STATE OF CALIFORNIA

DEPARTMENT OF MANAGED HEALTH CARE

FINANCIAL SOLVENCY STANDARDS BOARD (FSSB) MEETING

ONLINE/TELECONFERENCE MEETING

HOSTED BY THE

DEPARTMENT OF MANAGED HEALTH CARE

SACRAMENTO, CALIFORNIA

WEDNESDAY, NOVEMBER 16, 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

Mary Watanabe

Amy Yao

DMHC STAFF

Pritika Dutt, Deputy Director, Office of Financial Review

Amanda Levy, Deputy Director, Health Policy and Stakeholder Relations

Jordan Stout, Staff Services Manager

Leslie Thompson, Acting Staff Services Manager

Michelle Yamanaka, Supervising Examiner, Office of Financial Review

ALSO PRESENTING/COMMENTING

Vishaal Pegany, Deputy Director
Office of Health Care Affordability

William "Bill" Barcellona
America's Physician Groups

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PROCEEDINGS

10:01 a.m.

CHAIR DEGHETALDI: Welcome everybody to our last quarterly FSSB meeting of 2022; so welcome everybody. And I -- before we jump into Board introductions let me, let me go through sort of the ground rules, what we call the housekeeping notes, and just go with me on this. You have heard this before but it is important that we state them at every public meeting.

So for Board Members, please remember to unmute yourselves when making a comment and mute yourselves when not speaking. For our Board members and the public, as a reminder, you can join the Zoom meeting on your phone should you experience a connection issue.

Questions and comments will be taken after each agenda item. For the attendees on the phone, if you would like to ask a question or comment please dial *9 and state your name and the organization you are representing for the record.

For attendees participating online with microphone capabilities, you may use the Raise Hand feature and you will be unmuted to ask your question or comment. To raise your hand click on the icon labeled Participants on the bottom of your screen, then click the button labeled Raise Hand. Once you have asked your question or provided a comment please remember to click Lower Hand. All questions and comments, thank you, Jordan, will be taken in the order of raised hands.

As a reminder, the FSSB is subject to the Bagley-Keene Open Meeting Act. Operating in compliance with the Act can sometimes feel inefficient and frustrating but it is essential to preserving the public's right to governmental

transparency and accountability.

Among other things, the Act requires the FSSB meetings to be open to the public. As such, it is important that members of the FSSB refrain from emailing, texting or otherwise communicating with each other off the record during the FSSB meetings because such communications would not be open to the public and would violate the Act.

Likewise, the Bagley-Keene Act prohibits what are sometimes referred to as serial meetings. A serial meeting would occur if a majority of the members emailed, texted or spoke with each other outside of an FSSB meeting about matters within the Board's purview. Such communications would be impermissible, even if done asynchronously. For example, member one emails member two who then emails member three. Accordingly, we ask that Members refrain from emailing or communicating with each other about Board matters outside the confines of a public meeting.

So with that there let me ask, starting from the south, moving north, for Board Members to introduce themselves.

MEMBER DURR: So I think I might be furthest south in San Diego; so I am Paul Durr, CEO for Sharp Community Medical Group, an IPA in San Diego. Welcome, everybody, and glad to be here. Thank you, Larry.

CHAIR DEGHETALDI: I am not sure who is next. Maybe Amy. I don't know where you are based.

MEMBER YAO: Oh, hi, this is Amy Yao. I am actually in San Francisco and I don't know who is further north than me but I am the Chief Actuary from Blue Shield of California.

CHAIR DEGHETALDI: Great. Then who is next? Sorry I did the

geography thing.

MEMBER COFFIN: I'll go, I am slight to the east there. Scott Coffin, CEO for Alameda Alliance for Health in Oakland.

CHAIR DEGHETALDI: Next?

MEMBER COURSOLLE: I can take us back down. This is Abbi Coursolle, Senior Attorney with the National Health Law Program based in LA.

CHAIR DEGHETALDI: Great Abb. Your audio is a little bit crackly but we did, I did hear.

I think Dr. Mazer is not going to be able to join us; as Dr. Rideout also won't be able to.

So I am Larry DeGhetaldi and I am a physician based in Santa Cruz and I am currently involved with health equity, quality and public affairs for Sutter Health.

Did we miss anybody? I can't see the full roster. I think that's it.

MEMBER WATANABE: I think that's it for the Board.

CHAIR DEGHETALDI: Well let me -- a couple of tributes. I have known Ted Mazer for 20 years, feisty and a patient advocate and an advocate for physicians. He has been just a marvel. And I believe he will be, because he has moved to Florida, he will no longer be with the Board next year. And I know, Mary, you will comment on recruitment. But I just -- and maybe, Paul, you could comment on what it is like to have been, to work in a county where you have a Ted Mazer and what a hole he will leave for San Diego.

MEMBER DURR: Yes, I think you said it well, Larry, is that what Ted brings is the physician voice. Always first and foremost representing the needs of the physician in any setting and recognizing the value that they bring to

the community. So his voice through not only here locally in San Diego but through the CMA and then also with FSSB has been a great advocate for the physician side of making this health ecosystem work very well and representing the providers on the ground. So he will be missed but never forgotten for the great work that he has done to pave the way for future physician involvement in the health care policy direction setting.

CHAIR DEGHETALDI: Thanks, Paul. And I'd also like to call out, I think we did a couple of years ago, on the eve of her retirement from public service, Congresswoman Jackie Speier. And as you -- you may not remember but it was Jackie, in her time as a state senator, she spent eight years as a county supervisor in San Mateo County, ten years in the assembly, I think eight years in the State Senate where she essentially was the -- was responsible for the legislation that established the FSSB. And then for the past 14 years she has been representing parts of San Francisco and much of San Mateo County in Congress. And she will be leaving office in early January, and I just wanted to acknowledge her again.

Let me just share just a brief personal story about her. My mother and her worked for a couple of decades on health issues in San Mateo County. And my mother on just about her 98th birthday was -- right on the eve of the 2016 election, wanted to hang onto her mail ballot. And I asked her, why are you waiting? It is the day before the election. Well, Jackie Speier is going to come visit me. This was the day before the 2016 election. And she held her ballot out in front of the congresswoman and said, Jackie, I was born, my mother did not have the right to vote. I want you to look at my ballot and notice that I am voting for a woman for Congress, a woman for Senate and a woman for President. This

fulfills my life. And the two ladies became very emotional. So I have a soft spot for Jackie Speier. So thanks for that.

Okay. Let me move to the second item on the agenda and ask for comments on the excellent transcript and meeting summary from August 10. Any comments or corrections from the Board?

Hearing none, I would love a motion to accept the minutes.

MEMBER DURR: Motion to approve.

CHAIR DEGHETALDI: And second?

MEMBER COFFIN: Second.

CHAIR DEGHETALDI: Anyone opposed?

(No audible response.)

CHAIR DEGHETALDI: Great.

Mary, let's move to Director's Remarks.

MEMBER WATANABE: Thank you, Larry; and thank you for the tributes both to Congresswoman Jackie Speier and to Dr. Mazer. We will talk about the solicitation in a minute but really have appreciated Dr. Mazer's perspective that he has brought to the Board and pushed us to update and revise our reporting and really focus on accountability. So I just appreciate the valuable contribution that he has made to the Board and he'll be missed but wish him the best in his transition that he is taking at this point in his life.

I do want to just take a minute to introduce our DMHC staff that we have with us today. So we have, as always, Pritika Dutt, our Deputy Director for the Office of Financial Review. We have Michelle Yamanaka, our Supervising Examiner in the Office of Financial Review. We also have Amanda Levy, our Health Policy and Stakeholder Relations Deputy Director who joins us annually,

usually to talk about legislation. And we have got a lot of health care related legislation that was signed by the governor this year so Amanda will be talking about some of the new work coming towards the Department. And then we also have, let's see, Jordan Stout and I think Leslie Thompson with us today providing administrative support. So appreciate all the work that goes into preparing for these meetings.

And then I will just note, I am really excited to have Vishaal Pegany join us today from the Department of Health Care Access and Information to talk about some of the Department's initiatives and the Office of Health Care Affordability. I had the pleasure of working very closely with Vishaal over the last, I don't know, maybe year or so, he was our Assistant Secretary at the California Health and Human Services Agency. Prior to that he was at Covered California and has just been doing a tremendous amount of work on health care policy, and particularly on the Office of Health Care Affordability for the last three years. So I know this is a presentation the Board has been asking for and we are very much looking forward to that discussion later in our agenda.

So I have just a few brief updates. I think as we have been talking throughout this year, one of our really priority initiatives has been the Health Equity and Quality Committee. The committee had their final meeting in September. We wrapped up with kind of a review of the draft report. And the meetings really since our last Board meeting focused on the benchmarks.

As I mentioned at our last meeting, the committee reached consensus on recommending 13 measures. This included 12 Health Care Effectiveness Data and Information Set or HEDIS measures and one Consumer Assessment of Healthcare Providers and Systems or a CAHPS survey consumer

satisfaction measure related to getting needed care. Of those 13 measures, 9 of the measures already require stratification by race and ethnicity by NCQA; and the committee recommended that the additional four measures also be stratified by race and ethnicity using the National Committee for Quality Assurance or NCQA race and ethnicity reporting methodology.

The committee had a robust discussion on where to set the benchmark. Again, this is, this is a very kind of innovative approach to take a regulatory approach and enforce benchmarks. And they reached consensus on using the annually adjusted Quality Compass data from NCQA and there was strong support that we should apply the same standard regardless of line of business, whether that's medical or commercial, and they recommended using the national Medicaid performance scores in setting the benchmark.

However, the committee has left me with a very difficult decision because they did not reach consensus on which percentile to use. The committee was evenly split in recommending either the national 25th percentile or the 50th percentile. There was some discussion about kind of splitting it in the middle and using the 33 and a third. But that, you know, there is a very split recommendation on where we land with that. So a lot that I am still considering. More discussions are happening about what that means, the difference between the 25th and the 50th with this regulatory and kind of enforcement approach.

A summary of the committee meetings and the recommendations have been summarized in a report that is in final review. We shared the draft report at the September committee meeting; actually received quite a bit of public comment as well as comment and feedback from the committee which has been incorporated. We are expecting to release that soon.

In addition, we expect to release guidance to the plans on the measures that will be reported for Measurement Year 2023 as well as more guidance on the stratification and benchmark.

2024 will be the first year that this data is submitted to the Department and we will publish our first annual report in 2025.

So again, this is really innovative, exciting work that we will be doing and we will continue to share information out with the Board as that evolves.

The last update I have is really just related to regulations. We normally have Sarah Ream join us to do an update on regulation, federal activity. But we didn't have a whole lot of updates and wanted to allow enough time for a robust discussion about the Office of Health Care Affordability so I am just going to provide a few updates on a couple of regulations that have gone through at least one round of informal stakeholder feedback and will begin formal rulemaking probably by the end of this year or early into next year.

The first one is AB 72, which was around surprise balance billing. We are making a change to align with the guidance from the Department of Insurance to include an inflator in the average contracted rate, updated at a regular interval. So this is a fairly minor change but something I know that particularly our physicians are interested in.

The big one is probably what most people are waiting for is related to SB 55, which relates to implementation of mental health and substance use disorder coverage requirements. The bill required plans to follow the most recent criteria and guidelines developed by the nonprofit association for the relevant clinical specialty when conducting utilization review and for arranging and

required the plans to arrange for out-of-network services when in-network care is unavailable. So we have had a lot of stakeholder engagement and review on that regulation and we are hoping to have that out for public comment by the end of the year.

The next one is iatrogenic fertility preservation, which will require plans to cover fertility preservation treatments when a covered health care treatment may directly or indirectly cause infertility. This is another one where we have had a lot of discussions with plans and stakeholders on that regulation and that should be coming up soon as well.

And then the final one, I think I have been talking about this one for seven and a half years, which is related to provider directories and SB 137 Implementation. This regulation will put into formal regs many of the processes and requirements the DMHC has required for several years through guidance. We are also reviewing the No Surprises Act and how that will impact the regulation as well. So this one we will probably start formal rulemaking in the early part of next year, I am not sure we have enough time to squeeze in four regulation packages by the end of the year. But that is another one to keep an eye out for.

And I think that is it for my updates but I am happy to take any questions from the Board or members of the public. With that I will turn it over to you, Larry.

