counter COVID tests to
16 enrollees. So under this model instead enrollees go to any retailer and purchase
17 their tests and then they submit their receipts or their box tops or whatever the
18 plan requires to the plan. The difference though with the reimbursement model
19 versus direct coverage is that under reimbursement the plan's amount it has to
20 reimburse the enrollee is not capped at $12. So instead the plan must reimburse
21 the enrollee in whatever amount the enrollee actually paid for the test, whether it
22 is $9, $12, $500, the plan has to cover the full amount of out-of-pocket that the
23 enrollee paid.
24 So the federal government, they have been very transparent in why
25 they have set this up the way they did. Their hope is to incentivize plans to

1 contract with a sufficient number of retailers so that enrollees can go and get the
2 test without paying anything out-of-pocket, so that is why the feds have done this
3 direct coverage versus the reimbursement model.
4 So turning to California law, I have SB 510 here on our slide. SB
5 510, which was enacted last year, requires, reiterates the plans have to cover
6 COVID-19 testing and had some other requirements. The DMHC, though, has
7 interpreted SB 510 to require plans to cover at-home COVID tests. So we will be
8 issuing an All Plan Letter shortly to clarify these requirements. We shared a draft
9 of that All Plan Letter in mid-December with stakeholders and received some
10 very good feedback. Essentially, what we are going to be saying is that SB 510
11 requires plans to cover 9 at-home COVID tests similar to what the federal law
12 does. It is not additive, however. So you don't take the federal law plus SB 510
13 and equal 16 tests per month, per enrollee; rather, it is eight tests per month per
14 enrollee. So we are hoping to issue that final APL later on in, later on in March.
15 Turning to the next big, big thing going on at the federal level is the
16 No Surprises Act. So this Act took effect January 1st and there's obviously a lot
17 of overlap between the No Surprises Act or the NSA and California law. So both
18 protect, and I am happy to say actually, much of the NSA largely mirrors
19 California law so I think that is a feather in, a feather in California's cap that we
20 are sort of the model for the, for the nation.
21 So what both laws do is they protect enrollees from balance billing
22 in emergency and non-emergency situations. They include consumer notice and
23 consent requirements and each have provider directory requirements. And both
24 state and federal law have dispute resolution processes available for providers to
25 dispute the amount that they are reimbursed in a non-contracted setting.

1 The NSA recognizes that some states like California already have
2 robust balance billing protections, and in those instances the NSA deems that the
3 state law can control. So we have had a number of conversations with CMS
4 about when California law will control and when the federal law will control.
5 And we are going to be issuing an APL, an All Plan Letter,
6 providing more detail; and we already shared a draft of that All Plan Letter and
7 had some very good feedback. But here is a high level breakdown of what that
8 All Plan Letter says. So in non-emergency situations where an enrollee receives
9 care in an in-network facility but from an out-of-network provider, California law
10 will control. And this is a situation that is governed by AB 72, which was enacted
11 back in 2016. So an example is if an enrollee has surgery in an in-network
12 hospital, but the anesthesiologist doesn't contract with the enrollee's plan, per AB
13 72 the anesthesiologist cannot balance bill the enrollee. Rather, AB 72 requires
14 the plan to pay the higher of the average contracted rate or 125% of Medicare. If
15 the anesthesiologist is dissatisfied with that amount, thinks that they should be
16 reimbursed more, DMHC has a process by which those claims can be submitted
17 to independent dispute resolution.
18 So for emergency services, we and CMS have also determined that
19 California law controls. So for years emergency providers in California have
20 been prohibited from balance billing enrollees. And that prohibition was found in
21 some Supreme Court case law and in DMHC regulation. We initially had thought
22 that CMS' position was that the No Surprises Act trumped the California law and
23 regulations, in which case the No Surprises Act would have controlled for
24 balance billing in emergency situations. This would not have necessarily
25 impacted enrollees. In either instance enrollees would have been protected from

1 balance billing, but it would have impacted how the plans calculate
2 reimbursement for non-contracted emergency services. However, we had
3 several conversations with CMS and now understand their position is that
4 California law does continue to control for emergency services so plans will
5 continue to calculate reimbursement for non-contracted emergency services like
6 they have been doing for years. And as I mentioned, we are finalizing an All Plan
7 Letter on this that goes into much greater detail on the No Surprises Act and how
8 it interacts with California law and we should be issuing that final letter in the next
9 several weeks. So with that, I am happy to take your questions.
10 CHAIR DEGHETALDI: Ted.
11 MEMBER MAZER: I am back. Two questions, one on the COVID
12 issue and the other one on the dispute resolution.
13 So on COVID, what notices are being required by both DMHC-
14 covered, and if you know, by the DOI-covered plans to go out to their enrollees to
15 let them know who is the contracted entity? Is there any such requirement? I
16 have a PPO that I have not had any word from. So that is on the COVID testing.
17 And the other one is I am glad to hear that the feds are agreeing
18 that California preempts the federal rules on the dispute resolution and the
19 payment. However, whose rules will apply when you go to dispute resolution,
20 California's or the not very favorable federal rules that are being fought now?
21 MS. REAM: Thank you for those questions. So regarding the
22 notices that plans need to give to their enrollees, the federal guidance does not
23 specifically require any specified notice to enrollees. SB 510 doesn't either.
24 However, we have asked plans to tell us in a filing, how are the plans complying?
25 What are they doing to comply? And we are reviewing those to make sure that

1 the plans do alert their members. So again, it is not, it is not overly prescriptive
2 or directive but the anticipation is that the plans are alerting their members.
3 I think the good news is that even if a plan does have contracted
4 providers, if an enrollee -- like I said, if an enrollee goes out of network to
5 purchase tests they still are entitled to reimbursement, $12 a test. You know, I
6 think right now that is a fairly reasonable amount for these over-the-counter tests,
7 we will see how that plays out.
8 The feds also, just in full transparency, acknowledge that there will
9 be some bumps in the road as this rolls out, in large part because if a plan has
10 contracted with providers for the tests and retailers for the tests but doesn't have
11 enough retailers, then enrollees obviously can go out of network and get
12 reimbursed for whatever amount they spent. The feds though have not defined
13 what is a sufficient network, they are really leaving that open to interpretation. So
14 I anticipate we are going to have some situations where an enrollee says, well, I
15 couldn't find a test at in-network retailer, I went out of network, I bought it off of
16 Amazon and it cost me a lot more and then there will be some disputes and
17 discussion about whether the retail network was actually sufficient.
18 MEMBER MAZER: Can I get an answer to the question on whose
19 rules on dispute resolution, please?
20 MS. REAM: And then for dispute resolution, California's rules will
21 apply, CMS confirmed that for us.
22 CHAIR DEGHETALDI: Abbi, go ahead.
23 MEMBER COURSOLLE: Thank you, thank you so much for the
24 presentation, Sarah.
25 I was just wondering if you know whether DMHC has received any

1 calls, consumer calls to the Help Center on NSA yet? And then also whether any
2 cases have gone through the IDR process, our California IDR process yet? And,
3 you know, whether there has been any confusion about the fact that people will
4 have to go through the federal IDR process for some services and the state IDR
5 process for other services?

