STATE OF CALIFORNIA

DEPARTMENT OF MANAGED HEALTH CARE

FINANCIAL SOLVENCY STANDARDS BOARD (FSSB) MEETING

ONLINE/TELECONFERENCE MEETING

HOSTED BY THE

DEPARTMENT OF MANAGED HEALTH CARE

SACRAMENTO, CALIFORNIA

WEDNESDAY, AUGUST 11, 2021

10:00 A.M.

Reported by: Ramona Cota

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APPEARANCES

BOARD MEMBERS

John Grgurina, Jr., Chair

Larry deGhetaldi, MD

Paul Durr

Jen Flory

Theodore Mazer, MD

Jeff Rideout, MD

Mary Watanabe

DMHC STAFF

Pritika Dutt, Deputy Director, Office of Financial Review

Jessica Petersen, Assistant Chief Counsel

Sarah Ream, General Counsel

Daniel Rubinstein, Associate Governmental Program Analyst

Dan Southard, Chief Deputy Director

Jordan Stout, Associate Governmental Program Analyst

Michelle Yamanaka, Supervising Examiner, Office of Financial Review

ALSO PRESENTING/COMMENTING

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

William "Bill" Barcellona
America's Physician Groups

Jadie Mayes
Magellan Health and Human Affairs International

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PROCEEDINGS

10:01 a.m.

CHAIR GRGURINA: As a reminder for our Board Members, unmute yourselves when making a comment and mute yourselves when not speaking. For our Board Members and the public, reminder that you can join the Zoom meeting on your phone should you experience any kind of connection or technology issues.

Third, questions and comments will be taken after each agenda item. For the folks who are on the phone, if you would like to ask a question or make a comment please dial *9 and when you have the opportunity to speak state your name and the organization you are representing for the record. For attendees who are participating online with microphone capabilities you may use the Raise Hand feature and you will be unmuted to ask your question or provide your comment. To raise your hand click on the icon labeled Participants on the bottom of your screen and then click on the button labeled Raise Hand. Once you have asked your question or provided a comment please click Lower Hand. All questions and comments are going to be taken in the order of raised hands.

And then lastly, as a reminder, the Financial Solvency Standards Board is subject to the Bagley-Keene Open Meeting Act. Operating in compliance with the Bagley-Keene 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 Bagley-Keene Act requires the FSSB meetings to be open to the public. As such, it is important that the members of the FSSB refrain from emailing, texting or otherwise communicating with each other off the record during FSSB meetings because

such communications would not be open to the public and would violate the Act. So just a reminder, I think a reminder for the Chair.

And so with that let's go ahead and do Welcome and Introductions and as I call on the Board Members if you can introduce yourself and the organization you are representing. Jen, why don't we go ahead and start with you.

MEMBER FLORY: Hi, good morning, Jen Flory with Western Center on Law and Poverty.

CHAIR GRGURINA: All right, thank you, Jen.

All right. Ted, why don't you go next.

MEMBER MAZER: Ted Mazer, independent physician, initially appointed through California Medical Association.

CHAIR GRGURINA: All right, thank you, Ted.

Jeff.

MEMBER RIDEOUT: Jeff Rideout, CEO of IHA, the Integrated Healthcare Association.

CHAIR GRGURINA: All right, thank you, Jeff.

Paul.

MEMBER DURR: Good morning, everybody. Paul Durr, Sharp Community -- representing Sharp Community Medical Group, CEO in San Diego and independent physicians.

CHAIR GRGURINA: All right, thank you, Paul.

Larry.

MEMBER DEGHETALDI: Yes. Physician area, CEO for Palo Alto Medical Foundation, Santa Cruz.

CHAIR GRGURINA: Larry, your full name, please.

MEMBER DEGHETALDI: Lawrence David deGhetaldi.

(Laughter.)

CHAIR GRGURINA: Thank you, Lawrence.

And I am John Grgurina, the CEO of the San Francisco Health Plan.

I do have a quick announcement. A little more than two years ago Betsy Imholz from Consumers Union was our chair and a really good chair. Then Betsy retired and then I was asked to go ahead and become the chair and I thought, you know, I'm a follower so I am going to follow Betsy. And I announced to my staff and board last week that I will be retiring as of April 2nd of 2022 so this most likely will be my last year on the Financial Solvency Standards Board so not only an opening there but also a chair opening to our fellow members; and as we get into Director's remarks Mary will talk a little more about that.

So with that, let's move on to the transcript and the meeting summary from our May 27th meeting. Do I have a -- first let me ask, are there any comments or questions on the transcript?

Seeing none, do I have a motion to move the minutes?

MEMBER MAZER: So moved.