CHAIR DEGHETALDI: Yes, sure. Please, let's start with Board Members, if you have any questions on Mary's report. Jordan, I don't see any hands raised.

Mary, I do have a clarifying question. On the selection of the P-25

or P-50 you said all lines of business, or is it the national Medicaid P-25 and P-50?

MEMBER WATANABE: So the committee's recommendation was to use the national Medicaid performance, but where they were split is whether that's the 25th percentile or the 50th percentile.

CHAIR DEGHETALDI: Got it.

MEMBER WATANABE: And I should just note, I think, you know, one area of concern that we heard from both the plans, from the physicians, those that kind of understand the quality space, is it is one thing to achieve that at the aggregate level, but when you look by subgroup by race and ethnicity there is some concern that the 50th percentile would be unattainable for all plans and so we would be taking enforcement action against all plans. And so I think, you know, we absolutely want to move the needle and raise the bar for all groups and make sure everybody has access to care, but that was probably the biggest point of kind of disagreement between the 25th and the 50th. When you look by subgroups, you know, that could be very challenging.

CHAIR DEGHETALDI: And one other question. Is this patient-reported race and ethnicity data that we will be using or some other demographic tool to identify the race and ethnicity of the patients that we serve?

MEMBER WATANABE: Yes. So we did not necessarily get into a lot of discussion about how that, how that will be reported. I will say that the goal is to have patient-reported ultimately, we'd like to have patient-reported data on race and ethnicity. I will also just note that there was a lot of discussion at the committee about the need to have more robust demographic data beyond just race and ethnicity and language, around disability status, sexual orientation and

gender identity. There's a lot happening nationally, as well as in California, with the Data Exchange Framework. So the goal would be as that data becomes available and more robust that we would have the ability to further stratify those measures by other demographic factors. But this -- we repeatedly, you know, reiterated, this is an equity initiative, it is not just about quality, so at a minimum we will be looking to stratify by race and ethnicity using the NCQA methodology.

CHAIR DEGHETALDI: Scott.

MEMBER COFFIN: Thank you. Dr. Watanabe -- Mary, you are now a doctor. All right.

MEMBER WATANABE: I am not a doctor or an attorney, despite many people's assumptions about that, that I am.

MEMBER COFFIN: Let me start over. Okay. So I wanted to point out something that the Local Health Plans of California is talking about with the Department of Health Care Services. And it ties in with quality and it is really about the intersection of the health outcomes and that intersection with geography. So when we look at our quality scores they vary as we look at the socioeconomic, the demographic factors, you know, just again, the geography has an effect on these quality scores. And so we are working with the Department of Health Care Services and would invite a conversation too with the DMHC just to make sure we are all on the same page about that correlation of how health factors tie in to quality scores and would ask the Department to also consider that.

MEMBER WATANABE: Yes, no, I appreciate that, Scott. We have actually been, we have worked very closely with both DHCS and Covered California because this is new work for us. And one, we want to make sure we

are aligning as closely as we can with what they are doing but also learning from their experience. You know, I think that it is another factor that we, that I am considering very seriously as we set the benchmark. Because if we are not considering the geographic variation, the social determinants of health, you know, where do you set a benchmark that, you know, in some ways captures all of that?

So, you know, this is, this is new. In some ways we will be trying some things and maybe make some adjustments. But yes, I am excited about the work that's happening both at DMHC but there is a lot happening also with DHCS and Covered California and CalPERS. I think there is some hope that we will actually be able to move the needle on quality and addressing disparities; but appreciate your comment.

MEMBER COFFIN: Great. And I will make sure in whatever forums we are having that you and your leadership team are aware so that it would really make sense to share this information about how we consider geography into the quality scoring.

MEMBER WATANABE: Absolutely, thank you.

MEMBER COFFIN: Thank you.

CHAIR DEGHETALDI: Any other Board comments or questions?

And I just want to, Scott, thank you for bringing up geography because it raises the concerns that not all patients, even in the, in the Medi-Cal space, have the same access or ability to, you know, have a provider, to get to see the provider. And Mary, you are spot on, it is more than race or ethnicity, it is where you live --

MEMBER COFFIN: Yes.

CHAIR DEGHETALDI: It is your disability status. And I would, I would just love to see a day when all Californians had the same P-50 target, not just that defined, you know, for the Medicaid national population, anyway.

Jordan, any comments from the public on Mary's report here?

MR. STOUT: There are none at this time.

CHAIR DEGHETALDI: Fabulous. So, Mary, let's hear about Agenda item 4, Board Member Solicitation.

MEMBER WATANABE: Yes. So with Dr. Mazer's exit from the Board, I will just note that his three year term was up at the end of this year so it wasn't just his relocation, we will be releasing a solicitation looking for applicants to participate as a Board Member. Board Members serve three year terms. There will be information that will be released in a solicitation after this meeting about kind of the criteria of what we are looking for. I will just say I would be really happy to have another physician serving on the Board. I think Dr. Mazer brought a unique perspective that really kind of helped to round out our other participants on the Board. So I will make a plug for that for those of you that work with physicians or know someone that may be interested. We are going to have a filing due date, I believe, it is of December 19, so we will allow about a month for applications to come in. But our hope is that we will be able to have our new Board Member join us at our, I believe it is February Board meeting, so the first meeting of 2023.

So that is the update, happy to take any questions. There will be contact information, I think for Jordan Stout, who can help respond to any questions that anybody has about the solicitation, but please share if you know someone that would be interested. And that's it. Happy to take questions from

the Board or the public if there's any.

CHAIR DEGHETALDI: I think we have none.

Any, Jordan, from the public?

MR. STOUT: None from the public.

CHAIR DEGHETALDI: Great. Just somebody who is less of a troublemaker than Dr. Mazer, perhaps, Mary, if that's possible. Or that's easy, actually. (Laughter.) Okay.

So this this next topic we asked, we talked about at I think our last meeting. And I just want to say, and call me a nerd, but population health data and having access to patient data that allows health systems in the state of California to drive to higher levels of value, lower per capita expenditures, better patient experience, better quality, better prevention, lower unnecessary use of EDs and facilities. That is the future. I am just so excited by the new, reinvigorated, reborn OSHPD. For those of you who read Tolkien, it is Gandalf the Grey becoming Gandalf the White. So I think Gandalf is here with us.

Vishaal, do you want to -- Mary, you already introduced Vishaal but I am super excited. We set aside, Vishaal, 30 minutes, but please go longer as you see fit. You are going to have questions. And I just can't say how excited I am personally for your work and what you are going to share.

MR. PEGANY: Thank you, Larry. I look forward to giving this presentation and answering any questions.

So I am here to -- if somebody could turn to the next slide. So today I will be going over the transition from OSHPD to HCAI and kind of, you know, the direction HCAI is heading and some of the context for the Office of Health Care Affordability.

And then I will give an overview of the Office itself and the key provisions. Some of the milestones we want to achieve during the first two years. And then also since we have new, new concepts for total health care spending and how to measure it, I am going to go over some of the distinctions between what OHCA is going to be reporting in data and then what the HPD is going to be collecting and reporting as well. Next slide please.

So, you know, many of you are familiar with HCAI historically as OSHPD. In the 2021 Budget Act it transitioned to a renaming and rebranding as the Department of Health Care Access and Information. This was done to reflect its growing portfolio and have a more descriptive name. Historically, OSHPD has been known for its data assets on health facilities, utilization data, financials and such, and then also being the hospital building department for seismic compliance. Next slide, please.

So here's the vision for the Department. It is to have a healthier California where all receive equitable, affordable and quality care. It is consistent with the agency vision as well for Health and Human Services. Next slide.

So HCAI also updated its mission. So the current mission is to expand equitable access to affordable health care for all Californians through resilient facilities, actionable information, and the health workforce each community needs. Next slide.

So this is a slide laying out all the program areas of HCAI ;it is pretty vast. You know, historically it has been focused on facilities, as I mentioned.

And it has a few niche programs known as the Cal Mortgage program, which allows nonprofit healthcare facilities to tap into loan insurance

which improves their ability to get new facilities constructed or expand services.

And OSHPD also has a large workforce portfolio to promote a culturally competent and diverse healthcare workforce. In the last budget alone there were significant investments to expand the primary care workforce, nurses and other professions.

So as I mentioned earlier, data assets and making data available for health facilities, for stakeholders and the healthcare industry and for researchers, that's kind of been OSHPD or HCAI's wheelhouse. So because of kind of the data activities of HCAI and then also the HPD, which is the Healthcare Payments Database, which is the state's all payer claims database. Because HCAI was administering those programs there is a lot of synergy with the Office of Health Care Affordability and that was the reason it was placed within HCAI.

In terms of affordability, this new responsibility that HCAI has for affordability programs, it would be to analyze healthcare cost trends, drivers of spending, enforcing cost targets, and then also addressing drivers of costs, which include market consolidation. Next slide.

So I want to lay out some of the context for why, you know, the legislature and the administration enacted an Office of Health Care Affordability. I won't spend too much on it since I don't need to kind of make the value proposition or business case. But I will just kind of, just to lay the context I will go over a few data points. Next slide.

So, you know, many of us have seen this slide about health care spending at the national level consuming about a fifth of our economy. So in 1970 it was 7% of GDP and since then it is grown to 20%. Many factors, you know, driving up the spending including prices, coverage expansion and such.

So just in the last -- you know, this shows a percentage in terms of GDP. But in terms of dollar amounts, in the last 20 years alone since 2000, healthcare spending has grown fourfold from 1 trillion in 2000 to over 4 trillion in 2020. Next slide, please.

So in terms of the impact to California families, CHCF has done some great work on surveys. And, you know, it may be a little difficult to see the slide but I do want to call out some of the statistics here from their research, from their survey findings.

Half of Californians and fully two-thirds of those with lower incomes, so lower income is defined as less than 200% FPL, report that they themselves or a family member skipped or delayed at least one kind of health care service due to cost in the past 12 months.

And then among those that report skipping or delaying care due to cost, about half report that their conditions worsened as a result. Next slide. One more, please. Thanks.

So in July as part of the Budget Act, in Senate Bill 184, which is the health trailer bill that was part of the budget, it included authorization for establishing the Office of Health Care Affordability within HCAI.

So California joined nine other states that have developed statewide initiatives to address health care costs in terms of a state cost target program. There are some numbers that have been reported that with California joining, as high as 20% of Americans live in, live in a state that has a cost target program, with California's entry.

So the state that is, you know, most well-known and has the most well developed program is Massachusetts, they have a Health Policy

Commission. Since then, you know, other states have expanded. You know, a few that are shown on here are Connecticut, Rhode Island, Delaware has a program, and then on the West Coast, Oregon, Washington and Nevada.

And then in terms of our approach for a cost target program, it is described as one of the most comprehensive programs. It is not just focused on transparency, like Massachusetts' program, but it does have enforceable cost targets that do allow for a progressive enforcement approach that does include penalties. Next slide.

So just wanted to kind of lay out kind of a few high level points before I dive into the specifics.

So as I mentioned earlier, OHCA is going to examine cost trends, drivers of spending, enforce targets and then address proposed healthcare consolidations. And then the process itself is referred to as a cost and market impact review and it is very much modeled after the approach in Massachusetts and Oregon as well.

OHCA is going to have a decision-making board. It is going to be a panel of experts that are going to serve on this Board that don't include active market participants. So the appointing authorities are making decisions about who will sit on that Board. They are going to not only advise on key activities and give input to the process but they also have approval for specific components such as what the values of those cost targets are going to be.

And the last point I want to make here is that we don't want to focus just on costs alone. The goal isn't just to simply have a low cost system. We also want to monitor other important metrics such as the quality and equity of care, the level of investments being made in primary care and behavioral health,

shifting the system away from fee for service, payments that reward volume and orient them towards APNs and other value-based payments. And then also make sure that, you know, this was a concern brought up along the way, that cost targets aren't achieved to the detriment of frontline health care workers. So being able to ensure that we have some way to monitor and make sure that health care entities are achieving cost containment without harming the workforce. Next slide.

So these are kind of the three major buckets for OHCA's work.

So the first one is manage cost growth. So the Office is going to need to collect data and analyze data on total health care spending. This is a new acronym we are going to be using is Total Health Care Expenditures. And I will be going over in a later slide what the components are for that. And it is important to call out that this would be data reported by the payers on total health care expenditures. And I will also go over who the cost targets apply to as well in a later slide.