6 MS. REAM: Regarding whether we have received complaints. I
7 checked a couple of weeks ago and we, as far as I recall, we had not. It might
8 be a little early to be receiving complaints at this point because somebody, you
9 know, a person would have had to receive service and then received a bill and
10 then. Really, our hope is that because California has such strong protections
11 already in place for enrollees we really aren't, from the enrollees' perspective
12 there shouldn't be a change. They should -- no enrollee should have been
13 balance billed prior to the NSA, they shouldn't be balance billed now.

14 Now, I anticipate we might be receiving calls from enrollees who
15 aren't in a product covered by the DMHC. You know, there are self-insured or
16 some such thing. In which case there is a -- the feds have established a process
17 or they are in the process of establishing a process that will allow us to transfer
18 or send those folks over to the right entity at the, at the federal level to have that
19 resolved.

20 And did I? I mean, I think. Did I answer all, fully answer your
21 question?

22 MEMBER COURSOLLE: There was sort of two parts, one about
23 calls to the Help Center, which it sounds like no. And then cases that have gone
24 through IDR, which it sounds like it is also no. I just wanted to clarify that.

25 MS. REAM: So under the DMHC's AB 72 IDR process we have

1 had cases go through. I want to say over 100, fewer than 500, I would say, and
2 others would have a better number on that, so it hasn't been an overwhelming
3 amount of cases gone through. And that, you know, the claims will -- the non-
4 emergency claims will continue to go through that AB 72 process. Emergency
5 claims also will continue to be processed through. We have a non-binding IDR
6 process for emergency claims from providers so that will also continue to apply.
7 MEMBER COURSOLLE: Thank you.
8 CHAIR DEGHETALDI: And, Paul.
9 MEMBER DURR: Sarah, a question with regards to SB 510 on the
10 over-the-counter tests. Will the regs provide any guidance on reimbursement
11 that the plans have to provide to providers? Because we as provider community
12 have actually been having to pay for those tests and so now we are negotiating
13 with the health plans on how we are going to get reimbursed back for that. So
14 obviously, that is always a negotiation but it shouldn't be. In our mind this is
15 clearly the financial responsibility of the health plans but we are getting some
16 feedback from the health plans that they are waiting for guidance from the DMHC
17 on that so just your thoughts on that? Thank you.
18 MS. REAM: Yes, no, thank you for that. So SB 510 makes clear
19 that unless the plan and provider have specifically negotiated a rate for COVID
20 testing that risk remains with the plan. So our 510 APL is quite lengthy and it
21 does get into a lot of details on that about when, under what circumstances the
22 risk would shift to the provider, how quickly the providers need to reimburse the --
23 excuse me --how quickly the plan needs to reimburse the providers for
24 COVID-19 tests and whatnot. So yes, hopefully it will answer your questions. If
25 not, you know, any providers or plans are always welcome to submit questions to

1 us and we can try to find the answers.
2 CHAIR DEGHETALDI: Abbi, do you have a follow-up question? I
3 see your hand up.
4 MEMBER COURSOLLE: Yes, sorry. That question reminded me
5 that I do have another question about the over-the-counter COVID testing. The
6 draft guidance that DMHC released did not address reimbursement or coverage
7 for tests purchase in 2021. And certainly at the HCA we have gotten a lot of calls
8 from people who, you know, obtained tests in late 2021 When Omicron first came
9 around and it was very difficult to get PCR tests. I spoke briefly with Amanda
10 Levy who said that that might be addressed in a future FAQ, I was just wondering
11 if you have any update on that?
12 MS. REAM: I don't at this point, only that I need to take that one
13 back. But that is on our radar.
14 CHAIR DEGHETALDI: And so I have two clarifying questions,
15 maybe fairly simple. For at-home testing mandates, does it apply to the
16 managed Medi-Cal plans and for the 14 million Californians who are covered by
17 DHCS?
18 MS. REAM: So SB 510 applies to Medi-Cal managed care plans.
19 My understanding is the DHCS is working on guidance to address the specifics
20 with respect to how the managed Medi-Cal plans will comply with that so I would
21 defer over to them, but SB 510 does apply to managed Medi-Cal.
22 CHAIR DEGHETALDI: And on the No Surprises Act. Some 7
23 million or so Californians are in an ERISA-sponsored plan. Would federal law
24 apply to them and state law have no impact on their dispute resolution and their
25 balance billing stuff?

1 MS. REAM: Correct, that is correct. That has been the hole, you
2 know, in the California law.
3 CHAIR DEGHETALDI: I would just point out that providers have no
4 clue. Generally, when a, when a patient is covered, you know, is covered by
5 federal regs versus state, it is a tough one, yes.
6 MS. REAM: Yes, hear you.
7 CHAIR DEGHETALDI: Any other questions from the Board?
8 Then we go to questions, Jordan, from the public.
9 MR. STOUT: There are none at this time.
10 CHAIR DEGHETALDI: Okay, then we go back to our favorite
11 annual topic of the dental medical loss ratio; which Lindy teed up as something
12 that may become increasingly germane for us so, Pritika, thank you.
13 MS. DUTT: Thank you, Larry. Good morning, I am Pritika Dutt,
14 Deputy Director of the Office of Financial Review I will provide you an overview
15 of the 2020 Dental Medical Loss Ratio reports. In addition to the PowerPoint
16 presentation we also have the 2020 Dental Medical Loss Ratio Summary Report
17 that was included with the meeting handouts. The handouts provide the
18 enrollment and dental MLR information for 2019 and 2020 for all dental plans that
19 were subject to the reporting requirement.
20 Health plans that offer commercial dental coverage are required to
21 file annual dental MLR reporting forms. The DMHC worked with stakeholders on
22 the creation of the dental MLR reporting forms and instructions for completion.
23 Unlike the full service commercial health plans who are required to
24 meet the MLR requirement, and pay rebates if they fail to meet the MLR
25 requirement, there is no standard MLR requirement for dental plans.