MEMBER RIDEOUT: Second.

CHAIR GRGURINA: Ted and then second, was that you, Jeff?

MEMBER RIDEOUT: Yeah, that's fine.

CHAIR GRGURINA: All right, great, thanks. All those in favor?

(Affirmative responses.)

CHAIR GRGURINA: Great. Hands, thumbs up and ayes coming

from Jen. Unanimous, thank you very much.

All right, with that let's go ahead and move over to Mary and the Director's Remarks.

MEMBER WATANABE: Great, thank you, John. And I will start by just acknowledging and thanking John for his service to the Board. I am personally really excited for you in this next chapter of your life. I am excited that we have some time with you still on the Board. I have really appreciated your support and the continuity through my transition into the Director role but you will be missed.

John and I have talked that we will likely have him continue on through the end of this year both in the Chair role and on the Board. Our plan right now is to issue a solicitation to fill the vacancy behind John.

Jen and I have also, we have been connected on this as well. Jen's position, her three year term ends in March of next year so we will likely go out for two vacancies on the Board, probably a staggered start for those positions. But for those of you out there that are interested in participating in the Board it is a great opportunity so we will be issuing that solicitation later this year.

We talked about this earlier in the year as John had agreed to stay on as the Chair for one more year but we will be looking for someone to take over the Chair responsibilities next year. So I hope that someone on the on the Board here will consider that; please let me know if that is something you are interested in. We decided that if nobody volunteers John gets to, as his final act, appoint somebody, so whoever maybe has not been as kind to him you may be tagged to be our Chair. So definitely will be looking for someone to take on that role. I will offer that we do everything we can to support you and make that job

as easy as possible but recognize that everybody has a lot on their plate and this is an additional responsibility. So more to come on that.

Moving on to other updates. We recently released our 2020 annual report and if you didn't get a copy of that you can find it on our home page at healthelp.ca.gov under What's New. But this one is particularly significant because it is our 45 year anniversary of the Knox-Keene Act, the 20 year anniversary of the Department and the 10 year anniversary of the Affordable Care Act and there is quite a history lesson in there too so I would encourage you to check it out if you haven't already seen it.

At the last meeting I discussed the Children and Youth Behavioral Health Initiative that was part of the governor's May revise and I am really excited to say that at the end of July the governor signed AB 133, which included a lot of exciting health care initiatives but in particular the Children and Youth Behavioral Health Initiative. We don't have any resources associated with this but we will be very actively involved in the implementation to ensure that children and youth, regardless of insurance coverage status, will be able to get services through schools or link through schools. So there's a lot of exciting work that will be happening in the space and we will continue to update the Board on those activities as we move forward.

My next update here is on the individual market rates. On July 28th Covered California announced the preliminary health plan premium rates for 2022 citing an average statewide rate change of 1.8%, which is a third straight year of low rate changes so very good news there.

We received and are currently reviewing 13 individual rate filings with an effective date of January 1st, this includes 12 on-exchange filings and

one off-exchange filing. There is a new entrant for the 2022 plan year which is Universal Care. They will be offering individual products on the exchange in Region 5, which is Contra Costa County.

Health Plans were also asked to provide the estimated impact of COVID on their proposed rates. This is something we are continuing to be very interested in tracking. We are working closely both with the plans and our actuarial consultants to analyze this impact on premiums, medical costs, utilization and medical loss ratio.

For the 13 individual rate filings the proposed rate change ranges from a decrease of 3.2% to an increase of 9.1%. We will finalize our review of the filings by October 1st and at our next meeting in November we will have a more comprehensive overview of the individual market rate filings.

And just a reminder, you can review the filings and submit public comment by visiting our rate review web page. To do that you can find an option under our Featured Links on our home page that says Submit Public Comments on Premium Rates. So for those of you that really want to dig into the detail, feel free to visit that page.

Quick COVID update: I know with the fourth surge COVID is top of mind for all of us. We haven't had a whole lot of activity since our last Board meeting but we have issued two All Plan Letters related to COVID-19 testing. These All Plan Letters reminded health plans that federal law continues to require them to cover COVID-19 testing when the testing provides an individualized assessment of whether the enrollee has a COVID-19 infection. Health plans must cover testing whether it is performed in or out of network and may impose no prior authorization or cost-sharing and they must cover testing

when a person is symptomatic or asymptomatic, regardless of whether or not they've had recent or suspected exposure. Again, you can find a link to that All Plan Letter on our home page under What's New.

Our most recent All Plan Letter was issued on July 26 and references the recent California Department of Public Health state public health officer order related to health care workers in high risk settings.