But in addition to collecting data the Office is going to need to develop a cost target methodology. And then also, you know, what are the cost targets? What is the numeric value for those cost targets? So based on other states that have set up a methodology and a cost target setting process, this is going to involve the Office doing the day-to-day work in terms of developing a methodology, workshopping it with stakeholders, getting input from an advisory committee that is established in statute, and then moving up those recommendations for consideration by the board.

So the cost target methodology is going to need to consider, you know, trends in health care spending. You know, historical trends in terms of

Medicare spending, Commercial, Medicaid. Take all those inputs and also input some other economic indicators such as GDP growth. And then take all those various -- but it is also, you know, trends in labor, demand for health care workers and then, you know, all the recent activities in inflation. And take all those inputs to set a cost target. The first one would be set in 2025; it would be a reporting year only. The target would be for growth and per capita health care spending. So other states have typically set it in the range of 3 to 4%. And, you know, some have set it on an annual basis and others set it for a multiyear period. So, you know, these decisions are pending and a lot of design decisions need to be made and it will all be a public process to lay all that out.

So initially there is going to be a statewide target. So this would apply to health care entities, which include payers, providers and fully integrated delivery systems. And OHCA is unique because it has the authority to also set sector-specific targets. This wouldn't happen until later on in terms of the timeline. So that statewide cost target I mentioned, 2025 would be the first year. It would be a reporting year, we wouldn't take any enforcement on it. 2026 would be the first enforceable year. And then I will be walking over kind of the timelines for enforcement because there is a data lag associated with collecting and reporting the data.

Going back to sector specific targets. So the idea here is that if we need to deviate from the statewide target and have kind of a more tailored approach for setting targets on different sectors in the industry, the Office would have the authority to do that. First we would need to define what those sectors are. So in 2028 it would define the sectors and then cost targets could be established starting with calendar year 2029. And I will go over progressive

enforcement in a later slide.

So the second bucket here is monitor system performance. So like I mentioned earlier, that we don't want to just report on costs alone but we also want to have quality and equity metrics to show that we could reduce per capita total health care expenditures but also maintain or improve the quality and equity of care. So for this component the Office is going to be collecting a subset of measures. The intent here isn't to establish new metrics, there is plenty of work being done by our sibling departments, various groups out there, like the Integrated Health Care Association, Federal Quality Reporting Program, so we could -- we have a pool of measures that are currently being used that we could pull from.

So another great part of OHCA is that we would have the authority to set benchmarks for primary care and behavioral health spending. So other states have adopted these types of initiatives, Oregon being the most prominent example. So this would be collecting -- that THCE term that I mentioned earlier, that's total health care expenditures, that would be the denominator. So we would need to set up a process to define, you know, how is primary care spending going to be counted. And there is a lot of great work that has already been done on types of provider settings in which primary care takes place, and then the procedure codes. So we think, you know, there's a few models out there that we could look to and then have a process to work with stakeholders to define a California-tailored approach.

And then the Office would also set goals for APM adoption. So we would report on -- have payers report data on what types of payments and kind of what buckets they fall under. The health care payments -- Health Care

Payment Learning & Action Network is a framework that some of you might be familiar with, the four categories that run the continuum of fee for service to category for population-based payments. Covered California does this with their QHPs for attachment one, so we'd want to look to those types of models for the approach that OHCA would take in this area.

And then lastly, for persistent performance, workforce stability is an area that we'd want to monitor to make sure that healthcare entities, you know, engage in cost reducing strategies that don't harm the workforce. And later, later on when we do start engaging in progressive enforcement, the performance improvement plans that we would approve, if an entity is found to be not achieving the cost target, we'd want to make sure that whatever they propose to the Office that it doesn't have a negative impact on workforce and access.

So the third bucket here I want to touch on is assessing market consolidation. So the intent here is to fill gaps in California's approach for market consolidation. DMHC has activities here when it involves a health care service plan. The attorney general has jurisdiction over the nonprofit hospitals. So the idea here is to fill in the gaps where certain types of transactions are being looked at. We kind of find out about them after the fact and, you know, there is evidence about market consolidation and its impact on prices.

So there would be a process similar to DMHC and the AG's office where entities would submit a notification. And we'd still need to define those thresholds for what would trigger a notification. And then based on the Office's review we would make an assessment about whether that transaction, whether that transaction could, you know, go ahead and not be looked at. And then if there is a concern about the transaction involving having a material change, that

would have a significant impact on competition costs, affordability quality, we would want to take a closer look at that. So the transaction wouldn't proceed until the Office completes its cost and market impact review and releases a public report.

I do want to be clear that the Office doesn't have the final thumbs down or thumbs up in terms of approving a transaction or placing conditions on it. Similar to the undertakings it is more about public transparency and there would be some components related to working with other regulators. So, you know, this could be working with DMHC if it involves a health care service plan and then also with the attorney general's office if there are some concerning trends we are seeing that we'd want to be happy in coordination with the attorney general's office if it needs to be escalated to them. Next slide, please. I think that was the previous slide.

So these are the three categories that are laid out in the statute for who is subject to the cost target. So while the Payer data is going to be used to report on how total health care expenditures are -- how performance on cost is being reported, we are going to report on report on it through payer data, but these are the entities that would need to comply with the cost target. So the payers on the left include the Commercial plans as well as public Medi-Cal managed care plans and such.

The Providers category here is also listed. Physician organizations. I will go over kind of the components for that in the next slide. But hospitals are listed here, outpatient hospital departments, and so on.

And then Fully Integrated Delivery System. This would be Kaiser, it would be the only entity that meets this definition. So because of its kind of

structure it is, it would still be held to the cost target. But in terms of its kind of integrated approach we would need to kind of have their data reported in a different way but they would still be held to the cost target. And I see a question and I am happy to answer.

MEMBER YAO: Oh, hi, this is Amy from Blue Shield. I know that one of the key drivers of the cost trend is pharmacy. And here I am not seeing pharmaceutical companies or PBMs as part of the scope so I am curious why they are not there?

MR. PEGANY: Yes, that's a really good question. So pharmacy spending, including specialty drug spending, it is going to be reported in the data for total health care expenditures. That is definitely, you know, health care spending. But in terms of the Office it wouldn't, you know, have a cost target applied to a drug manufacturer or a PBM because of the, you know, the federal government has jurisdiction over those types of entities. But their data will be included in total health care expenditures. And in terms of specialty drugs and kind of the trends we observe there, like the granular data for drug trends in specialty drugs and specific drugs, the HPD data wen it is in a state that's -- it is going to be substantially complete next year. But down the road OHCA is going to be able to do more deeper dives on, you know, if we are noticing a category of THCE for prescription drugs has grown significantly we'd want to know why and kind of what are the drivers. So the HPD will allow for that granular analysis and then also some of the, kind of the just the overall trends in the industry that we are observing. We will be able to kind of look at our HPD data to validate that. Next slide please.

So as I mentioned earlier, a Physician Organization, since it is a

pretty kind of large set of providers, we do define it a little more specifically. So, physician organization means RBOs, restricted health care service plans are limited, health care service plans, medical foundations. And then kind of medical group practices that have at least 25 physicians would be held to the cost target, you know.

And if the practice is found, has less than 25, you know, it could be an entity that has 10 physicians or there could be 24 positions, we could still bring them back in and hold them to the cost target if they are found to be a high-cost outlier. So, this would be looking at data such as the HPD. And if we find that their costs for the same services provided are substantially higher compared to the statewide average, the Office would make a determination that they are a high-cost outlier and should be held to the cost target.

And the last point about physician organizations. So currently RBOs report to DMHC, financial statements. So HCAI would have the authority to require additional classes of physician organizations to report audited financials. And if they don't do audited financials because of, you know, their size, we would have an alternative for a verified comprehensive financial statement. To reduce administrative burden we wouldn't require entities to report the same information to us again if DMHC, our sibling department, already has it. So there is some data sharing agreements in the statute and direction to the Office to work with sister departments to get certain data, should it need it. Next slide.

So this slide just kind of goes over, you know, the differences between the Advisory Committee and the Affordability Board. The Affordability Board, is a decision-making Board and the Advisory Committee gives input but

doesn't have any formal authority.

The Affordability Board would be the decision maker in terms of cost targets, both the statewide and the sector target.

They'd also approve key benchmarks for primary care such as primary care and behavioral health investments.

They would appoint the Advisory Committee Members. So there will be a process for them to receive nominations and then formally appoint those members.

And as I mentioned earlier, members of the Board may not receive compensation from health care entities. This is to prevent conflicts and also to make sure that, you know, regulated entities aren't in the position of setting the cost targets on themselves.

In terms of the composition, it would include eight members by statute. The Health and Human Services Secretary is on there and is a voting member, the CalPERS Chief Health Deputy is a nonvoting member and that's to get the purchaser perspective on the Board, four appointees from the Governor's Office and then one appointee each from the Assembly and Senate. And we have asked the appointing authorities to make their decisions by the end of the year. If they are able to complete it by that time, that will allow us to start our board meetings in February or March, around February of early next year.

And then on the right, you know, we definitely want the industry's input as well as other stakeholders like consumer advocates. To make this all work and, you know, any, you know, processes for data collection or the setting of cost targets, we want it to be informed by the approach of those being subject to the cost targets and also needing to comply with them in terms of data

submission. So the Advisory Committee would be able to also give input through the Committee, also to the Board during public comment as well. And it would include a wide representation of entities that are listed such as payers, providers, consumer advocates, and so on.

And then both are, both of these bodies are subject to the Bagley-Keene Open Meeting Act. Next slide.

So this is high level to your, to your milestones. I am the first hire for OHCA as a Deputy Director. So we are going to be hiring our leadership team in terms of the Assistant Deputies that will be in charge of those three areas I mentioned earlier.

We'd want to, by the end of the year, have our Board Members hopefully and named publicly.

We are doing a lot of implementation planning and bringing on contract resources, consultants that have worked with state cost target programs and can help us on the consolidation work as well.

And in 2023 we would convene the Board. There would be two, as well as the Advisory Committee.

There will be two major areas of focus, developing that cost target methodology and regulations development for collection of total health care expenditures.

And then for the cost an market impact reviews of proposed transactions, establishing regulations for notifications and, and timelines for when the Office needs to complete its, its review.

And in 2024 we want to give the industry significant lead time so we'd want to set the cost target. In statute there are certain timelines we need to

follow. So by March 1 of 2024 the Office would publish a proposed cost target for 2025. And then it would need -- the Board would need to finalize and approve a cost target by June 1st.

And then the other activities would include adopting APM targets, worked for stability standards, and then collecting some baseline data on 2022 and 2023. The baseline data would be collected but it wouldn't be used to set cost targets; it is more to get a snapshot of health care spending before the targets take effect.

And then in 2024 we'd also, in January we'd start receiving notifications of proposed market transactions. And the requirement in the statute is a 90 day notice. So January 1st we'd start receiving it for transactions that take place April 1 or later. Next slide.

So this is a slide laying out enforcement. Kind of the stepwise approach is in the blue box above. We really are, it is a progressive approach where we start with information sharing, technical assistance, and then we could compel public testimony at a public meeting, performance improvement plans, and then as a last resort, financial penalties.

So as I mentioned earlier, 2026 is going to be the first enforceable year. That target is going to get set sometime in -- according to those March-June timeframes, in 2025.

2026 is the first year of enforcement but we won't receive the data on what happened in 2026 until a good six to nine months later. So, you know, towards mid to end 2027 we'll have the data; we will need to analyze it.

And then sometime in 2028 we will be able to report on what happened in 2026. So there is a lag. It has a lot to do with data settling and

claims rollout. And so in 2028 depending on kind of how health care entities perform we could begin the progressive enforcement approach. Next slide.

These are just some resources. At your leisure you could consult these. Some major groups that are providing resources on cost target programs. Next slide.

We do -- for interested stakeholders please join our listserv. We are going to be communicating major updates through that channel.

We have an OHCA landing page on the HCAI website. It has frequently asked questions, links to the statute, a fact sheet, and then we will be posting our schedule for the Board meetings there as well. Next slide. Next slide.