1 The annual dental MLR report is organized by product type, which
2 is dental HMO and Dental PPO, and by market type, individual, small group and
3 large group.
4 The plans first reported data in 2015 for the 2014 reporting year.
5 Current data is for the reporting year for calendar year 2020. We received dental
6 MLR data from 18 plans that covered 5.9 million enrollees.
7 For reporting year 2020 we had 18 plans that offered Dental HMO
8 products and these were the same 18 plans that reported data for 2019. The
9 dental HMO individual market MLR ranged from 6% to 76%; and the average
10 MLR, which is weighted by enrollment, was 59%. The small group market MLR
11 ranged from 37% to 86%; with weighted average MLR of 51%. And for the large
12 group market, the MLR ranged from 38% to 76%; with weighted average MLR of
13 62%. I wanted to point out for the individual line here, the 6% is from a health
14 plan that was recently purchased. They are trying to transition out of the old so
15 they are retiring the old products, they are introducing new products. So as the
16 plan was getting, you know, transitioning enrollees out of the old products, that is
17 why you see MLR there.
18 In 2020 the weighted average MLR remained consistent with plus
19 or minus 2% from 2019 for individual, small group and large group market, so the
20 weighted average MLRs between 2019 and 2020 were pretty consistent. Now in
21 reporting year 2019 for the individual market weighted average MLR was 60%,
22 for the small group market it was 52%, and for the large group market it was
23 64%.
24 There were a total of three DMHC plans that offered dental PPO
25 products. There are two plans in the individual market that reported MLR of 60%

1 and 69%; and the weighted average MLR for the two plans was 64%. For the
2 three plans in the small group market MLR ranged from 52% to 58% and a
3 weighted average MLR of 58%. And for the three plans in the large group
4 market the MLR ranged from 52% to 87% and the weighted average MLR was
5 37%. The large group dental PPO market made up for over 50% of the total
6 dental enrollment. For reporting year 2019 the weighted average, the weighted
7 average MLR for the individual market was 67%, for the small group market was
8 60%, and then for the large group market it was 88%. Again, it was comparing
9 the 2019 data for 2020. The reported MLR varies widely amongst the product
10 and market types due to differences in benefit plans, premium structure and
11 provider payment arrangements. For some of these dental plans we have seen
12 their premium as low as $4 per member per month. Next slide.
13 Okay, so the dental MLR report is a report we present every year
14 because there was interest from the Board for the DMHC to present the
15 information at DMHC. However, until legislature takes action to set up minimum
16 MLR requirement or some other standard of measure, we don't really have
17 anything else we can do other than to continue to present the information. So we
18 get the reports from the health plans, we compile the information and present it
19 here at the Board meeting. So with that, I will take any questions.
20 CHAIR DEGHETALDI: Any questions from the Board?
21 Pritika, one comment; and I have sat through a number of these
22 with comments from some of the dental health plans. In general, what we see
23 with the MLR, the higher risk the population, think of an end-stage renal disease
24 patient, the MLR is going to be higher, right? Because the more you spend for
25 health care, the administrative side of support is smaller. The opposite is true for

1 the dental side of the business where, you know, the benefits are small and there
2 is a basic administrative overhead needed. And with that in mind it has puzzled
3 us why the MLRs or the dental MLRs looks so low but I think that is what we
4 have heard from the health plans. I just, I just worry that somebody will think that
5 85% dental MLR is the, is the, is the target and I don't know if that is achievable.
6 Those are my concerns as we have looked at this.
7 MS. DUTT: And Larry, you do make a good point that what we
8 have seen is that administrative costs are way higher for the dental plans.
9 Because for the claims processes you still need those e same administrative
10 functions in place as full service plans have to have in place with, you know, just
11 the premium being so much lower in the dental arena.
12 MEMBER WATANABE: And, Larry, I will just jump in and add for
13 our new Board Members and any members of the public that have not heard this
14 report every year for the last, I don't know, seven years. Delta Dental did a
15 presentation back I think it was at our June 2016 meeting that did a good
16 overview of why dental is different. I think one of the things we continue to
17 highlight is just the lower premiums with the same, in many cases, administrative
18 costs for things like provider directories and all of the other things that we think
19 about in terms of administrative expenses. So I will just reference that
20 presentation that was done in the past, I think it is still very relevant to the
21 discussion.
22 As Pritika mentioned, we would need the legislature to take action
23 to give us authority to do something different in this area. We have had a lot of
24 discussion about whether there is some other metric versus a medical or dental
25 loss ratio. But again, we would need some additional authority. This is one of

1 the reports that we had some discussion last year about whether we should, you
2 know, just share it publicly but not discuss it and I think the Board at that time
3 agreed that there was some value to us at least presenting a high level overview.
4 So we will we will plan to continue to do that but appreciate the continued
5 discussion about why dental is a little bit different.
6 CHAIR DEGHETALDI: Any other questions from the Board?
7 Scott.
8 MEMBER COFFIN: Director Watanabe, I would encourage the
9 Department to consider where we are going with population health. You know,
10 there is an argument to make that managed care and dental managed care
11 should be working more and more together. I am not attempting to drive up
12 dental's medical expense but it is a natural outcome, you know, as we do more
13 and more integration. So from a policy perspective I would encourage that we
14 consider population health.
15 MEMBER WATANABE: I appreciate that, Scott, having worked on
16 a couple of oral health initiatives for children early in my career. I always felt like
17 there really needed to be closer coordination on the medical side too so
18 appreciate your comment.
19 CHAIR DEGHETALDI: You know, Scott, I would just say, ask any
20 infectious disease expert who have cared for patients with very expensive
21 cardiac consequences of periodontal disease. The body has teeth, so I
22 appreciate what you said.
23 MEMBER COFFIN: Mm-hmm.
24 CHAIR DEGHETALDI: Any comments, Jordan, from the public
25 here?

1 MR. STOUT: There are none at this time.
2 CHAIR DEGHETALDI: Okay. Then we go to some of the core
3 work here, Michelle.
4 MS. YAMANAKA: Hi, good morning, everybody. Today, I am
5 going to give you an update on RBO financial reporting for the quarter ended
6 September 30th, 2021. Since there are new Board Members I am going to
7 quickly start my update with a summary of the RBO regulations that were revised
8 in October of 2019. I am going to start with four areas that I want to discuss and
9 then to let you also know that these changes strengthened the RBO solvency
10 requirements as well as the Department oversight of RBOs.
11 So the first area is the survey reports. Prior to 2019 RBOs needed
12 to file a balance sheet, income statement, statement of cash flows and a
13 calculation of the grading criteria. With the revised changes the RBOs need to
14 continue to provide those statements as well as the statement of net worth, notes
15 to financial statements, enrollment information, and detailed information in the
16 areas of cash receivables, risk revenue, administrative expenses and claims.
17 In addition to the survey reports, prior to October 2019 we had what
18 we called a compliance statement and there were RBO -- RBOs that had less
19 than 10,000 enrollees assigned to them were able to file a compliance statement,
20 which is the RBO attesting that they are meeting the solvency criteria. This
21 represented about 25% of the RBOs. But as of October 2019, regardless of the
22 number of enrollees assigned to an RBO, they need to file the quarterly survey
23 reports.
24 The second area is the grading criteria requirements. Three
25 changes here. The first has to do with the tangible net equity or TNE