And finally, I wanted to give you a little bit of a preview of our next meeting. We have a very full agenda with a lot of information today but we have also been talking about how November was going to be a very busy meeting. We will talk again, as I mentioned, about individual market rates, risk adjustment transfers, we will have the Medi-Cal managed care financial report, and we will have an update on legislation that has passed and signed by the governor. As some of you are well aware, it has been a very busy legislative session as well. We will also have a proposal for our 2022 meetings schedule.

The other item I want to just highlight is at our last, it was either our last or the one before that, meeting, we had indicated that we would be meeting virtually through the end of this year. We recognize that the governor's executive order related to virtual meetings actually expires at the end of September so absent an extension of that executive order we will actually need to meet in-person. We, two years ago, renovated and made a significant change to one of our conference rooms to allow us to be able to hold public meetings on our fifth floor, so in the event that we meet in-person we won't be on the second floor as we have done previously, we will actually be in our fifth floor conference room.

As you are probably aware, the administration also issued new guidance related to state employees and vaccine and testing requirements which

extends to those visiting our offices and so if we, in fact, will meet in person in November we will make sure we share well in advance any protocols around-just to keep everybody safe-around vaccines and testing. So more to come on that.

I think with that I will turn it over to John. I will just make one quick note before I do that. In an effort to try to bring you as much timely information as we could we, I know there were a lot of last minute presentations that were sent out and I know Jeff and a couple of our team members have been feverishly working on information up to the last minute and so I appreciate the tremendous amount of work that went into bringing some timely information to you and for everybody's patience and flexibility as we pushed information out. With that I will turn it over to you, John.

CHAIR GRGURINA: Well, thank you, Mary. And of course, obviously, you will let us know as soon as any, any changes and developments regarding whether or not we are in-person in November or we are we are back online, and we will find out. As well as if we are in-person, the rules that we will have to follow.

Jeff, I saw earlier you had your hand up. Did you have a question or comment?

MEMBER RIDEOUT: No, Mary answered it in her own comments. I was just looking for that range on the rate submission so thank you, Mary.

CHAIR GRGURINA: All right, great, thanks.

Larry, do you have a question or comment?

MEMBER DEGHETALDI: Yes. Mary, I am so excited with Covered California's rate in aggregate but just a couple of comments. We haven't yet seen the rate increases by region. And Covered California up until

about two years ago was actually listing I think the Silver Plan price by health plan. They no longer do that, they just show the year-over-year increase. It is just an omission I think that consumers if we, you know, obviously we can't control Covered California. But being as transparent as possible at the region level for pricing is really important.

I just wanted to compliment you on the 2020 annual report, the 45 years, 20 years is great. And I just had the thought as I was reading it, this is appropriate and germane to the managed care covered lives of California but we have -- Californians are, you know, are regulated by Department of insurance, US Department of Labor, DHCS. It would be nice for Californians to know sort of holistically who is ensuring that they, that their health care is appropriately regulated and protected. Because it's, you know, it's the elephant and we have a piece of the elephant here but I'd love to see a comprehensive, you know, transparent view for consumers to know who is looking out for them. I don't know if that makes --

MEMBER WATANABE: Sure. Yeah, no, it does. And I will tell you the California Health Care Foundation released, they have an annual kind report and cheat sheet, I call it, of who the regulators are and the growth so that's always a good resource. I will tell you in our, in the outreach that we do we recommend that people start with us because we have got the bulk of the enrollment and then we ensure that they get to the appropriate regulator. But as you will see in I think our infographic and in the enrollment data we present here we are up to close to 28 million or even over 28 million consumers. We like to be the starting point and then happy to direct people as appropriate.

Regarding the Covered California rates and how we display data, I

appreciate that comment and I know Pritika is making a note of it. As we share information with you at the next meeting we will see if we can be responsive to that.

CHAIR GRGURINA: All right, Paul, and then Ted.

MEMBER DURR: Yes, thanks, Mary, great overview. You know, my question or comment is related to the sharing of the COVID impact on the rate setting and making sure the Department is where that still the provider groups are having to bear some of that cost. As you know there was the rule that you tried to issue and then was subsequently thrown out by the by the law for a technicality, that plans have basically assumed that that responsibility rests with delegated medical groups. So given the fact that they had to submit the rates prior to the conclusion of all of that, I would be mindful of looking diligently at what they are saying is their impact on the rates for COVID when some of that is still being pushed back to us as provider organizations. I know you do a very diligent review of that but just want to make you, remind you of that.

MEMBER WATANABE: We are very aware but thank you for calling that out.

CHAIR GRGURINA: Ted.

MEMBER MAZER: Thanks, John. To Paul's comment, yeah, I think that at some point, and maybe November is too premature, we do need to have a breakout of the COVID impacts on all of the plans, all of the RBOs, just to get a better picture of where the responsibilities were shifted.