So we get this question quite a bit. You know, we have a Healthcare Payments Database that's being developed. Like why, why do you need this whole kind of other set of requirements for data collection when you can do that all from the HPD? We get we get this question pretty often. But I do want to walk through some of the some of the differences and why the OHCA has a different approach for data collection.

So in terms of OHCA, the purpose is to measure cost growth from year to year, kind of what was the total health care expenditures.

And it is aggregate data that is collected from the payers.

The source is, you know, from their financial and accounting systems.

And then it is also an annual snapshot so there is going to be a defined period. And because this is a -- is a regulatory program and there needs to be a measurement period, so it is going to -- the Office is going to be

developing those specs for when data is submitted.

For the HPD it is really, it is a research database and it will be to research those more detailed questions because you could really get to granular claims level and encounter data and then eventually, you know, do financial analyses as well.

The source is claims and encounter data.

And then it is going to be a monthly submission so, you know, HPD data, as things get re-adjudicated, it could change and kind of be always kind of, you know, claims being added and such. Next slide.

So, total health care expenditures, it is a term I used a lot and I just want to kind of break it down for this group. So it does include about five components.

So fee for service payments is the first one. So that's essentially the claims payments.

Member cost-sharing. So payers would report how much consumers paid towards their cost-sharing, copayments, coinsurance, deductible.

And then capitation and APM. This bucket is essentially the non-claims payment so, it is going to include the capitation, shared savings, other types of incentives, APM payments. So the first three buckets are kind of the total medical expenses, kind of another way to think about it. You know, we highlighted this one in green because there is a lot of synergy with the HPD and we will need to coordinate since the HPD is also going to be laying out an approach for non-claims payment collection.

And then pharmacy rebates would also be collected that are, that

are, you know, on an aggregate basis. Just so that we could, you know, do that calculation where we offset kind of what the health plans receive for rebates.

And then administrative costs and profits at the health plan level would also be part of the calculation.

And this note in blue, rebates and admin costs and profits. It is in the THCE definition but it is it is not data that is being reported to the HPD. So this is kind of why we need this aggregate data submission because of some of the -- the HPD is not going to answer every area that's required to measure total health care spending. Next slide.

So this is just kind of a walkthrough of the distinctions between OHCA and HPD. As I mentioned earlier, the purpose of cost targets are to measure year to year change. We will break it out by, you know, high level categories so payers could report on, you know, inpatient, prescription drugs, et cetera. You know, that that will only tell you so much. It will just, you know, inpatient spending is going up in both dollar amount and percentage but you won't really know kind of why. So you will really need to go to the HPD to do that, that deeper dive on, you know, is it intensity of services, is it utilization going up, and such.

So a typical, like a kind of a simplified way of kind of understanding this is like, as I mentioned earlier, like, spending changes from one year to the next could be determined from the THCE data. But if we really want to know like what, what was the average cost of a hip replacement in different areas of the state, the THCE data wouldn't tell us that, we would need to go to a lot more granular source such as the HPD.

And then in terms of timeline, you know, those are laid out right

there in terms of some of the reporting for OHCA. And then for the HPD, it is going to start reporting some initial reports, some analytic reports, starting in 2023 on leveraging medical and pharmacy claims and encounters. And then there is a phased implementation to work with the Advisory Committee to add capitation and other non-claims data to the HPD. Next slide.

So that concludes kind of my presentation. I am happy to answer any questions.

CHAIR DEGHETALDI: Vishaal, thank you, this is fabulous. This is exactly I think what we wanted. I see an actuary hand up, no surprise.

MEMBER YAO: Yes. Thank you for this comprehensive overview. I really love the mission and very much aligned with our mission at Blue Shield. So we had affordability target setting for the past four or five years already so I just want to share a little bit of our learning. So at the beginning we had set an affordability target in aggregate as well. But quickly we realized the median income level and cost of living varies dramatically by region so we ended up going down to a much more granular level. Because when you think about affordability, it is not total cost of health care, it is total cost of health care as a percentage of the income, whether that's still affordable for you or not. So I just wanted to share that thought. To full understand at the beginning why we want to just set it at the aggregate level, but maybe considering the regional differences and population differences truly to make the matrix meaningful.

MR. PEGANY: Thank you, Amy. So were those -- for the work that Blue Shield did, was it as affordability targets, like a premium as a percentage of their income?

MEMBER YAO: Yes.

MR. PEGANY: Okay.

MEMBER YAO: It is a premium class number (overlapping) cost-sharing, and then divided by median income. We have it by region, by different type populations, Medi-Cal, Medicare, Commercial. We will have it by different products. We have like 50 to 60 little cells (overlapping).

MR. PEGANY: Yes, we'd be interested in learning more about that.

MEMBER YAO: Yes, absolutely, yes, I'd love to share.

MR. PEGANY: But to your point about kind of the regional variation. That's kind of why some of the provisions were built in for sector targets; if it is determined, you know, we need to focus on certain geographic regions. And the sectors could even include individual health care entities and can, you know, if a more tailored approach needs to be taken.

CHAIR DEGHETALDI: Paul.

MEMBER DURR: Yes, Vishaal, great presentation, as always. I think you are doing a wonderful job from my perspective. And being an employee of one in that group it is really hard to to keep that journey on in which you are doing a great job.

The thing that I would ask Mary and team is that, you know, we make sure that you keep coming to the FSSB for routine updates. Because I think as this kind of further gets developed it is going to be important for us to keep tabs on that because of the impact to our delegated medical groups. And just knowing where health plans will likely go is to try to reduce the cost to delegated medical groups, which are using that revenue stream, as you know, to cross-subsidize the underpayments that providers have for Medicare and Medi-Cal. So as this gets developed, I mean, you are you are at this level, which is

fabulous, and you do a wonderful job of presenting it. I just would encourage there to be more dialogue with FSSB and Mary and the team here that we have continued input or at least knowledge of what you are doing. Obviously, the Board is going to make the decisions but I think it is important about the downstream impact of that. So thank you for your wonderful presentation, your calm demeanor and approach to this, I appreciate that.

MR. PEGANY: Thank you.

CHAIR DEGHETALDI: And Abbi.

MEMBER COURSOLLE: Thanks. Yes. And Vishaal, I echo my colleagues in thanking you for the presentation; that was extremely interesting and really helpful to learn more about what you all are doing. I wanted to go back to what you talked about a little earlier in your presentation about the cost target and data reporting for physician organizations. And just also sort of building off what Paul just commented, wondering how much of the data that you all are collecting will be reported in some public way and if you -- I realize it is still pretty early on, but if you have any thoughts about what that might look like or how you may be sharing this data more broadly?

MR. PEGANY: Yes, yes, we will be putting out public reports. There is a requirement for an annual report where we publicly report on performance. So I could send DMHC a few links to Massachusetts as some of the examples of the reports that have come out from other states and we would do similar types of reporting.

CHAIR DEGHETALDI: Any other Board? I do have a couple of questions, Vishaal, and again, it's fabulous. Somewhere between six and seven million Californians are covered by self-funded or ERISA sponsored plans. Does

this statute have authority over those plans? And if not, will we just, you know, request reporting on a voluntary basis?

MR. PEGANY: Yes, that's a good question. Other states have been pretty successful in getting the self-funded payers to report the data. It just tends to be a, you know, a high profile kind of activity for states. And employers are also very interested in holding down health care costs so we are hoping to get the participation of self-insured plans. The HPD has done a lot of engagement of the self-insured stakeholders so we are hoping to kind of mimic some of that success and get a lot of cooperation. But in terms of like a, you know, given that they are governed by ERISA we don't have a direct lever, but we do hope to get their participation.

CHAIR DEGHETALDI: Great. And one other question. Later in our agenda we will discuss, as we do annually, or review, risk adjustment transfers. Which for the small and individual group markets really are a normalizing factor to not discourage plans and providers eventually from caring for higher risk populations. I didn't hear discussion about risk adjustment. Because one way to look for a provider organization or even a health plan to avoid healthcare inflation is to not take care of the more complex Californians geographically, you know, or clinically, or from social determinant perspective. Is risk adjustment in your, in your scope to ensure that we don't dis-incentivize the care for people that need care the most?

MR. PEGANY: Yes, that's -- yes, I didn't mention in my remarks, but the statute itself for the methodology of the -- for how we are going to report THCE, there are provisions for risk adjustment methodologies. So other states have -- there is kind of a wide range of approaches. Other states are kind of

letting the payers kind of -- as long as they are using the same methodology year to year they are letting the payers do it. Others are, you know, giving some guidance in terms of what tools they should use, or, you know, which factors to look at. So our statute kind of leaves it up to the Office and then the Board to approve a risk adjustment methodology.

CHAIR DEGHETALDI: Okay.

MR. PEGANY: And then -- that will be important if we are going to be comparing kind of payer groups.

CHAIR DEGHETALDI: Sure.

MR. PEGANY: And then in Massachusetts they describe it as risk adjusted total medical expense when they are, they are comparing physician organizations against one another. And then for we -- do have equity adjustments called out in the statute as well. This is an evolving area, it is not, you know, very well developed. So the thinking there is that if there is a provider that is serving a more vulnerable population the cost target shouldn't be a ceiling on how much they could spend. You know, there could be instances where a provider should be allowed to grow more where they could grow above the cost target. So we would need to develop a methodology for that and, you know, figure, to the extent that there is valid approaches out there.

CHAIR DEGHETALDI: Right.

MR. PEGANY: Kind of what comes to mind is kind of what the state did for COVID. Kind of opening up certain counties was, you know, the testing positivity rates needed to be improved in the lowest quartile census tracts. So there are some kind of, kind of new models out there that we could look at and then, you know, whatever else is out there in the literature and being done

we'd want to understand better.

CHAIR DEGHETALDI: Great.

Now let's, Jordan, I would be surprised if the public doesn't have a question or comment.

MR. STOUT: Yes, we have one comment from the public. When prompted please unmute yourself and state your full name and organization.

MR. BARCELLONA: Yes, hi, it is Bill Barcellona from APG. Just wanted to say thank you to Vishaal for the presentation today and just state again that America's Physician Groups is very supportive of the OHCA process and the HPD process. So thank you for your presentation.

MR. PEGANY: Thank you, Bill. Glad to have your support.

CHAIR DEGHETALDI: Jordan, any others?

MR. STOUT: There are none at this time.

CHAIR DEGHETALDI: This is fabulous. And you will be back, I assure you, if you would be so kind. Okay. Thank you. So let’s move to --

MR. PEGANY: Thank you.

CHAIR DEGHETALDI: Thank you. To Agenda Item 6, Pritika.

MS. DUTT: Good morning. I am Pritika Dutt, Deputy Director of the Office of Financial Review. I will provide you a quick update on the financial summary of the Medi-Cal Managed Care report for the quarter ended June 30, 2022. A copy of the comprehensive report is available on the public website under the Financial Solvency Standards Board section. My team prepares this report on a quarterly basis and we present it at the FSSB meeting twice a year. This report is prepared by DMHC, like I said, on a quarterly basis and it highlights enrollment and financial information for Local Initiatives, County Organized

Health Systems and Non-Governmental Medi-Cal plans. And we define Non-Governmental Medi-Cal plans as those plans that have greater than 50% Medi-Cal enrollment but are neither a Local Initiative or a County Organized Health System.

The report is divided into three distinct categories. First, focusing on Local Initiatives or LIs, the County Organized Health Systems or the COHS, and Non-Governmental Medi-Cal plans, which we refer to as NGMs in our report. Next slide.

So there are nine Local Initiative plans that serve over 6.1 million Medi-Cal beneficiaries in 14 counties. Our total enrollment increased by 2.7% compared to quarter. Since September 2020 all LIs have reported increases in enrollment. L.A. Care has the largest enrollment, Medi-Cal enrollment, with 2.5 million enrollees, and they had an increase of 2.5% increase since the last quarter. Overall, the LI plans' Medi-Cal enrollment increased by almost 628,000 enrollees since March of 2021.

The medical expenses remained relatively stable from March 2022 to June 2022. For the second quarter of 2022 the LI Local Initiatives reported total net income of $233 million. And the TNE to required TNE for the LI plans ranged from 543% 1005%, so all LIs met the DMHC's reserve requirement for tangible net equity. Next slide.

So there are six County Organized Health Systems or COHS plans that serve 22 counties.

We receive financial reports for five COHS. And as you may recall, Gold Coast does not report to the DMHC.