1 requirement. Prior to 2019, the minimum TNE needed to be positive. And after
2 the regulation, revised regulation was passed, the minimum requirement for TNE
3 is now 1% of -- the greater of 1% of annualized health care revenues or 4% of
4 annualized health care expenses.
5 And then in the area of working capital, unsecured affiliate
6 receivables are excluded from this calculation unless it is in the normal course of
7 business.
8 And the third is the cash-to-claims ratio where there was a change
9 in the type of receivables that could be used in this calculation. Previously, it was
10 receivables that were reasonably anticipated to be collectible within 60 days.
11 After 2019 it narrowed those types of receivables that could be used in this
12 calculation to HMO capitation receivables due within 30 days.
13 And the last is the subdelegating RBO reporting. And this is where
14 one RBO passes down risk to another RBO. The receiving RBO now needs to
15 file the financial survey reports with the Department.
16 Okay, the second -- the third area I want to touch on is the
17 sponsoring organization. And this is a guarantee, the RBO has a guarantee.
18 Normally it is a parent, but a guarantee to assist them with meeting the solvency
19 criteria. And so what we have, what the regulation change was basically there
20 was no end date to the use of that guarantee. With the revised regulation it
21 allows the RBO to use a sponsoring organization for one year with a possible
22 one time extension of an additional year.
23 And the last was -- did I -- I believe I already talked about
24 subdelegating RBO reporting. I think I went out of, out of -- sorry, I went out of,
25 out of my, my talking point. So again, the subdelegating reporting is having all

1 our RBOs, regardless if they are receiving
2 enrollment directly from a health plan or from an RBO, to require the financial
3 reporting with the Department.
4 Okay, next I am going to discuss the quarter ended September
5 30th, 2021 financial survey reports. We have 209 RBOs reporting to the
6 department. There was a decrease of one RBO that became inactive at this
7 quarter and we have 12 RBOs on a corrective action plan. When we, when we
8 prepared the slides there was one RBO that was a non-filer and with that RBO
9 we did take enforcement action as the RBO did not file their reports with the
10 Department. Subsequently, after that order was issued the RBO did file their
11 report. And we have -- RBOs are required to file annual survey reports, which
12 are due 150 days after the RBOs fiscal year end. To date we have, we have
13 received 14 annual reports. A majority of the RBOs have a fiscal year end of
14 December 31st and their filings would be due at the end of May. And we also
15 receive monthly financial reports from RBOs on corrective action plans and
16 currently there are three RBOs that are filing monthly reports to the Department.
17 Okay, next slide please.
18 Okay, so for the inactive RBOs. We keep track of the RBOs that
19 became inactive and we have certain inactive reasons when they are, when they
20 become inactive. They either have Financial Concerns, No Financial Concerns
21 or an Other category, which is a catch-all. For the quarter ended September
22 30th there was one RBO that I mentioned that became inactive and that RBO is
23 represented in the No Financial Concern reason. Okay. Next slide, please.
24 In addition to that, we also keep the enrollment of the inactive RBO.
25 This inactive enrollment is based on their last quarterly filing. Since 2005 we

1 have had 119 RBOs that have become inactive. This slide represents
2 approximately 69% or 82 of the RBOs had less than 10,000 lives assigned to
3 them when they became inactive. For the quarter ended September 30th, again,
4 that one inactive RBO was in a 10,000 to 30,000 enrollment range. Next slide
5 please.
6 Another change for the information from the revised regulations.
7 As of October 2019 RBOs are now required to file their enrollment information
8 with the Department. This slide represents approximately 8.9 million lives
9 assigned to the RBOs. This is a slight decrease from the previous reporting
10 period of approximately 21,000 enrollees. Next slide please.
11 Moving on to the RBO financial reporting for the quarter ended
12 September 30th, 2021. We have, again, 209 RBOs filing. With those RBOs, 196
13 are reporting compliance with the solvency criteria. Of that 196, 10 RBOs are on
14 our monitor closely list. This 196 represents 94% of the RBOs reporting
15 compliance. We have 12 RBOs reporting non-compliance, which represents 6%
16 of the RBOs. And as I mentioned, there was one non-filer when the slides were
17 produced. Subsequently, we did receive that filing. It was reviewed and that
18 RBO would be in the Compliant category.
19 Moving on to the next slide. There should be another slide
20 regarding corrective action plans. There we go. Thank you. Okay.
21 So the DMHC oversees the RBOs by conducting an ongoing
22 financial analysis of their financial submissions. When the RBO is non-compliant
23 with the grading criteria a corrective plan is required. This corrective action plan
24 process, or CAP process, serves as a mechanism for the RBOs to demonstrate
25 how they will obtain and maintain compliance with the grading criteria. This

1 process is a collaborative effort between the RBO, its contracting health plans
2 and the DMHC. Our process is to monitor the RBO's progress with its approved
3 CAP on a monthly and quarterly basis until the RBO is compliant with the grading
4 criteria.
5 There are RBOs that have two corrective action plans as they
6 became non-compliant with additional grading criteria while on a CAP, or there
7 are RBOs that do not meet their approved projections. In these cases, we work
8 with the RBOs to determine if they can get back on track with their approved
9 compliance date. In the event there are additional financial concerns, then the
10 DMHC may take enforcement action for the health plans to freeze enrollment or
11 de-delegate. However, we do not take these decisions lightly because many of
12 these RBOs serve California's health care safety net.
13 So for the quarter ended September 30th, 2021 we have 14
14 corrective action plans filed by 12 RBOs. There are two RBOs on two corrective
15 action plans. Of those 14 CAPs, 8 are continuing from the previous quarter and
16 6 are new as of September 30th, 2021. You will see a large decrease from the
17 previous quarter. There were, I believe, 17 CAPs that were completed after we
18 received the quarter ended September 30th financials as all of those RBOs did
19 meet their CAP compliance date and are compliant with all grading criteria. So of
20 those 8 continuing CAPs, 7 are improving from the previous quarter and 1 is not
21 improving. And that RBO we are working with them to determine if they are
22 going to meet their CAP compliance date. Next slide, please. Thank you.
23 We also conduct an analysis of RBOs that have Medi-Cal lives
24 assigned to them. And as of quarter ended September 30th, 2021 there were
25 approximately 4.9 million lives -- oh, there's a slide before this, I'm sorry. There