And then following back to Larry's comment, I was thinking the same thing. This entire insurance market is so fragmented it might be helpful, Mary, the page that you said breaks out who is the regulator for which plan, if

that page can be reproduced in the DMHC's publication? It is not just the consumers who are confused, it is the physicians who are confused and never know where to turn. It will take a burden off DMHC if it didn't have to be the gatekeeper for the inquiry of where do I go to complain.

CHAIR GRGURINA: All right.

MEMBER WATANABE: Thank you, we'll take that back.

MEMBER MAZER: Thank you.

CHAIR GRGURINA: Any other comments or questions from the Board Members? Okay, I will just echo the sentiments of several Board Members. Congratulations, Mary and DMHC on the 45 year anniversary. Great to hear the news from Covered California, although like Larry, I agree, it really does depend not only on region but also your age. I have a family member in Covered California. When I see the weighted average across the state that's great, but let's face it, we want to get to what does it mean to the individuals that we care about and love and those could be different. So I agree with Larry about the transparency of seeing as much as you possibly can, although congratulate them on the work.

And with that I think we are ready to go ahead and move on to the Department of Health Care Services update. Is Lindy with us?

MS. HARRINGTON: I am here. Can you all hear me? I'm having some connection issues so I was flipping in and out so I'm going stay off camera. But can you all hear me?

CHAIR GRGURINA: Yes, we can hear you, Lindy.

MS. HARRINGTON: Okay, fantastic. everyone asked me to do a quick update from the Department of Health Care Services and so the first thing I

wanted to talk about today was kind of our budget update. And so I think the first and foremost is to really talk about it was a historic budget from the perspective of the Department of Health Care Services. There are huge investments being made just kind of across the agency that touch DHCS but, you know, one of the most important being our Children and Youth Behavioral Health Initiative. Over $4 billion across multiple years with, you know, big functions of that being led by the Department of Health Care Services. And this is really an initiative to transform California's behavioral health system for children and youth and an innovative and preventive-focused system where all children and youth are routinely screened, supported and served for emerging and existing behavioral health needs, regardless of payer; and so that will be rolling out over the next several years as we implement that.

The other large component that came out was our home and community-based spending plan, which invests nearly $5 billion, $3 billion in ARPA funds and investments in our home and community-based services programs. The spending plan itself has been submitted to CMS and is under review with CMS so we will continue working with CMS for approval there. And that initiative broadly is posted online for everyone to read.

And then as we move into kind of direct DHCS activities I think there's a couple big components. First is our eligibility expansions that that we would want to talk about. So we have expanded coverage for undocumented older adults, so those 50 and over beginning in May of 2022, as well as an expansion for five years of Medi-Cal eligibility for postpartum individuals. So beginning April 1st of 2022 we will be expanding that postpartum coverage from 60 days to 12 months and that was authorized through ARPA.

We also -- I don't think we have ever had a budget where we have added so many benefits in one year. So we are adding doula benefits beginning January 1 of 2022. We are adding community health workers beginning January 1 of 2022. We are adding medication therapy management. That benefit began beginning July 1 of 2021. There was an extension of our telehealth flexibilities for an additional time period. So really some, some big investments in benefits as well.

And then as we move into kind of thinking about, you know, kind of where we are with CalAIM, there were also significant investments in CalAIM, general fund and ARPA investments. So for CalAIM we have invested $1.6 billion in funding in '21-22 and with an ongoing expected funding of $900 million beginning in '24-25.

As part of CalAIM we have proposed a population health management system and we did receive approximately, so we received general fund investment for that population health management system as well as funding for Medi-Cal Providing Access and Transforming Health, otherwise known as PATH, which included, the budget included one-time $200 million to build capacity for effective pre-release care for justice-involved populations to enable coordination with justice agencies and Medi-Cal coverage of services 30 days prior to release, so this is a really important component of our CalAIM proposal.

And so I think the other big change was funding associated with eliminating the Medi-Cal asset test, which will bring changes again to who is eligible for our program.

Related to CalAIM itself, DHCS submitted our 1115 and 1915(b)

fee waivers to CMS on June 30th. For our 1115 waiver CMS deemed it complete in July and it is currently out for the federal public comment period, which closes on October 15th. So if anyone wants to provide federal support letters we encourage you to send those to CMS.

Again, you know, we have continue to have conversations with CMS about CalAIM and reminded CMS that it is a broad transformational change to Medi-Cal. That it is not limited to our waivers. That it really is a puzzle of various authorities where we are taking our 1115 waiver authority and really transforming most of that into 1915(b) and state plan authorities, as well as continuing a small portion within our 1115.