The five COHS that report to the DMHC serves over 2.3 million

Medi-Cal beneficiaries. All COHS plans experienced enrollment growth for the last six quarters. CalOptima and Partnership Health Plan reported the highest enrollment numbers compared to the prior quarter. COHS plans Medi-Cal enrollment increased by 62,000 lives.

For the second quarter of 2022 the COHS plans reported total net income of $21 million.

All COHS plans reported over 500% of required TNE for June 2002. And then TNE to required TNE ranged from 505% to 1340%. Next slide.

There are eight NGM plans that serve 3.8 million beneficiaries, Medi-Cal beneficiaries, in 37 counties. All NGM plans reported an increase in Medi-Cal enrollment in June 2022 compared to prior quarters.

For the second quarter of 2022, NGM plans reported total net income of $356 million.

TNE to required TNE ranged from 213% to 927%. And then for the NGM plans you will notice that the TNE to required TNE percentages are lower. Because some of them do pay out dividends so that drops their TNE. Next slide.

So some of the takeaways from this report. So enrollment for Medi-Cal plans. We saw that the Medi-Cal enrollment decreased from December of 2017 all the way through the first quarter of the pandemic, which was March 31, 2020 and then we saw an uptick in medical enrollment for these Medi-Cal plans. And we saw the same trends continue for 2021 and first half of 2022.

For the first half of 2022, LI, COHS and NGM plans experienced decreases in medical expenses due to carve out of Medi-Cal pharmacy expense effective January 1st of 2022. A majority of the Medi-Cal managed care plans reported net income at June 30, 2022. And the DMHC will continue to monitor

the enrollment trends and financial solvency of all LIs, COHS and NGM plans reporting to the DMHC.

So with that I will take any questions.

CHAIR DEGHETALDI: Any questions from the Board? Paul.

MEMBER DURR: Yes, thanks. Pritika, always a great presentation, I always find it very fascinating. One question or two questions that came to mind is, you know, looking at the enrollment increases, I am wondering if a helpful statistic would be the percentage that they represent of that area of the eligible patients or the population. So Medi-Cal, obviously with the increase in enrollment, one would think it is getting to be a greater percentage of all people living in that county. I was just thinking that that might be a good way of looking at it. I don't know how we'd do that but that was one thought. Just because it makes it more meaningful as to is it growing faster than the population is growing in that service area, is where I am going.

The other question I had, in looking at the financial reports I noticed in all of those that the revenue was decreasing in every quarter. In like the second quarter in March and in June that the revenue trend which was up went down for LIs, COHS and the expenses went down. Is there -- you mentioned pharmacy and I was thinking that might be a piece to in like the March reporting compared to what it was. Is there anything that you can take away from -- any takeaway that you had from the revenue trend decreasing?

MS. DUTT: Like I said, it could be attributed to Medi-Cal, the pharmacy expense. I don't know, Scott, if you have any insight into the decrease in revenues for the Medi-Cal plans?

MEMBER COFFIN: Well, I know, I know with the transition of the

pharmacy benefit on January 1st that certainly had an effect. You know, the plans retained the physician administered drug administration but a majority, again, of the over the counter, shifted over to the state. I am trying to also think what else changed at that time. You know, major organ transplant was added back in so that actually increased revenue and expense. But I think probably the pharmacy would be a significant contributor to that, that initial shift.

MEMBER DURR: That makes sense, Scott. Yes. Just I would have thought that would have run out through March but I guess we will just watch it over time. Thank you.

CHAIR DEGHETALDI: Abbi.

MEMBER COURSOLLE: Thank you. Yes, just sort of building off this line of questioning. And we may not know, have answers for this yet, but obviously there are going to be really big changes coming to the Medi-Cal market in the next year. And I am just wondering, Pritika, if that's something that you all are starting to see or if there are particular trends that you are tracking, so we can understand, you know, how those shifts in the market are playing out and whether there are any areas for concern that we should really be looking at more closely?

MS. DUTT: So, Abbi, I think the change you are referring to hasn't hit yet. Of course, we are always tracking, always trending the financial information enrollment, as they are coming in. But we are looking at the changes and we are preparing for that. Just looking at the financial health of the health plans and, you know, making sure that the plans continue to meet compliance targets. And also like making sure we are keeping that open line of communication with the health plans and having those conversations, asking

those tougher questions of the health plans as we see any changes. Mary, anything to add from your perspective?

MEMBER WATANABE: Yes, no, no, I will just add, I mean, obviously, we are watching all of these changes unfolding and, you know, looking forward to see what happens and how everything lands over the next probably couple of months. I think from our perspective the thing we will be watching very closely is at some point there likely will be a transition, you know, as decisions get made. And we want to make sure that enrollees still have access in that time from when plans potentially start to wind down and we see enrollee transitions. We want to make sure the plans are still meeting their obligations under the law, have the administrative capacity to ensure enrollees have access. And obviously we will be monitoring the financial status as well. So, you know, I think there is a lot still up in the air. We are waiting for, you know, the outcome of decisions, potentially lawsuits, but we will be watching that closely. I am sure it will be a topic of discussion at our upcoming Board meetings over the next couple of years as well.

CHAIR DEGHETALDI: And this is maybe a Scott question, but from my perspective of watching these plans and serving on the Board for almost two decades, with the looming changes, Abbi, that you are describing from CalAIM, Whole Person Care, the duals transition, geographic expansion of many of the plans into counties that today they are not in, mandated transitions, penalties for quality underperformance. The plans are naturally incentivized to reserve, to be very conservative with their reserves, which puts downward pressure on provider rates, which puts downward pressure on patient access. And so this is all what's going on now. And frankly, I would just speak for the -- if

I was Dr. Mazer I would remind folks that the California physician Medi-Cal fee schedule has not been updated in a couple of decades. I am just very worried about all the changes being mandated and the plans have to absorb and patients may get caught with declining access. Scott, I don't know if I am being too worried here, you know.

MEMBER COFFIN: No, I think you have, you have coined it very well. Last week we hosted a discussion with officials from CMS Health and Human Services Agency as well as the Department of Health Care Services here in Alameda County. And one of the topics that was raised in this roundtable discussion was around, how do we attain better access, more timely access to care. And I shared, I shared with the officials that, you know, there are several strategies, you know, to be implemented, but one involves paying our doctors more and increasing the size of our provider network to create more choice. And to that end, you know, we have some follow-up appointments and discussions with CMS and the Region Nine in Baltimore officials as they want to understand more.

You know, the situation that was raised was the gap and the example was with professional services, the specialty access. You know, there is, there is a significant gap between the Medi-Cal reimbursement and the Medicare reimbursement rates, which is a struggle that all managed care organizations address. And quite frankly, it is, it is our doctors that bear the burden there of all the increasing costs and how to make Medi-Cal work in their practice. So it is something I have been working on the past eight years around payment equity. And since you bring it up I just share the we had a very encouraging conversation and I think we are going to create some momentum to

look at what doctors are being paid statewide.

CHAIR DEGHETALDI: Thank you.

MEMBER COFFIN: Yes.

CHAIR DEGHETALDI: Thank you, Scott.

Any other Board questions for Pritika?

Jordan, any from the public?

MR. STOUT: There are none at this time.

CHAIR DEGHETALDI: Well, great. Thank you so much, Pritika. As I recall, we hear that report twice a year, correct?

MS. DUTT: (Nodded).

CHAIR DEGHETALDI: Great, thank you.

Now, I think it is Amanda's turn. Mary, is that, is that correct?

MEMBER WATANABE: That is correct. She has a lot of new bills to update us on.

CHAIR DEGHETALDI: Oh, wow. Okay, hold on, here we go.

MS. LEVY: Great. Well, good morning and thank you all for having me here today. As you are all aware, as Mary mentioned earlier, we had another very busy year, the near record number of bills to implement in the coming months. Most of the bills that I will be discussing here today have a January 1, 2023 implementation date. I will note when it is different than January 1, 2023. But the Department is currently working on guidance via All Plan Letters to issue before the end of the year. And as you will also see, there’s a lot of bills that we might need regulation packages on so we will be working on those packages and I am sure we will be discussing them at this meeting at later dates as we move forward to implement those bills. Next slide.

Great. Well, this is a first slide that contains some of the bills that we will be implementing in 2023 that I won't go into great detail over. As you can see, they cover a wide range of topics including telehealth disclosures, specified notices to dependent adults, cleanup to our timely access statute and regulations, restating DMHC authority in the state of emergency, maternal mental health programs, and updates to a plan's API or Application Programming Interfaces. These are all effective as of January 1, 2023, with the exception of our last bill, SB 1419, that has a January 2024 implementation date. And you will see most of these bills in our guidance, in our legislative implementation All Plan Letter that will be due, that will be out before the end of the year. Next slide.

Great. So we wanted to first talk in more detail, I think we have about eight to ten bills here that we will talk in greater detail, and we have grouped them if we can and this was one group that there was a lot of attention paid in the legislature this year. These are all bills related to abortion care. These all passed the legislature, signed by the governor and become effective on January 1, 2023.

AB 2134 by Assemblymember Weber establishes the California Reproductive Health Equity Program within the Department of Health Care Access and Information, or HCAI as we just heard from, to ensure abortion and contraceptive services are affordable and accessible to all individuals, and authorizes Medi-Cal enrolled providers to apply for grant funding through this program. The bill further requires a health plan or insurer that provides health coverage to employees of a religious employer that does not include abortion and contraceptive benefits or services, to provide enrollees with written information on excluded abortion and contraceptive benefits or services.

Next, AB 2205 by Assemblymember Carrillo requires a health care service plan offering products on the California Health Benefit Exchange to annually report the amount of funds held in a segregated account pursuant to the Hyde Amendment and the Affordable Care Act. This bill requires an annual report to include the ending balance of the account and the total dollar amount of claims paid during a reporting year. The bill requires plans to submit an accounting of monies federal law already requires them to segregate into a separate account.

And last on these bills, SB 245 by Senator Gonzalez requires all full service health plans to cover abortion and abortion-related services, including pre-abortion and follow-up services, without a copayment, deductible or any other form of cost-sharing. This bill prohibits health plans from imposing any delays on outpatient abortion services including prior authorization, utilization review and management, and annual or lifetime limits. This applies to all health plans licensed by the DMHC and health plan delegated entities. SB 245 also applies to Medi-Cal plans, except those provisions prohibiting annual or lifetime limits. Next slide please.

AB 988 by Assemblymember Bauer-Kahan creates the Miles Hall Lifeline and Suicide Prevention Act to establish 988 centers in the state as an alternative for 911 calls for behavioral health crises.

The bill requires the California Health and Human Services Agency to create a five year implementation plan for the 988 system to include funding strategies, including for DMHC plan reimbursement for medically necessary behavioral health crisis services.

This bill is timely. Federal legislation established 988 as the

national suicide prevention and mental health crisis number on July 16, 2022.

As I mentioned earlier, the bill specifies that health plans and insurers must reimburse 988 centers and mobile crisis units for the medically necessary treatment of a mental health or substance use disorder that they provide to a plan enrollee.

This bill had an urgency clause so it became effective immediately upon signing. Next slide.

Great. AB 2352 by Assemblymember Nazarian. This bill requires a health care service plan or health insurer to furnish specified information about a prescription drug upon request by an enrollee or insured or their prescribing provider. The intent behind this bill is to allow prescribing providers and patients to discuss drug cost at the time the drugs are being prescribed, to avoid situations where a provider prescribes a drug for an enrollee who then learns at the pharmacy that they cannot afford that particular drug.

The bill prohibits a health plan or insurer from restricting a prescribing provider from sharing the information furnished about the prescription drug or penalizing a provider for prescribing a lower cost drug.

This bill becomes effective July 1, 2023.

Great. AB 2581 by Assemblymember Salas relates to mental health and substance use disorder provider credentialing. This bill specifically requires health care service plans and health insurers that provide coverage for the treatment of mental health and substance use disorders, and that credential mental health providers, to complete the credentialing process within 60 days from the time the provider submits their completed credentialing application. The bill requires timely review of mental health providers' qualifications so that the

health plans and insurers can more quickly add them to their provider networks.

Further, the bill requires that health plans and insurers, upon receipt of the application, to notify the provider within seven business days, verify receipt, and confirm that their application is complete.

This bill comes into effect on January 1 2023.