1 we go. There are approximately 4.9 million lives assigned to 85 RBOs. This
2 represents approximately 56% of the total lives assigned to the 209 RBOs. Of
3 those 85 RBOs, 72 RBOs had no financial concerns, 5 were on our monitor
4 closely, and 8 were on corrective action plans. Of those 85 we took the top 20
5 RBOs that had a majority of the Medi-Cal lives assigned to them. Next slide
6 please.
7 And this -- there were approximately 3.7 million lives assigned to
8 those RBOs, which represents 43% of the total enrollment; 16 of those RBOs
9 had no financial concerns, 2 were on our monitor closely list, and 2 were on
10 corrective action plans.
11 Before we go to questions I just also wanted to mention that there
12 was a handout for the corrective action plans, I provided additional details about
13 the RBOs that are on CAPs. It is sorted by the RBO's MSO, if they have one, but
14 it provides additional information such as the contracted health plans, enrollment
15 by ranges, the quarter the CAP, was initiated the compliance with its approved
16 CAP, and the grading criteria deficiencies.
17 And that concludes my presentation so open for questions.
18 CHAIR DEGHETALDI: Dr. Mazer.
19 MEMBER MAZER: Thank you, Michelle, thanks for the
20 presentation. I am not sure I believe that we have gone down from so many on
21 CAP to less than a third. My first question when I went through the slide set was
22 like, okay, what are they hiding? It is great. Now you have less work to do and
23 maybe we can do it even more forcefully on the few that are still out there.
24 I do have a question without naming the MSO but on the CAP
25 review summary there is one outstanding MSO that is now on -- several of its

1 plans, a couple of its plans have been going over a year on CAP, actually closer
2 to -- well, over a year because we don't have data on the last quarter. That
3 seems to be a real standout and I am curious as to what is being done, if
4 anything, to address those plans. They look like they are primarily managing
5 Medi-Cal plans.
6 MS. YAMANAKA: Sure. So without going into any detail on a
7 specific RBO, there are times that an RBO may need additional time to obtain
8 compliance. Based on the corrective action plan and the projections provided to
9 the department that extension may be granted, so some of these CAPs may take
10 a little bit longer. But as I mentioned, we monitor the RBOs on a monthly and
11 quarterly basis to ensure that they are meeting their approved projections. So
12 that is the short answer.
13 MEMBER MAZER: Thank you. I am just concerned because
14 those are plans with over 100,000 lives and I don't want to see a sudden
15 collapse, thanks.
16 MS. YAMANAKA: Okay, sure.
17 CHAIR DEGHETALDI: Paul, you raised your hand next.
18 MEMBER DURR: Yes, thank you, Michelle, great overview as
19 usual. I, like Ted, am surprised and glad to see the wonderful improvement in
20 the numbers in that there are so many more that are becoming compliant with
21 the CAP and so a few that are on our list of concerns. So overall that speaks
22 well, I think, to the fact that you are working with the, with the RBOs to make sure
23 that they have a plan and that it is being operated effectively and that is best for
24 all of us so I think that that attention to detail is very good.
25 My question was on the one RBO that you did have to take

1 enforcement action. Do you believe that they will continue to report? I mean,
2 they reported once because you had to take the action. The question is, do they
3 understand now that it is a requirement to do every quarter and they are not
4 going to need you to step in to force the issue?
5 MS. YAMANAKA: Sure. So the orders go out to the contracting
6 health plan. So I am sure that the contracting health plans are also working with
7 the RBOs. But I can't speak to the future but I can speak to Quarter 4. When we
8 received Quarter 3 we also received Quarter 4. Both were reviewed side by side
9 to verify compliance so they did get Quarter 4 in on time.
10 MEMBER DURR: That is comforting, thank you.
11 MS. YAMANAKA: Sure.
12 CHAIR DEGHETALDI: And Abbi.
13 MEMBER COURSOLLE: Thank you. Yes, thank you, Michelle, for
14 the presentation. This may just be sort of a newbie question since this is my first
15 meeting but I was just wondering if you could say anything about sort of the role
16 that DHCS plays in the oversight of the RBOs that fall into the Medi-Cal area?
17 MS. YAMANAKA: So I think that would be a question for DHCS.
18 MEMBER COURSOLLE: So there is no joint sort of cooperation in
19 terms of your oversight with DHCS, in other words?
20 MS. YAMANAKA: At this time we receive, we are mainly focused
21 on the quarterly survey reports. In the app, event there are concerns with an
22 RBO then there may, we may have those discussions with DHCS as well.
23 MEMBER COURSOLLE: Thank you.
24 MS. YAMANAKA: Mm-hmm.
25 CHAIR DEGHETALDI: Jeff had his hand up. He disappeared, I

1 see him coming back. Jeff, are you Zoomed in? I see him coming back.

2 Michelle, I would like to congratulate you, not to suggest that you

3 are hiding anything, but I think you have done -- this is a great result. People in

4 San Diego are a little bit more paranoid but I am really impressed. However, just

5 if you look at the many years of the RBO reports, they are disproportionately

6 tilted, those on CAPs, to those that serve the underserved population in

7 California. We have to keep looking through the work we do from a health equity

8 lens. And we can't stop. You know, we have to look at the forest, not the trees.

9 Because these trends, particularly for Abbi and Scott, we have been

10 disproportionately seeing RBOs on CAPs who serve Medi-Cal patients and there

11 may be a structural problem there, so.

12 And, Jeff, are you back?

13 MEMBER RIDEOUT: Yes, I have got kind of a --

14 CHAIR DEGHETALDI: Jeff, you are breaking up. Maybe you

15 could try to -- we can come back to, to you.

16 Maybe go to the public, Jordan, if there are any questions for

17 Michelle.

18 MEMBER RIDEOUT: Larry?

19 CHAIR DEGHETALDI: Yes, Jeff.

20 MEMBER RIDEOUT: I'm sorry, I have got a bad Internet

21 connection. Do I still have time for a question?