And I think the final component that folks were looking for me to provide an update on was Medi-Cal Rx. And really on Medi-Cal Rx I think most of you have probably seen the announcement that we have made the determination that we have a provable conflict avoidance plan from our provider. Therefore, we will be going live with Medi-Cal Rx beginning January 1 of 2022. The teams are kicking back off the various implementation work groups and activities to have a successful go-live on January 1 of 2022.

So that was a very fast update on the things that are happening here at DHCS and happy to answer any questions.

CHAIR GRGURINA: All right, thank you Lindy.

Any questions or comments from the Board Members? I have a hand up. All right, Larry first then Jen.

MEMBER DEGHETALDI: Lindy, thank you. I cannot agree more. I think your leading bullet point, which is the importance of access for all of our patients to behavioral health, particularly behavioral health that is integrated with

our primary care teams.

Just an observation going back even pre-COVID: Our FQHC partners are way ahead of independent physicians and medical groups in implementing the integration of behavioral health in their primary care sites. And I can't help but you know, it's going to lead me to this concern. Their business model, their financing of those services are sustainable and they are not in behavioral health for independent physicians and medical groups where most Californians get care.

I guess my point is, you know, the OSHPD data is very transparent that California's hospitals do okay with Medi-Cal, in general they do okay. It's not, it's not profitable for them, largely due to the hospital fee program 340B, the pharmacy funding, DSH funds. But, you know, and Ted will agree with me, we are very concerned about access for non-FQHC physicians and specialists. Has the Department ever looked at the adequacy of payments to ensure access, particularly as we expand to, you know, patients over 50 who are undocumented? I am concerned. I think that payment adequacy is great in the FQHC space, it's okay in the hospital space, but I am worried about in physicians and -- just a question. And the behavioral health comment, you know, it makes this problem pretty obvious.

MS. HARRINGTON: So, I mean, I think, I think there's a couple things happening. One, when you talk about access, yes, we do have the, we do access studies, we look at and review access. There's a report that goes out every three years and the last one was done in 2019 that's posted on our, on our website.

When we start talking about behavioral health we are undertaking a

pretty significant behavioral health payment reform initiative in order to assist and ensure that those rates that the counties have, you know, some additional flexibility in how to pay providers as well as work with our managed care plans to improve the coordination of those services.

CHAIR GRGURINA: All right, thank you, Lindy.

Jen and then Ted and then Jeff.

MEMBER FLORY: Yeah, I just wanted to say congratulations to the Department. This was probably the biggest lift we have seen since the original implementation of the Affordable Care Act and just so many pieces on eligibility and expansion of services that I know like as consumer advocates, you know, we are starting to see a world where we get that final group of immigrants between 26 and 50 and a couple final things to the non-(indiscernible) legacy side of the program. But just, yeah, AB 133 is one of the biggest health bills I have ever seen so just congratulations on that.

MS. HARRINGTON: Thank you. we are incredibly excited and, you know, currently doing lots of work to figure out how we make sure we have successful implementations of this budget.

CHAIR GRGURINA: All right, Ted.

MEMBER MAZER: In comment to the access, particularly outside of the FQHCs or even the patients who are coming through the FQHCs. I think there are two factors that you need to pay attention to. One is the payment rate. Frankly, with the small population still in a fee-for-service Medicaid program it is not what it used to be because a lot of those programs are able to access at least most specialties, not so much behavioral health, for services outside the FQHC. But in the private community, not so much so. The other thing aside from

finances, and again, the fee-for-service payments are still abysmally low and the handful of fee-for-service patients really does have trouble accessing care. But you also need to look at location of care and the fact that a lot of the FQHCs, a lot of the managed care programs have limited access and patients don't have easy transportation to get services all across a county area that may be served by that plan. We still have that same issue in San Diego of patients who might be receiving multi-modality care, they can access through their managed care plan but they need a bus or a taxi or an Uber, if anybody wants to pay current Uber prices, to go to the northern coastal area to get their radiation therapy and all the way to the South Bay Area to get chemotherapy. So it is both access location as far as the network adequacy as well as the payment rates that are still interruptive in getting that specialty care.

MS. HARRINGTON: I hear the feedback.

CHAIR GRGURINA: All right, thank you.

Jeff.

MEMBER RIDEOUT: Hi, Lindy. Hopefully this doesn't sound like piling on. I was just provided a DHCS report on vaccination rates for Medicare-eligible patients versus the population that is county-specific. I was wondering if you could -- an FQ provided that to us and we were reviewing it in our new health equity committee, which is kind of exciting. But the rates for Medi-Cal-eligible people are dismally low and consistent across all counties. And I realize there's potentially some vaccine hesitancy potentially in that population but they are really 15 to, in some cases, 25%, lower. So I am kind of wondering about whether that is a canary in the mine in general for these access concerns but whether you had any general comments about that report that you, DHCS

issued?