SB 523 by Senator Leyva relates to contraceptive coverage expansion. This bill requires health plans to cover contraceptive drugs, devices and products for all enrollees without a prescription.

Enrollees would not be charged cost-sharing for over-the-counter contraceptives obtained at in-network pharmacies. Further in the bill, voluntary tubal ligation and vasectomy services and procedures would also have to be covered without cost-sharing.

This bill has a bit of a delayed implementation; it becomes effective January 1, 2024. The DMHC will likely be working on a regulation package to create a process by which an enrollee or a provider could request the plan cover an alternative prescribed contraceptive we will go into more detail on implementation of the bill. Next slide.

Great. SB 858 by Senator Wiener relates to corrective action plans and fines.

This bill revises the administrative and civil penalty provisions of the Knox-Keene Act and increases various specified penalty amounts assessed against health plans and others for violations of the Knox-Keene Act. It amends Health and Safety Code Section 1387 which states that persons violating the Knox-Keene Act are liable for a civil penalty of up to $2,500; it increases that amount to $25,000.

Further, the bill provides the DMHC with specific authority to impose corrective action plans.

This bill also has an effective date of January 1, 2023.

And a note: Beginning January 1, 2028 and every five years thereafter, the amount of the penalty as stated in the bill will be adjusted based on the average change in premium rates for the individual and small group markets, weighted by enrollment since the previous adjustment, so it contains that inflator. Next slide.

SB 923 also by Senator Weiner relates to gender-affirming care training. This bill requires health plan staff who are in direct contact with enrollees to complete evidence-based cultural competency training so that they can provide trans-inclusive health care to individuals who identify as transgender, gender diverse or intersex, abbreviated here as TGI. The bill creates a workgroup tasked with developing a quality standard for patient experience to measure cultural competency related to the TGI community, in addition to the workgroup recommending an appropriate training curriculum to provide trans-inclusive health care.

Further, this bill becomes effective on January 1 2023. There are many benchmarks and dates to meet a phased-in implementation to allow for the workgroup to meet. But beginning January 1, 2023, another provision of the bill, the DMHC will review gender identity-related complaints and must refer complaints to our civil rights department and determine if any enforcement action must be taken.

One last provision: No later than March 1, 2025 health plans would need to add information on gender-affirming service providers, accessible in

provider directories and call centers and health plans and at that time will need to comply with the training requirements that the workgroup will be working on. And the workgroup will convene no later than March 1, 2023 so coming up very soon here.

SB 1338 By Senator Umberg relates to CARE Court and I am going to talk specifically about the DMHC's role in the implementation of this bill.

Just a little bit of a more global view, the bill authorizes the creation and implementation of a court-ordered Community Assistance, Recovery and Empowerment or CARE plan for adults with untreated schizophrenia, schizophrenia spectrum and psychotic disorders who are in need of supports and services.

For DMHC, requires health plans to cover services for an enrollee pursuant to their CARE plan.

Implementation of the CARE Act would be staggered. Seven specified counties will begin implementation in October 2023 and the remaining counties will come online at the end of 2024, so December of 2024. And next slide.

SB 1473 By Senator Pan has two purposes, it relates to open enrollment and COVID-19 therapeutics.

This bill establishes an open enrollment period for products offered through Covered California from November 1 of the preceding calendar year to January 31 of the benefit year.

The bill also requires health plans to cover the cost of COVID-19 therapeutics, without cost-sharing, prior authorization, utilization management, or in-network requirements. Requires the health plans to cover cost-sharing for

screening, testing provided by an out-of-network provider for six months after the end of the federal public health emergency. I think the intent of this was to lower financial and administrative barriers to COVID-19 therapeutics and to mitigate harm to our public health caused by COVID-19.

This bill also had an urgency clause so it became effective immediately upon signing, so it is effective as of now. Next slide.

That brings us to questions so I am happy to take any questions.

CHAIR DEGHETALDI: Amanda, whirlwind, whirlwind, fabulous.

MS. LEVY: It's a lot. That was a brief overview of everything.

CHAIR DEGHETALDI: A brief overview. A little bit of legislative activity. (Laughter.)

MS. LEVY: Yes.

CHAIR DEGHETALDI: Any Board Members with questions?

MEMBER COFFIN: No, no questions. Just, I think, compliments to, you know, everyone that worked on all these important bills and driving them forward. They are, they are all for the right reasons and we are working very hard to comply with each one of them as we get ready.

MS. LEVY: Yes, our legislative team was very busy and did a tremendous amount of work this year so now we are --

MEMBER COFFIN: Pass along --

MS. LEVY: -- handing it over to implement.

MEMBER COFFIN: Please pass along the appreciation, a lot of work.

CHAIR DEGHETALDI: Jordan, from the public?

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

CHAIR DEGHETALDI: Excellent. So we will hear more in the future but let's I think then move back to Pritika and the risk adjustment transfer update.

MS. DUTT: Hello again. I will provide you an update on the 2021 risk adjustment transfers. Please refer to the report titled 2021 Risk Adjustment Transfers included as part of the meeting handout. The handout shows all the transfer amounts for California plans and insurers for 2021 and 2020.

The federal Affordable Care Act included three premium stabilization programs, risk corridor, reinsurance and risk adjustment. The risk corridor and reinsurance programs lasted from 2014 to 2016 and the risk adjustment program continues to date. The risk adjustment program transfers funds from lower risk plans in the individual and small group markets to higher risk plans both in and out of Exchange. The purpose of the program is to discourage cherry-picking the healthy population out there. The plans that end up with healthier populations must compensate plans that have more costly enrollees. Next slide.

For benefit year 2021, $1.44 billion was transferred between California plans and insurers.

Four DMHC health plans were on the receiving end. Blue Shield received $1.2 billion in risk adjustment transfers and Anthem Blue Cross received $126 million. Sharp received $11.5 million and Ventura County received $84,000. That's all for the receivers.

We had 13 DMHC health plans that ended up on the paying end, which was Aetna, Chinese Community, Health Net, Kaiser, L.A. Care, Molina, Oscar, Sutter, United Healthcare, the United Healthcare Benefits Plan, Valley

Health Plan and Western Health Advantage. So these 13 plans ended up paying into the program, with Kaiser paying the largest at $867 million.

Overall, the PPO plans ended up on the receiving end while the HMO plans ended up paying. The results have been consistent compared to previous years. The same plans on the receiving end and the same plans end up paying each year. Next. Thank you.

In 2018, CMS added a high-cost risk program, risk pool program, to the risk adjustment transfer methodology. The high-cost risk pool helped ensure that the risk adjustment transfers better reflect the average actuarial risk while also providing protection to issuers with exceptionally high-cost enrollees. To fund these payments the high-cost risk pool collects a small percentage of a health plan's total premium. The high-cost risk pool charge was 0.31% of premium for the individual market and 0.49% of premium for the small group market nationally. Again, so the charge was less than a penny for every dollar. The high-cost risk pool reimburses issuers, or health plans, for 60% of enrollees aggregated paid claims costs exceeding $1 million. So again, the program is to ensure that the health plans with high-cost enrollees get some help.

The DMHC-regulated plans received $212 million. Blue Shield received $98 million, Kaiser received $70 million and Anthem received $32.5 million. Next slide.

On this slide I will touch briefly on the impact of the risk adjustment transfer program on premium rates and medical loss ratio.

So risk adjustment transfers represent an average of 8% of premium. The amount of risk adjustment assumed in setting rates varies by plan depending partly on the relative risk score, which is the health status of its

members to the statewide average risk score. The 2021 risk adjustment transfers from CMS may be used by health plans to estimate their 2023 risk adjustment transfer amount that the plans use in their 2023 rate setting; and we will be talking about the individual rates for 2023 in the next presentation.

Similar to others assumptions used in rate setting, an over or under estimate in risk adjustment payment or receivable may impact rates, profit, as well as the plans medical loss ratio.

For medical life loss ratio purposes, or MLR, if the plan receives risk adjustment payment from CMS, the plan's medical expenses decreases by that amount, hence reducing its MLR. And vice versa, meaning if the plan paid for risk adjustment, the payment increases the plan's medical expenses and it will increase their medical loss ratio.

With that, I will take any questions.

CHAIR DEGHETALDI: Any questions from the Board?

I don't see any. I typically ask each year we look at this if this is equitably prepared? This is brilliant public policy, in my opinion. And I will always ask Amy, do you feel that it was actuarially sound from the perspective of a receiver organization?

MEMBER YAO: Yes, okay. I am not going to speak on behalf of Blue Shield; I cannot as a Board Member.

CHAIR DEGHETALDI: Okay.

MEMBER YAO: Actually I will say for 2021, even though the model is there, but I do not think it is adequate for Blue Shield, for a couple of reasons, obviously. I think we are under the COVID environment so we -- we are the only -- Blue Shield is the only broad PPO network on the Exchange. We

absolutely attract the sickest members. Actually, the COVID -- in addition to that, under (indiscernible) and COVID there are a couple policies and also spear more anti-selection to Blue Shield's broad network. One is related to the year-round, basically, year round -- so we end up with many, many short-term members coming in for a couple of months, get the surgery done and leave. The other piece is the enhanced staff. So making it very easy. So even though the PPO network product is high priced, but after the subsidy it actually it is very affordable. So we have probably mis-proportional a greater share of both short-term tuition members. For those short-term tuition members you don't get compensated on the risk adjustment. You basically get compensated like 20 cents on the dollar. The coefficient factor is so, so, so low. Actually for 2021, as a result of that, we have material determination on the medical loss ratio for the individual product. So we want to continue to provide this broad network PPO product for Exchange members so a member can have a choice. But if we don't fix some of the issues, I do not know, it is definitely going to create a massive challenge. So I do have a suggestion in terms of how we report risk adjustment transfer money. Maybe we could also report it as a percentage of total cost of health care. If you look at the dollars, yes, it keeps going, but as a percentage of cost of health care, that really has decreased as a receiver.

CHAIR DEGHETALDI: Let me just publicly say, state Amy, I just value Blue Shield's commitment to higher risk patients staying in the PPO market, which you know, automatically has adverse selection built in.

MEMBER YAO: Yes.

CHAIR DEGHETALDI: So I just appreciate your insight on this.

I do have a question. CalOptima is planning to go into Covered

California?

MEMBER YAO: Not in 2023.

CHAIR DEGHETALDI: Yes, right. Will they be as -- if managed Medi-Cal plans enter Covered California will they be enrolling small individual group market members and be in the risk adjustment transfer pool?

MEMBER YAO: If they are joining the Covered California, yes, they will be covered.

CHAIR DEGHETALDI: Okay. Okay, thank you. Any other questions?

And, Jordan, any from the public?

MR. STOUT: There are none at this time.

CHAIR DEGHETALDI: Okay, then we go -- I think we are staying, we stay with Pritika.

MS. DUTT: Okay. So the purpose of this presentation is to provide you an update of the 2023 rates in the individual market. For this presentation you can also refer to the 2023 Rates in the Individual Market, the handout that was included with the meeting materials.

We received the 2023 individual rate filings from 14 health plans, but only 13 of the health plans are moving forward with offering products in the individual market. Universal Care or Bright submitted its rate for the Department's review. However, the plan withdrew from the individual market prior to the start of open enrollment for 2023.

The average rate change ranged from 11 -- let me back up. The average rate change ranged from 1.1% to 12.1%. Overall, the average rate increase was 6.6% across all health plans. The averages you see here may

differ slightly from what Covered California posted because the rate filings submitted to the DMHC also include, in addition to the on-Exchange products, it also includes the off-Exchange products.

Twelve health plans offer individual products on the Covered California Health Exchange.

Sutter Health plan offers all non-Exchange individual products.

Aetna Health Plan is a new plan on the Exchange for 2023 and will be in Rating Region 3, which is Sacramento, El Dorado, Yolo and Placer; and then Rating Region 11, Fresno, Kings and Madera.

The average premium ranged from $448 to $869 per member per month.

The next three slides show the final average rate change and projected enrollment for the remaining, the remaining nine plans. The list is sorted by plans with the highest average rate change to the lowest. Oscar has the highest average rate increase for 2023 at 12.1%. Go back to the -- there you go. So Oscar had the highest average rate increase for 2023 had 12.1%. However, Oscar had the second lowest average premium at $508.

Blue Shield has the most projected lives in the individual market and the average rate change for Blue Shield was 9.6%. Next slide.