22 CHAIR DEGHETALDI: Sure.

23 MEMBER RIDEOUT: This is more for Mary and it goes to kind of

24 the extent of regulatory authority over RBOs. And the context here is the Office

25 of Affordability and their attempts to define a provider group that they can, in fact,

1 oversee. And I realize that is a different department but I think starting with an
2 RBO as sort of the first unit of analysis is probably a safe bet because they are
3 defined, they are regulated, they are contracted --
4 CHAIR DEGHETALDI: Jeff, you froze.
5 MEMBER WATANABE: I think he froze up again.
6 CHAIR DEGHETALDI: Okay. He is probably in Oakland.
7 MEMBER WATANABE: I know. Larry, maybe I will just jump in
8 and say, you know, obviously, we have been working very closely with HCAI and
9 are very, tracking very closely the work with the Office of Health Care
10 Affordability and want to make sure there is alignment. We are trying to share all
11 of our knowledge with them as they get things stood up. I will say as we talked, I
12 think, previously about just the establishment of the Board and SB 260 back in
13 1999.
14 I think there is an acknowledgement that some of these definitions
15 of what is an RBO? You know, things have changed. The marketplace has
16 changed, the complex contracting arrangements have changed so it is something
17 we are keeping an eye on. And I think particularly as HCAI gets some of their
18 new work up to speed they are another stakeholder that we might want to have
19 come and just talk to the Board about the things that they are doing and the
20 potential alignment. So I am not sure if that was quite Jeff's question but
21 acknowledge that there's been some changes in the delegated model and what
22 we typically have talked about when it comes to an RBO.
23 MEMBER RIDEOUT: Yes, and I caught most of that, Mary. I'm
24 sorry, I am going to be unstable it seems like, but not emotionally but just in
25 general here. My sense is as I am watching this unfold --

1 CHAIR DEGHETALDI: Jeff, we lost you again.
2 Sorry if I already asked, Jordan, any questions on this topic from
3 the public?
4 MR. STOUT: There are none at this time.
5 CHAIR DEGHETALDI: Okay. While Dr. Rideout gets his Internet
6 back maybe we can come back to Pritika on the health plan quarterly stuff.
7 MS. DUTT: Check the time here, okay. So it is good afternoon. I
8 am Pritika Dutt, Deputy Director of the Office of Financial Review. The purpose
9 of this presentation is to provide you an update of the financial status of health
10 plans at quarter ended September 30th, 2021. We also included a handout that
11 shows the enrollment at September 30th, 2021 and tangible net equity, or TNE,
12 for five consecutive quarters starting with September 30th, 2020 through
13 September 30th, 2021 for all licensed plans; and it is broken out by full service,
14 restricted full service and specialized. And I wanted to highlight that the TNE or
15 tangible net equity is the minimum financial reserve requirement for health plans
16 licensed with the DMHC.
17 As of January 3rd, 2022 we had 141 licensed health plans. We are
18 currently reviewing 8 applications for licensure, which includes 6 full service and
19 2 specialized. Of the 6 full service, 1 is seeking licensure for Medicare
20 Advantage, so they want to contract directly with CMS and offer products to
21 Medicare beneficiaries, 3 for restricted Medicare Advantage and 2 for restricted
22 Medi-Cal. And for the 2 specialized plans, 1 is looking to get licensed to offer
23 employee assistance programs or EAP and one for dental.
24 As of September 30th, 2021 there were 28.23 million enrollees in
25 full service plans licensed with the DMHC. Total commercial enrollment includes

1 HMO, PPO, EPO, and Medicare Supplement. As you can see on the table,
2 compared to the previous quarter, total full service enrollment increased by
3 270,000 enrollees at September 30th, 2021, with Medi-Cal adding 170,000 of the
4 enrollees. So the government enrollment here is broken up by -- it includes
5 Medicare and Medi-Cal enrollment.
6 This chart shows the enrollment trend since 2017 for commercial
7 and government enrollment for the DMHC licensed health plans. The gap
8 between the commercial and government enrollment widened until 2019 and
9 then 2020 we can see that government enrollment surpassed commercial
10 enrollment.
11 This slide shows the makeup of the HMO enrollment by market
12 type. HMO enrollment in all markets remained relatively stable compared to the
13 previous quarters.
14 This slide shows the makeup of the PPO/EPO enrollment. As you
15 can see on the table, total enrollment increased by 60,000 lives at September
16 30th compared to the previous quarter.
17 This table shows the government enrollment, which is, again, Medi-
18 Cal and Medicare. Overall the government enrollment increased for all five
19 quarters. You can see it increasing quarter by quarter.
20 There are 4.7 million enrollees in the closely monitored full service
21 plans. Of the 31 closely monitored full service plans, 17 are restricted licensees
22 with 1.2 million enrollees. The restricted licensees include 4 that are restricted to
23 Medi-Cal, 9 restricted for Medicare, 4 for commercial. The total enrollment for
24 the 4 specialized plans was 243,000 lives.
25 And I wanted to point out since we have new board members here

1 we have plans that we monitor closely due to their financial performance. If we
2 see any changes in their enrollment mix, if they newly licensed plans, so there
3 are various reasons. If we see something happening with the parent entity,
4 anything in the news, we watch those plans a little bit closely.
5 Four health plans did not meet the Department's minimum financial
6 reserve or TNE or tangible net equity requirement at September 30th, 2021.
7 Brown and Toland Health Services, Inc. reported a TNE deficiency at September
8 30th, 2021 and also for month ended October 31st, 2021. The plan received a
9 cash contribution of $15 million from its ultimate parent, which is Blue Shield, to
10 cure the TNE deficiency in November. The plan confirmed its TNE to required
11 TNE at 105% for November 30th, 2021. We are currently working with the plan
12 and trying to get some financial projections. And also we have asked the plan to
13 provide the steps they are taking to maintain compliance with the TNE
14 requirement going forward.
15 Dignity Health Providers Resources, Inc. The plan reported TNE
16 deficiency also at September 30th, 2021. The plan received a capital
17 contribution of $2.5 million from its parent company, which is Dignity Health
18 Systems. The TNE is compliant.
19 Next is Golden State. You probably recall this plan on here for a
20 few quarters now. The plan has not cured its TNE deficiency. Currently, the
21 DMHC issued a Cease and Desist Order on April 27, 2021 that prohibits Golden
22 State from accepting new members effective May 1st, 2021 so for the current
23 open enrollment for Medicare the plan was not able to add additional lives. So
24 the DMHC issued an Accusation on July 1st, 2021 to revoke Golden State's
25 license and Golden State had 15 days to request a hearing, which it did. The

1 hearing is currently scheduled for the week of July 15th. The plan is currently
2 working with potential investors to get additional funding to cure its TNE
3 deficiencies. So it is a Medicare plan and we are working very closely with CMS
4 on any action we are taking and we are working very closely on our oversight
5 activities.
6 And then the next one is Vitality Health Plan. The plan first
7 reported a TNE deficiency in December 2018 and the DMHC worked very closely
8 with CMS and the plan through the process. As you may recall from the previous
9 FSSB meeting, in December 2020 the plan filed a Chapter 11 bankruptcy. We
10 received a change in control filing from the buyer, from a buyer in November of
11 2021. The Department approved the plan's change in control filing on December
12 31st, 2021. The new owner and Vitality entered into several undertakings as a
13 condition of the Department's approval. So one of the conditions we placed on
14 this change of control was the new owner had to maintain a tangible net equity of
15 200% of required TNE for the next two years. So as of January the plan has the
16 cash infusion from the new owners and the current TNE level is at 200% of
17 required TNE, so good news there.
18 This chart shows the TNE of health plans by line of business. A
19 majority of the health plans with over 500% of required TNE are specialized
20 health plans with lower TNE requirements. Next slide.
21 This chart shows the TNE of full service plans by enrollment
22 category; 63 health plans or over half of the total licensed full service plans
23 reported TNE of over 250% of required TNE.
24 This chart here shows the breakdown of the 21 full service plans in
25 the 130% to 250% of required TNE range. And as a reminder, if a plan's TNE