MS. HARRINGTON: Sure. So I think we announced on Friday that we are implementing a vaccine incentive program with our managed care plans that will, we are putting forward about $350 million, $250 million to the plans for increased metrics associated with vaccine rates as well as $100 million for direct beneficiary incentives. As well as we have convened groups and are working through to try to determine if there are steps that we can take to increase those vaccine rates. The state, you know, takes this very seriously and we are looking for opportunities to reduce that gap in vaccine rates.

MEMBER RIDEOUT: So can I before Larry jumps in but I just wanted to, as a follow-up, so is the Department seeing this as a financing issue or is this more a health education issue?

MS. HARRINGTON: We do not see it as a financing issue, we see this more as an education, a hesitancy, how do we improve the rates and bring our, and bring our beneficiaries in?

CHAIR GRGURINA: Go ahead, Larry.

MEMBER DEGHETALDI: Jeff, thank you for bringing up disparity work and I think we are all in this, we are all in this together; it is an exciting time to look at disparities. My organization takes care of 10% of Californians across all payers, ethnic groups, and you have heard me say this before, we do not see much disparity across race and ethnic groups, it's across payer class. And payer classes. As Jeff points out, we have a lot of work to do to make transparent and to raise the bar, whether it's COVID vaccination rates, A1C control, mammography rates, we need to make visible and close the gaps and raise Medi-Cal performance to where, say, commercial HMO patients are. That I

think -- Jeff, I am not on your disparities committee but that is an important observation to keep in mind.

MEMBER RIDEOUT: Yeah, and Larry, you can join if you wish. I think we have somebody from Sutter there, your lead in that area.

MEMBER DEGHETALDI: Yes.

MEMBER RIDEOUT: There was one anecdote that came out of that committee that I just wanted to share, which shocked me as a physician, but this came from a very prominent executive leader at a hospital that serves primarily Medi-Cal and indigent communities. But the number one surgical procedure done in this facility is amputation for diabetics. It's absolutely terrifying, terrifying that that is true.

CHAIR GRGURINA: All right, any other comments, questions from Board Members? If not I will go ahead and conclude. Wait, hold on Lindy, don't go away just yet. So three comments from me. The first one is, and this conversation we are currently on, we do have to do more. Even though in San Francisco we have the highest rates of coverage of vaccinations of Medi-Cal folks, we are still 19 points below what the city is. So we have work to do and a lot of it has to do with education. Each area is different. We don't really have the public transportation issue about getting to the appointments, it really isn't about having enough places to get the appointments, it is about the communication, it is about overcoming what some of the beliefs are, about getting those trusted community-based organizations out there to work with folks. So we do have a ways to go and I appreciate Jeff and Larry raising that.

The second thing is, and I will join in with Jen, which is talking, Lindy, about this historic budget. Some of us have been around a long time,

were in other historic budgets, not good historic budgets. So I can go back to 1990 when there was no money and state employees weren't paid, we were given IOUs. So it is very, very pleasurable to be in this historic budget versus old historic budgets.

And then lastly, this also makes the comment adding to what Jen said which is, the ability to make sure that everybody is covered. And this is one of the things that I have truly loved about being in San Francisco is with our access program, Healthy San Francisco, there is something for absolutely everyone living in the city. And I will just tell you, that is an unbelievable joy to know. And we run our own enrollments center in order to get to everybody to make sure whether they are on Medi-Cal, they are in private insurance, they are in Covered California, or if not any of those programs we still have Healthy San Francisco for them and that's where I would love to see us as a state and we are getting closer and closer.

So thank you, Lindy, for all of those updates and thanks for joining us. Thanks for joining by phone since the technology wasn't going to allow both the phone and the video. We appreciate, we appreciate you coming before us.

MS. HARRINGTON: Thanks, everybody, have a great rest of your day.

CHAIR GRGURINA: Wait a minute. Hold on, Lindy, hold on, hold on, I apologize. That's just the Board Members. I do see there's at least one attendee with the hand up so actually can -- let's see, let me go to, I think Daniel is running it. Daniel, do we have any comments or questions from either those on the phone or those online?

MR. RUBINSTEIN: Yes, we do have one hand raised and that

would be Bill Barcellona, I am unmuting him. Bill, please state your full name and your affiliation for the record.

CHAIR GRGURINA: Bill, I think you need to unmute yourself.