Kaiser has the second highest projected lives in the individual market and the average rate change for Kaiser was 4%.

Sutter Health, which I mentioned earlier, offers all non-Exchange individual products and has a projected enrollment of 3,268 and an average annual increase of 3.3%. Next slide.

This slide shows the rate changes for the four health plans with the

lowest average rate change. L.A. Care has an average rate increase of 2% and has the lowest average rate at $448 per member per month.

Health Net has an average rate increase of 1.6%. Additionally, Health Net -- I wanted to point out, Health Net moves its PPO line of business from CDI to DMHC for 2023.

As mentioned earlier, Aetna is a new entrant in the individual market for 2023 and will be offering products on the Exchange.

And Universal Care will exit the individual market for 2023.

So this slide is not showing the four lowest, but rather showing the two plans with the lowest rate -- three plans with the lowest rate increase and then Aetna which is the new entrant and Universal Care which is exiting the individual market for 2023.

The rate changes are primarily driven by medical costs trends including merging and projected experience, changes in risk adjustment, administrative cost, projected profit after tax, COVID-19 impacts, benefit plan mix and anticipated changes in the market-wide health status (indiscernible).

While the DMHC does not have authority to deny rate increases, the DMHC's rate review efforts hold health plans accountable and ensures consumers get value for the premium dollar and saves Californians money. Since 2011 the rates review process has saved consumers $296 million in premium savings.

We also look at the plans rate filings to ensure the plans projected to meet the medical, the required medical loss ratio. If a plan fails to meet the MLR requirement they are required to pay rebates to enrollees. And this is something we pay close attention to as we are conducting our rate review of a

plan's future rate filings. And since 2011 health plans have paid $656 million in MLR rebates. And I would like to give a shout out to the rate review team, our actuaries here. This year we did get a second set of rate findings from health plans because of, you know, additional subsidies that were available to the health plans under the IRA program. So I want to give a shout out to my rate review team, they did look at our two sets of rates.

With that I will take any questions.

CHAIR DEGHETALDI: Any questions from the Board?

Are the PPO rates going up faster than the HMO rates? Back to Amy's point. Do we differentiate there?

MS. DUTT: So the PPO rates are higher and we do see that. We do get the average rate increases for the plans and the PPO rate filings are slightly higher than the HMO rates.

CHAIR DEGHETALDI: Jordan, any questions from the public?

MR. STOUT: There are no questions from the public.

(Member Mazer joined the meeting.)

CHAIR DEGHETALDI: Okay, then. Thank you, Pritika, great. I think you are coming back after Michelle.

MS. YAMANAKA: Thank you, Larry; and good afternoon, everyone. Michelle Yamanaka, Supervising Examiner in the Office of Financial Review. Today I am going to give you an update on the risk bearing organization or RBO financial solvency for the quarter ended June 30. Next slide.

For the quarter ended June 30 we have 207 RBOs reporting to us. Two RBOs filed their annual survey reports for the quarter ended -- for the fiscal year end March 31, 2022 and we have nine RBOs filing monthly financial

statements as a requirement of their corrective action plan or CAP. We have three new RBOs reporting this quarter and we have three RBOs that no longer met the definition of an RBO and their accounts were inactivated. And this quarter we had an increase in corrective action plans. We have 25 RBOs that are filing 30 corrective action plans. More information to come on those CAPs in a later slide. Next slide please.

So for the inactive RBOs, at the time of inactivation we classify them in certain categories, if they have Financial Concerns, No Financial Concerns, and an Other category to catch all. Since inception we have inactivated approximately 126 RBO accounts. For the quarter ended June 30, I mentioned that three RBOs' accounts were inactivated. Two of those are in the Financial Concerns category, one was in the No Financial Concerns category. Next slide, please.

So we also track those RBOs that were inactivated, the enrollment assigned to them as at their last filing. For the 126 RBOs approximately 69% of those RBOs had less than 10,000 lives assigned to them when they were inactivated. For quarter ended June 30, the 3 RBOs were in the zero to 5,000 enrollment category. Next slide please.

Moving on to the financial survey reports that were received for quarter ended June 30. We have 182 of the 207 RBOs reporting compliance with all solvency criteria. Of those there are 9 RBOs on our monitor closely list but are meeting all financial requirements and we have 25 RBOs on corrective action plans.

Moving on to corrective action plans. As I mentioned there was an increase in CAPs for quarter ended June 30. We have 14 CAPs that are

continuing from the previous quarter and 16 new CAPs for quarter ended June 30. Of those 14 CAPs, 12 CAPs are improving and two CAPs are not. For those 2 CAPs, there is one RBO that has two corrective action plans. For that one RBO we are working with that RBO along with their contracting health plans to determine next steps in their corrective action, in the corrective action process.

Of the 16 new CAPs, 10 of the 16 CAPs were due to RBOs not meeting the claims timeliness requirement, and 6 CAPs were due to not meeting the financial metrics, TNE, working capital and/or cash to claims. For those 10 RBOs on the corrective action -- for the claims timeliness CAPs, a majority of them were due to staffing challenges. There are a couple of RBOs that had system redesigns or problems with their system where there is limitations on those. But there were just a couple of those, the majority of them were due to staffing challenges. And for the 6 RBOs that were non-compliant with one or more of the financial metrics, they were due to yearend adjustments and/or financial reporting issues. For the 30 CAPs, 26 are approved, 4 are in progress, and we are close to approving those CAPs but are still in progress with the health plans. And subsequent to the June 30 filings we have completed 2 of those CAPs; those RBOs are meeting all financial requirements.

For additional information regarding the CAPs we have a handout that lists the 30 CAPs. It is sorted by the management services organization if the RBO is contracted with them to provide administrative services. It also offers additional information which includes their contracting health plan, the enrollment in ranges, the quarter the CAP was initiated, the CAP compliance status with the approved CAP and the grading criteria deficiency. Moving -- next slide, please.

Moving on to enrollment. As part of the RBOs financial filings they

submit their enrollment information to us and this information is captured through those reports. There's approximately 9 million lives assigned to those 207 RBOs. And we continue to see the increase in the Medi-Cal enrollment, which is approximately a 104,000 increase from the previous period. Next slide please.

For those RBOs that have Medi-Cal lives assigned to them, there are approximately 5.2 million lives assigned to 92 RBOs. This represents 58% of the total enrollment for the 207 RBOs. Of those 92 RBOs, 73 have no financial concerns, 3 are on our monitor closely list, and 16 of those RBOs were on CAPs. For those 16 RBOs, 12 of those RBOs were on a CAP for claims timeliness.

Moving on to the top 20 RBOs that have greater than 50% Medi-Cal lives assigned to them. Next slide please. Of those top 20, approximately 4 million lives assigned to those 20 RBOs. Of those, 13 had no financial concerns, one was on our monitor closely list, and 6 RBOs are on corrective action plans. Again, those six RBOs were all on corrective action plans for claims timeliness and they are financially solvent. The remaining 72 RBOs that are assigned the 1.2 million lives, Medi-Cal lives, 60 of those had no financial concerns, 2 are on our monitor closely list, and 10 of those are on corrective action plans.

And that concludes my presentation and welcome for any questions.

CHAIR DEGHETALDI: Board, Board Members?

Thanks, Michelle.

MS. YAMANAKA: Sure.

CHAIR DEGHETALDI: Abbi.

MEMBER COURSOLLE: Thank you. Thank you, Michelle, for the presentation. I just wanted to go back to the slide where you talked about the

RBOs that are currently on CAP. And I can't remember the exact number but you mentioned that several of those CAPs resulted from staffing issues. And I was just wondering if you could say a little bit more about those staffing issues and how those resulted in the need for corrective action.

MS. YAMANAKA: Sure. So that would be -- let's go back to the slide. I believe it is for our corrective action plans slide. No, a couple more back. One more. There we go, there we go. So, we do -- there were -- there were -- we currently have -- well, 28 CAPs now but as of June 30 filings there were 30 corrective action plans. One of the issues, the reasons why -- the reason why there are so many corrective action plans is if there is an MSO that is having issues, for example, in this case it could be staffing issues, you know, it affects a majority of their RBOs or capitated providers that they provide those services for.

So when we do, when we receive the CAPs, you know, one of the things that the CAP shows is the financial assumptions and what they need to do to fix the issues with the root, the root cause. So we just -- we have noticed that a majority of the CAPs are coming in with these RBOs having financial -- staffing issues. When you don't have enough staffing to process the claims there becomes a backlog and such. And then when they are geared up, get that staffing to process those claims, that's when you see the non-compliance with the team claims timeliness because they are beyond 45 days to process those claims.

MEMBER COURSOLLE: Thank you, that's really helpful.

MS. YAMANAKA: Okay. Sure.

CHAIR DEGHETALDI: Other questions?

And, Jordan, from the public?

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

CHAIR DEGHETALDI: Okay, then we go from RBOs to health plans.

MS. DUTT: Good afternoon. The purpose of this presentation is to provide you an update on the financial status of health plans at quarter ended June 30, 2022. All licensed health plans are required to submit quarterly and annual financial statements with the DMHC. Additionally, we get monthly financial statements from health plans that are newly licensed or the plans that their TNE falls, their tangible net equity falls below 150% of required TNE. Or if we have concerns with a health plan's financial solvency we may place them on monthly reporting.

We also included a handout that shows the enrollment by line of business at June 30, 2022 and TNE for five consecutive quarters, going back from June 30, 2021 to June 30, 2022, for all licensed health plans. And the handout is broken into three categories, full service plans first, then restricted full service and then specialized. As I --

MEMBER DURR: I'm sorry to interrupt, Pritika. I just need to let everyone know there is a fire alarm in our building so I need to evacuate, unfortunately. So hopefully I will be back before the meeting ends.

MEMBER WATANABE: Good luck, Paul.

CHAIR DEGHETALDI: Good luck, Paul.

MEMBER DURR: We are doing new construction so I am sure it has something to do with that. But I am the leader, I've got to help everyone get out; so I will be back hopefully.

MS. DUTT: Good luck with that, Paul.

As of October 10, 2022 -- slide 2, please, the next slide. Thank you. As of October 10, 2022 we had 144 licensed health plans. We licensed one restricted Medi-Cal plan, which was Family Choice Health Services, since the last FSSB meeting. So that was the only plan that we licensed since the last FSSB meeting.

We are currently reviewing 11 applications for licensure, 7 full service and 4 specialized. Of the 7 full service, 2 are seeking licensure for Medicare Advantage, 3 restricted Medicare Advantage and one is seeking licensure for Medi-Cal and one for restricted Medi-Cal.

For the 4 specialized plans, two are looking to get on into the EAP business, one dental and one discount. Next slide.

At June 30 2022 there were 29 .2 million enrollees in full service plans license with the DMHC. Total Commercial enrollment includes HMO, PPO/EPO and Medicare supplement. As you can see on the table compared to the previous quarter, total full service enrollment increased by approximately 300,000 enrollees. Government enrollment increased by 320,000 lives, while Commercial enrollment dropped by 20,000 lives. Next slide.

This slide shows the makeup of HMO enrollment by market type. HMO enrollment in all markets remained relatively stable compared to previous quarters. However, we saw the large group HMO enrollment decreased by 40,000 lives and individual enrollment decreased by 20,000 lives; so there was a drop of 60,000 lives in the HMO Commercial enrollment. Next slide.

This slide shows the makeup of PPO/EPO enrollment. As you can see on the table, PPO/EPO enrollment remained relatively stable, adding 40,000 lives for the quarter. So there was an increase in the large group commercial

PPO by 30,000 lives, small group increased by 20,000 lives, and the individual market saw a decrease of 10,000 lives in the PPO market. Excellent, thank you.

This table shows government enrollment, which is Medi-Cal and Medicare. Overall the government enrollment increased. The majority is due to Medi-Cal enrollment, which increased by 310,000 lives. And this is based on the information received for June 30, 2022. Next slide.

There were 3.8 million enrollees enrolled in the closely monitored full service plans. Of the 27 closely monitored full service plans, 12 are restricted licensees and had 392,000 enrollees, so these are smaller plans. And then the makeup of the restricted licensees include 2 which are restricted for Medi-Cal, 7 restricted for Medicare and 3 restricted for Commercial. So, they might have been placed on the closely monitored list because either they are newly licensed, small membership or, you know, just financial performance.