1 falls below 230% of required TNE the plan is placed on monthly reporting. We
2 also monitor the plans, health plans closely if we observe a declining trend in
3 their financial performance, which includes TNE, net income, enrollment,
4 amongst other financial measures.
5 And this chart here shows the TNE of full service plans by quarter.
6 And for more detailed information on health plan TNE levels and enrollment
7 please refer to the handout that was provided with the meeting materials.
8 Okay, and this concludes my presentation, I will take any questions.
9 CHAIR DEGHETALDI: Any questions from the Board? Paul.
10 MEMBER DURR: Yes, always appreciate your update, Pritika.
11 You know, one thing I was just looking at on the supplemental material is the
12 specialized health plan TNE. And when you look at that, the requirements,
13 especially like on behavioral health or vision, those TNE requirements are just
14 really, really high. And I think about the fact that especially in behavioral health,
15 the need for us to invest more in providers and that means to compensate
16 providers maybe more to come to California. This can't help but think -- it is more
17 a comment, Pritika, is that if they were to use some of that excess TNE when you
18 are -- when you have a TNE that in one of the bigger plans, right, to look at, is at
19 almost 600% of requirement, you start to wonder, could you use that for
20 recruiting new providers into the community to really look at expanding access
21 that is so vitally needed. Or even on the vision one is even more impactful
22 because I wonder how much of that is, you know, provider versus private equity
23 or venture capital backed and where is that money really going? It should be
24 coming to the provider community rather than going to excess TNE in some of
25 those cases. So just a comment and appreciate your report. Thank you.

1 MS. DUTT: Thank you, Paul. One comment back is the minimum
2 required TNE for specialized plans is 50,000, so if you look at 600% it is only
3 $300,000. So again, the minimum is 50,000 or a percentage of revenues,
4 premium revenues, or a percentage of medical expenses. So again, with a
5 50,000 minimum TNE it is only 300% so they cannot like -- we still want them to
6 maintain some reserves in the plan.
7 MEMBER DURR: Yes, that is a great point, Pritika. So maybe just,
8 maybe an enhancement would be is to put the minimum requirement on the
9 report because that changes my perspective completely if I had known that. And
10 so that might be a nice enhancement is to say, for these plans it is 50,000 or for
11 these plans it is X percent of whatever. That would be helpful, thank you.
12 MS. DUTT: Thank you, Paul, for the feedback.
13 CHAIR DEGHETALDI: Any other questions?
14 Pritika, I just was struck again by that point in 2020 when we pass
15 this inflection point where we had more government HMO lives than commercial.
16 We are heading in the not-to-distant future to have more Medicare Advantage
17 beneficiaries than fee-for-service in California and a lot of that growth will be in D-
18 SNP. Do we ever pull out the D-SNP plans to see whether their solvency -- I
19 don't know how to ask this question. But those plans I am worried about will care
20 for more complex patients and should we look with more granularity at D-SNP
21 plans?
22 MS. DUTT: So, Larry, we are not getting enrollment broken out by
23 the various Medi-Cal lines of business, like you know, D-SNP all the various
24 special needs programs that are in place. But we are -- I know that for the Medi-
25 Cal plans they are switching the Medi-Cal lives to D-SNP, so we will be looking at

1 that closely and then working with CMS for oversight activities. But we are aware
2 of the change and we are looking at these expenses.
3 CHAIR DEGHETALDI: Right.
4 MS. DUTT: Because not all Medicare plans are making money at
5 the end of the day. So we are working closely. And as you can see, some of
6 those plans that are TNE deficient are Medicare plans.
7 CHAIR DEGHETALDI: Yes, thank you.
8 Any other Board questions?
9 And then from the public, Jordan?
10 MR. STOUT: There are no questions from the public.
11 CHAIR DEGHETALDI: I just want to point out we are two minutes
12 behind on our agenda, our packed agenda. Wow, what a team.
13 Okay, so public, this next item would be for public comment on
14 matters not on the agenda and that would be an opportunity for the public to
15 raise their hand for Jordan to call on them. I assume we have none, Jordan?
16 MR. STOUT: There are none at this time.
17 CHAIR DEGHETALDI: Okay, then for the Board, agenda items for
18 future board meetings. Any thoughts here? Okay.
19 MEMBER DURR: Larry?
20 CHAIR DEGHETALDI: Yes, Paul.
21 MEMBER DURR: Yes, sorry. One thing that I know we have
22 talked about before is the rising cost of these specialty drugs and the impact they
23 are going to have on the provider community and the interpretation as to whose
24 risk it is. As we know, the health plans will continually try to push that risk as
25 medical group risk and provider risk when we just don't have the wherewithal to

1 make that happen so it worries me. It does tie into something that I think has
2 become apparent with regards to the whole SB 510 regs where the health plans
3 are required to provide provider groups with an actuarial assumption of the risks
4 that we are taking and many times that is not done. So when we go back to the
5 plans to say, show me how pandemic risk was negotiated in our contract, or in
6 the risk assumption that we are taking, it wasn't in our contracts. But show me
7 on the annual filing that they are supposed to do to say, well, here is the
8 expected risk you are going to have. I worry that even the high cost drugs they
9 are going to kind of do the same thing and say, well, it is kind of built into that risk
10 assumption. It is something that we need to be planning for because they are
11 becoming more and more -- there's more and more of them and they are very
12 expensive. And I don't know that we have a solution for that but that is
13 something that could significantly create financial challenges for California.
14 CHAIR DEGHETALDI: Ted.
15 MEMBER MAZER: Yes, Larry. I don't think it needs to be a
16 standing item but maybe a once or twice a year follow-up on what's happening
17 with out-of-network IDRP and appeals, both the frequency, whether it is specific
18 plans, and maybe the outcomes of IDRP relative to whatever standard we want
19 to put on there, whether it is -- who won the battle, I guess, would be one way to
20 look at it. It might give us a little bit better handle on how many people are going
21 out of network and whether it is a plan here or whether it is just disparate.
22 MEMBER WATANABE: I will just add, Dr. Mazer, we do have a
23 quarterly report that we do so we would be happy to add that as a standing
24 agenda item either quarterly or twice a year. But we will be keeping an eye on
25 that, I think particularly with the No Surprises Act, but we would be happy to bring

1 that back for future meetings.