MR. BARCELLONA: Well, I guess that would help, wouldn't it? (Laughter.) Let me repeat that introduction. Bill Barcellona, Executive Vice President, America's Physician Groups. Thank you. Thanks to the Board for today and, Lindy, thanks for your report.

Lindy, after the most recent SAC meeting APG submitted a letter of concern to the DHCS and copied Director Watanabe as well. In your re-procurement presentation the Department stressed that it's going to use value-based arrangements with providers to better align payment with quality of care and performance as a priority. Our letter of concern outlined the fact that with all of the changes that are occurring with Cal Rx, CalAIM, and the re-procurement and some of the other initiatives that you mentioned today, we really want to emphasize that stable and predictable risk-based contracting between plans and providers is essential to the continued financial solvency of those risk bearing providers, which of course, is what we are meeting on today.

We can't stress enough the need for stakeholders at the plan and the provider level to sit down with the DHCS and the DMHC to talk about the frequency of change in risk bearing arrangements in the Medi-Cal marketplace, and how that impacts the financial solvency of these organizations.

I have been monitoring this Board, well, for a long time, 20 years, and at every meeting DMHC staff always cites risk bearing groups that are on corrective action plans and the majority of those groups for the past 20 years have been Medi-Cal managed care groups. It is not just rates that are

determinative of them ending up on CAPs. It is also their ability to manage in a predictable and stable way the risk bearing arrangements in Medi-Cal managed care between those plans that you at DHCS supervise and these groups. And so I hope the Department reads our letter and I hope that we are able to sit down with the Department, with both Departments in the near future, and discuss some of these incoming issues as we expand a lot of these programs here over the next six months or so. Thank you.

CHAIR GRGURINA: Thank you, Bill.

Daniel, do we have any other comments or questions from members of the public?

MR. RUBINSTEIN: No, Bill was it.

CHAIR GRGURINA: All right, thank you very much.

All right, Lindy, you are free. Thank you for joining us, we appreciate it.

MS. HARRINGTON: Thank you everyone. Have a great rest of your day.

CHAIR GRGURINA: All right. Okay, next up we have the 2021-22 budget and Dan will lead us through that.

MR. SOUTHARD: Thank you, John. Good morning. My name is Dan Southard, I am the Chief Deputy Director of DMHC and I will be providing you with an update on the DMHC's fiscal year '21-22 budget, which will include some information on our spending authority of our funding, our authorized positions, and then I will conclude my update with some information overview of the three DMHC fiscal year '21-22 budget change proposals. So if we can move to the next slide, please. Thank you.

As you will see here, our spending authority has increased by about $7 million dollars from fiscal year 2020-21 of $96 million to $103,396,000 for fiscal year '21-22.

Our authorized positions have also grown by 11, moving from 505 authorized positions in 2020-21 to 516 positions in fiscal year '21-22. Next slide, please.

This slide shows a chart of our progressive and gradual growth of the Department, not only in our spending authority or funding but also our authorized positions. And for some context, the growth in our spending authority has increased by 64% from fiscal year '14-15 and our authorized positions have increased by 77% since fiscal year '14-15.

Next slide, please.

So next I want to spend some time giving you a brief summary or overview of the three fiscal year '21-22 budget change proposals for the DMHC starting with SB 855.

SB 855 amended California's mental health parity statute requiring full service health plans in group and individual markets to cover treatment for all medically necessary mental health and substance use disorders listed in the most recent version of the Diagnostic and Statistical Manual of Mental Disorders or DSM. This included expanding substance use disorder coverage requirements to health plans in the large group market. SB 855 requires the DMHC to annually review health care service plan documents for compliance with the mental health and substance use disorder treatment requirements. The funding we received for this SB 855 is a little over $1.3 million and 5.5 positions ongoing.

Moving on to AB 1124. AB 1124 requires the DMHC to authorize two pilot programs in California, one in Northern California and one in Southern California, no later than May 1, 2021. Under each pilot program a voluntary employees' beneficiary association or VEBA or a trust fund would be permitted to undertake risk bearing arrangements with providers without being subject to licensure under the Knox-Keene Act. The pilot program will begin independently and operate through January 1, 2022 -- from January 1, 2022 to December 31st, 2025. The purpose of the pilot program is to demonstrate whether this contracting arrangement leads to better control of health care costs, improves health outcomes and quality of service when compared to a fee-for-service provider reimbursement model. The DMHC will commission a report to the legislature by January 1, 2027. The DVC will also use a consultant to review the clinical patient outcomes reported by the pilot participants to assist with preparing the report to the legislature. The funding we gained through this AB 1124 is limited-term expenditure authority ranging from $413,000 in fiscal year '21-22 to $342,000 in fiscal year '26-27.