The total enrollment for the four specialized plans is 250,000 lives. The composition of the specialized plans on the closely monitored list includes one vision plan, two dental and one behavioral.

And this slide shows the one plan that was TNE deficient at quarter ended June 30, 2022. Brandman Health Plan reported TNE deficiency for monthly financial statements from April 30, 2022 through August 31, 2022 and for quarter ended May 31, 2022. So this plan is not on a standard quarter system so their year-end is August 31 so their quarter ended as of May 31, 2022 instead of June 30. The plan has not cured the TNE deficiency as of October 7, 2022. The plan mutually terminated its contract with CMS effective March 1, 2022 and currently has no enrollment. So again, this plan was newly licensed, was offering benefits to Medicare beneficiaries through 2021. It had about 100 enrollees and

then mutually terminated its contract with CMS effective March 1, 2022.

This chart shows the TNE of health plans by line of business. A majority of the health plans with over 500% of required TNE are specialized health plans. This is because the required TNE is substantially higher for the full service health plans due to the medical expenses or risk being higher for the full service plans. Again I want to point out that the minimum required TNE for a full service plan is $1 million, as opposed to a restricted plan which is 50,000. And the plans have to maintain greater -- for the full service plans they have to maintain TNE levels greater of a million dollars or a percentage of their premium revenues or a certain percentage of their medical expenses. And for the specialized plans it has to be the greater of $50,000, a percentage of premium revenue or a percentage of medical expenses. Next slide.

This chart shows the TNE of full service plans by enrollment category. Sixty-three health plans or over half of the total licensed full service health plans reported TNE of over 250% of required TNE. Plans whose TNE fell to 150% are required to file monthly financial statements with the DMHC. So as you can see, currently we have 9 plans that are below the 150% threshold. However, we may have additional plans on monthly reporting due to various reasons. Again, we may have financial concerns or, you know, just issues we have seen during the examinations. Next slide.

This chart shows a breakdown of the 23 full service plans in the 150% to 250% range. If a health plan’s -- like I said before, if a plan’s TNE falls below 150% the plan is placed on monthly reporting. We also monitor the health plans closely if we observe a declining trend in their financial performance, which is TNE, net income, enrollment, other claims payment issues. So again, we don't

even wait till the plan hits the 150 mark. If we start seeing the health plan's TNE on a declining trend we start having this conversation to the health plans early on.

And this chart shows the TNE of full service plans by quarter. For detailed information on health plan TNE levels and enrollment please refer to the handout that was provided with the meeting materials. So this slide here kind of summarizes the handout referred to at the beginning of the presentation.

So with that, I will take any questions.

CHAIR DEGHETALDI: Well first let me welcome the former San Diego guy, now Floridian. What is it, Ted?

MEMBER MAZER: Floridian.

CHAIR DEGHETALDI: Floridian, welcome. And hurricane survivor. Welcome, good to see you.

MEMBER MAZER: Thank you, sir. Good to see all of you.

CHAIR DEGHETALDI: Any questions?

Well, great. Any questions from the public?

MR. STOUT: There are none at this time.

CHAIR DEGHETALDI: And I see the fire alarm was a false alarm; is that correct?

MEMBER DURR: Correct, I came back, false alarm.

CHAIR DEGHETALDI: Okay, great.

Okay, then let's -- Mary, let's talk about 2023 and virtual versus in-person meetings.

MEMBER WATANABE: Yes. Maybe let's go to the next slide there, Jordan. We didn't have any concerns with the dates we proposed for 2023

so these will be our meeting dates going into next year. We are planning to hold the first two meetings virtually. We have some allowances to allow virtual meetings to continue through June. But absent some sort of statutory change or legislative change we will plan on meeting in-person for August and November. More information to come as we get closer but we will at least plan to be virtual for those next two meetings.

Dr. Mazer, we said a lot of very nice things about you in the beginning that you missed; but I just wanted to take the opportunity to say thank you for your participation on the Board. You have brought a lot of very unique perspective and really rounded out our group and you will be missed, but have been thankful for your service for the last three years.

MEMBER MAZER: Thank you, Mary. I guess I will have to read the transcripts if anybody will send them to me. (Laughter).

MEMBER WATANABE: We'll send that part to you for sure.

MEMBER MAZER: And I apologize that I couldn't make this meeting, I was actually flying back from the meeting in Hawaii for the American Medical Association. If I can take just 30 seconds. Thank you all for allowing me to participate. It has been an experience of a different kind for me for various administrative things that I have done. I hope I really did contribute to both those meetings and maybe refocusing where the FSSB goes in the future. So I appreciate your letting me serve. I am sorry that you will not continue to let me serve because I have moved my geographic location. But watch out, I am still paying attention.

MEMBER WATANABE: Thank you.

CHAIR DEGHETALDI: Thanks, Ted. Are you done with that one,

Mary?

MEMBER WATANABE: I am done, yes.

CHAIR DEGHETALDI: Okay. Now we move, Jordan, to public comments on matters not on the agenda. So this is an opportunity for the public to raise concerns or offer comments. Any hands raised, Jordan?

MR. STOUT: There are none at this time.

CHAIR DEGHETALDI: Okay, then we have an opportunity for the Board to comment on topics that they might be interested in for future agenda items.

MEMBER DURR: Larry, this is Paul.

CHAIR DEGHETALDI: Yes.

MEMBER DURR: So one of the things I want to make sure, and I mentioned it earlier, is that Vishaal keeps providing some routine update to the FSSB, sort of like I think we have routine updates in different areas. So I think that would be something that, Mary, how we would want to schedule that, maybe quarterly, semiannual or something to that effect. But I think it is important as that further progresses that impacts potentially the FSSB or the delegated group, so I would think just having routine updates would be helpful. That was one item.

The other item that I seem to keep forgetting is really looking at some of the regulations that are in place. More specifically, I am referring to a regulation that is in place that basically requires health plans to notify delegated medical groups of the expected risk that they are undertaking. I know this has come up more recently in certain issues in particular, as we are all aware of, but, you know, it speaks to that regulation in particular because we have asked routinely health plans for that and get told, we don't have that, we can't provide

that to you. And so it really does speak to if we as delegated groups are going to take risk we need to know what the anticipated risks that we are assuming, and that is required to be taken. So I don't know if that's appropriate for here or maybe that's an offline discussion, Mary, but something it speaks to, especially in the Financial Standards Solvency Board. You know, the financial viability of groups is really understanding the risk that they are taking and making sure that they under understand and agree with that. So that might be something that we would want to consider. Thank you.

MEMBER WATANABE: Yes, no, I appreciate that, Paul. We will definitely take that back. I will say just on the Office of Health Care Affordability, there is a lot more detail for us to flesh out with OHCA just on our coordination as well. I actually have an email drafted to Vishaal to thank him for his presentation but also to kind of figure out the right cadence for him to come back and provide updates.

MEMBER DURR: Mm-hmm.

MEMBER WATANABE: I think we will give him a little bit of time to get staffed, maybe even convene the Board and the Advisory Group. But I agree, I think we will want regular updates from him. We will have to kind of think about how we do that, along with the DHCS updates. With all of the changes and things happening in Medi-Cal I want to be mindful that we don't turn these into a non-DMHC meeting. But there is so much impact on the financial status of our RBOs and plans that I think it is very important that we continue those updates. We also have kind of an internal list of some things we may be bringing you for next year for discussion as well, but appreciate the input.

CHAIR DEGHETALDI: Great. Scott.

MEMBER COFFIN: I would like to raise a topic for a future meeting and that is the unwinding of the public health emergency and really its potential effect on Medi-Cal beneficiaries. And I think this is really focused, my comments focus more about the patient here, the adults and children that are covered in the program and the effect of what will happen. While we don't know exactly when the public health emergency will, will be officially terminated, we do know there is going to be an effect from that that is going to be significant on folks accessing health care and all matters of health service. So I propose we consider that for a future agenda item.

MEMBER WATANABE: I've got it on my list, Scott, thank you.

MEMBER COFFIN: I am happy to -- we are, we are very active here in Alameda County on initiating a PHE unwinding plan so I am happy to present or at least kick it off at the next meeting if that's, if that's decided to be part of the agenda.

MEMBER WATANABE: Okay, thank you.

CHAIR DEGHETALDI: Mary, to follow up on -- Abbi, why don't you go, sorry, I'll go last.

MEMBER COURSOLLE: Thank you. I mean, I am just -- I wanted to follow up a little bit on what both Paul and Scott raised. But I do think, as somebody who mostly is in the Medi-Cal space, I am very concerned about, you know, the changes coming to Medi-Cal over the next year, year and a half, and the impact on plans and financial solvency. So this is not a totally well formulated ask at this point but t I do think, you know, to the extent that DMHC starts to notice trends within the Medi-Cal plans, that's something that we check in on regularly anyway but it might be helpful to just see if there are other

indicators that are starting to pop up as these changes go into effect and we are starting to understand what impact they are having a little bit more clearly.

CHAIR DEGHETALDI: Amy.

MEMBER YAO: Mary, I really appreciate your comment, we don't want to turn this meeting into updates from everywhere. I do want to bring up, you know, individual, and it does have a large impact on the provider groups and that's a really unique population. I don't know whether we ever had like a Covered California to give us an update on what they are doing. And especially now it looks like the Office of Affordability is going to try to connect its (indiscernible) and Covered California to sync up on some kind of methodology and policies. It would be good to hear from them.

MEMBER WATANABE: That's a good point. I don't, I don't recall a Covered California update at the FSSB meetings in my time in seven and a half years. Larry is saying no, Larry would know.

CHAIR DEGHETALDI: No, no.

MEMBER WATANABE: So yes. You know, I do know there is a lot, there is a lot that is in the works at Covered California, a lot of things that they are thinking about. So yes, we will have to think about how we kind of stagger our department presentations but I appreciate that idea.

CHAIR DEGHETALDI: Mary, along those lines, I was struck by Vishaal's comment on our sibling partners within the state, which is a new term and obviously you live it. There is another sibling organization within DHCS, the Office of Medicare Integration. And just reflecting, we are at the point now where half of Californian Medicare beneficiaries or in MA. It might be time to refresh a comparative look on access, quality. Solvency is difficult because, you know,

lots of -- I don't think we have data on the Medicare ACO performance of our, you know, various physician organizations but I am curious about that.

And I think Scott's point is troubling me on access. I am concerned that rural Californians and Californians covered by Medi-Cal have significantly worse access to care. Because you can't address healthcare disparities when access gaps are or where they are. Just to understand, again, maybe an access status report by geography, by plan, ultimately by race and ethnicity, would be fabulous.

MEMBER COFFIN: I second that.

MEMBER WATANABE: You've given us a long list for next year.

CHAIR DEGHETALDI: Any other comments?

I just thought today was just spectacular. I already miss Ted Mazer, I have to say it. I never thought I'd say it but I miss my, my friend and troublemaker, so thank you, Ted.

Any other comments from the Board or Mary?

MEMBER WATANABE: I will just, you know, thank the Board for their flexibility and patience with us throughout this pandemic as we have navigated this virtual world. I think overall these meetings have gone really well even in our virtual setting.

And we will just take the opportunity to wish all of you a very happy Thanksgiving and holiday season and look forward to seeing you in the new year. Because we have got, we have got a lot of work at the Department, a lot to keep you updated on, but just appreciate your service to the Board.

(Background audio was heard.)

MEMBER MAZER: Happy, happy, will miss you guys.

(Background audio was heard.)

MEMBER WATANABE: I am not sure that's for us.

CHAIR DEGHETALDI: It probably isn't but it was interesting. (Laughter.)

We'll see you all next year. Thank you. Thanks, Mary.

MEMBER WATANABE: Thank you. Bye

(The meeting was adjourned at 12:40 p.m.)

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CERTIFICATE OF REPORTER

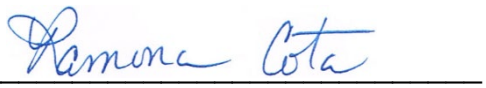
I, RAMONA COTA, an Electronic Reporter and Transcriber, do hereby certify:

That I am a disinterested person herein; that the foregoing

Department of Managed Health Care, Financial Solvency Standards Board meeting was electronically reported by me and I thereafter transcribed it.

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

IN WITNESS WHEREOF, I have hereunto set my hand this 29th day of November, 2022.



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