2 MEMBER MAZER: Yes, thanks. And I don't think it needs to be

3 quarterly, I don't think there will be that much data to present.

4 MEMBER RIDEOUT: Larry?

5 CHAIR DEGHETALDI: Yes. Is that Jeff, 415?

6 MEMBER RIDEOUT: I'm sorry, I have been on the phone for the

7 last 30 minutes or so, I just figured out how to unmute. The only thing I might

8 suggest for future would be just like we have a regular DHCS report we might

9 also want to consider a semi-regular HCAI report on the Office of Affordability

10 and the HPD, especially given DMHC's role in the standardized quality and

11 equity measures.

12 CHAIR DEGHETALDI: Great suggestion. And those of us

13 Luddites will translate HCAI into OSHPD but we are just Luddites. Scott.

14 MEMBER COFFIN: As Lindy Harrington from the Department of

15 Health Care Services presented today on the budget and funding for calendar

16 year '22 and beyond it started getting me to think about it may be helpful for this

17 board to have an overview of the impact of all the CalAIM initiatives on what that

18 means to risk for the organizations. There are so many in the state that are

19 serving the Medi-Cal managed care populations. We have well over 14 million

20 beneficiaries now and it continues to grow so it may be helpful to understand how

21 those initiatives feed into or impact those reserves.

22 CHAIR DEGHETALDI: And I would add, Scott, that twice a year

23 we look carefully at the local initiatives and the COHS, we have a drill down. And

24 I totally agree with you, the map of who is a local initiative and the counties that

25 are going to have managed Medi-Cal, I would like to understand that more. And

1 again, sort of a big, hairy audacious goal would be to understand the risk burden
2 by plan, by county, for the 14 million Californians and are we adequately paying
3 for the work to address social determinants and other disparities? Because we
4 can measure it and aspire to get there, but if we don't pay more for sicker
5 patients we are going to fail.
6 MEMBER COFFIN: Yes.
7 MEMBER RIDEOUT: Larry?
8 CHAIR DEGHETALDI: Yes.
9 MEMBER RIDEOUT: I'm sorry, this is Jeff, I keep interrupting
10 because I don't know where I am in the queue. This is no criticism of Lindy but I
11 don't understand what the follow-up process is for some very important questions
12 that were asked and deferred and that kind of happens each quarter with the
13 DHCS report because it is so broad and there are so many people involved in
14 that department. So I don't, I don't -- I am just curious if there is a way to ever go
15 back to what we asked last quarter and have it addressed?
16 CHAIR DEGHETALDI: Jeff, I might suggest that we could send the
17 summary of the meeting with the outstanding questions to her and ask for DHCS,
18 routinely ask for the department to come back to answer those questions in a
19 subsequent meeting.
20 MEMBER COFFIN: And I would --
21 MEMBER RIDEOUT: They are a guest, right? I understand that.
22 MEMBER COFFIN: Also --
23 ("Recording stopped" heard.)
24 CHAIR DEGHETALDI: Ted.
25 MEMBER MAZER: Yes. You know, I think it is a lot easier to make

1 them follow up on the questions. We have a transcript of this meeting. And I
2 think when the transcript is released we go through and we pose those questions
3 directly to them with an expectation of an answer to those questions at the
4 beginning of their next presentation.
5 MEMBER WATANABE: And I will just add that we can take that
6 back. One of the things, we do work closely with DHCS in advance of these
7 meetings. We have had kind of this agreement that René Mollow and Lindy
8 Harrington would take turn so that we get kind of the financial piece but we also
9 get more of the programmatic pieces under René. We have also asked to make
10 a little bit of a change so that Lindy comes when we do the financial summary of
11 Medi-Cal managed care plans and we have tried to coordinate those so she
12 stays to hear that and can be responsive to some of the questions; and, Scott,
13 we will be leaning on you for some of that as well. But one of the things that we
14 can do is regardless of whether it is René or Lindy, we can go through the
15 transcript and give a list of any questions that were deferred so that we can bring
16 those back. So appreciate that feedback and follow-up but we will take that on.
17 CHAIR DEGHETALDI: Scott's hand is up.
18 MEMBER COFFIN: Yes. You know, I was trying to jump in there
19 to say, this is my first board meeting so I am not sure if I am jumping the line here
20 but I would like to actually, as a board member, take that accountability on to
21 circle back with the Department's Director Watanabe. If I could partner with you
22 on that I would be happy to.
23 MEMBER WATANABE: Yes, thank you. And I am going to
24 apologize, I think we may be having some technical issues here. So if your
25 screen is moving just bear with us here.

1 But thank you, Scott.

2 MEMBER COFFIN: Mm-hmm.

3 CHAIR DEGHETALDI: And I, Mary, would also love to hear what

4 the Department is doing on its work on disparities. PBGH is working on that, IHA

5 is working on that DHCS is working on that. Hopefully we will converge on a

6 common data set and set of goals.

7 MEMBER WATANABE: As I mentioned earlier too, we are going to

8 have monthly health equity and quality committee meetings through, I think,

9 August with the committee's recommendations to us in September, so that work

10 is going to be moving very, very quickly. It will be a standing agenda item,

11 probably for me to do under my Director's Remarks, to keep you updated on that

12 work. But again, our goal is to have alignment across what is happening.

13 There's a lot of exciting work happening with Covered California, CalPERS and

14 DHCS. NCQA is doing a lot of exciting work in this space, IHA, and really happy

15 to have a representative from IHA on the committee as well. So we will make

16 sure we bring that back in future meetings, keep you posted on that.

17 CHAIR DEGHETALDI: Thanks. Any other comments? I think we

18 are right at three minutes ahead. It was a great meeting and thanks to everyone

19 and we will maybe see you in person on May 19th in Sacramento and thank you.

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

21 .

22 CERTIFICATE OF REPORTER

23

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

25 hereby certify:

1 That I am a disinterested person herein; that the foregoing
2 Department of Managed Health Care, Financial Solvency Standards Board
3 meeting was electronically reported by me and I thereafter transcribed it.
4 I further certify that I am not of counsel or attorney for any of the
5 parties in this matter, or in any way interested in the outcome of this matter.
6 IN WITNESS WHEREOF, I have hereunto set my hand this 28th
7 day of February, 2022.
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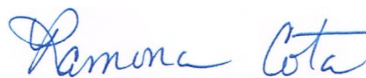
11 
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