Then moving on to the last update on the budget change proposals. This is regarding our annual health care services plan health equity and quality reviews. The statutory changes apply to full service and behavioral health plans licensed by the DMHC, including health plans that contract with the Department of Health Care Services to provide health care services to Medi-Cal beneficiaries. The statutory changes add the following new requirements:

The DMHC will convene a Health Equity and Quality Committee in the first half of 2022 that will make recommendations to the DMHC on a priority set of standard health equity and quality measures and annual benchmarks. The

Quality Committee members will include state departments, purchasers, consumer advocates, health care service plan representatives, provider representatives and representatives with expertise in quality measurement in health equity and disparities as well as health care delivery and other entities that the committee deems appropriate.

The DMHC will be contracting with an external consultant with expertise in the subject area to assist the Department in planning, organizing and facilitating the committee meetings. Based on the committee's recommendations the DMHC will establish a priority set of quality measures and health equity and quality benchmarks for all full service and behavioral health care service plans to be accountable to. The plants will annually submit a report containing data and information on the priority set of measures and annual benchmarks to DMHC beginning in 2024 for measurement year 2023.

The DMHC will have the authority to require corrective action plans and take enforcement action when health equity and quality benchmarks are not met. This includes monitoring corrective action plans and improvement efforts where needed and taking progressive enforcement action against non-compliant health care service plans. The DMHC will also produce an annual health equity and quality compliance report beginning in 2025 and that will be utilizing the data we receive in 2024 for measurement year 2023. The DMHC will make changes to the health equity and quality measures and annual benchmarks until the requirements are codified in regulations. In addition the plans and their subcontracted health plans will be required to obtain and maintain NCQA or National Committee for Quality Assurance accreditation by January 1, 2026 and this is in alignment with the requirements of DHCS. The development and

implementation of this proposal, the DMHC will continuously collaborate with OSHPD, DHCS, Covered California CalPERS and the Department of Insurance in establishing the priority set of standard quality measures and benchmarks. DHCS will coordinate with the DMHC to conduct similar work for county organized health systems, health plans that are not required to obtain a Knox-Keene license. The funding for this proposal is staggered over a number of fiscal years starting with two positions and $952,000 for fiscal year '21-22 and increasing to 24.5 positions and $5.4 million in fiscal year '28-29 and annually thereafter.

And that concludes my updates. More than happy to address any questions.

CHAIR GRGURINA: All right, thank you, Dan.

Board Members, are there any comments or questions for Dan? I see, Jen, you have your hand up.

MEMBER FLORY: Yeah, I just wanted to say that we at Western Center and other consumer advocates are really excited about this health equity proposal. We have been involved in efforts with Covered California and DHCS around health equity but it will be really interesting to see how this plays out differently when it is a regulator that is in charge. We are looking forward to continued work on this, thank you.

MR. SOUTHARD: Thank you, Jen. And I just want to, one other update real quick on this is we are currently drafting the solicitation for the committee meeting members and we hope to release that in the next 30 days or so.

CHAIR GRGURINA: Paul.

MEMBER DURR: I just want to compliment you, Dan, on the presentation but also to voice support for the AB 1124. I think it is innovative in approach and I applaud the Department for continuing to be mindful of that with working with delegated groups and big funding organizations like VEBA and applaud the Department for their expedience in reviewing the necessary documentation on that and being open to new, innovative models of providing care with delegated providers.

MR. SOUTHARD: Thank you, Paul.

CHAIR GRGURINA: All right. Other comments or questions from the Board Members?

Okay, Dan, I will just add to Jen's comment. Looking forward to the work on health equity and just as a reminder and underscoring what you had said, which is, the coordination between DHCS, Covered California, CalPERS, all payers, so that we are not running 15 different models that are then being run through the health plans and then of course, coming down to the providers who are then having to track and be able to try and make changes to hundreds of different equity measures. I know that that's part of the committee that is being put together and working across lines between major payer groups so thank you, I appreciate that.

MR. SOUTHARD: Thank you, John.

CHAIR GRGURINA: All right, let's go back and, Daniel, do we have any members of the public who would like to make comments or questions for Dan?

MR. RUBINSTEIN: We do not.

CHAIR GRGURINA: All right. Well, Dan, thank you very much and

we will move on to the role of the FSSB and future priorities and I believe Mary will take that on.

MEMBER WATANABE: Thank you, John. And Paul, not to put you on the spot but this is for you. We had a really good discussion regarding the role of the FSSB and future priorities at our last meeting but we wanted to bring this back. We were hoping, actually, Amy could be here too but we did want to just revisit again the purpose of the Board and some of the discussion we had. We also had the letter from APG, which we did not include in the materials for this meeting but you can find it in the materials for the previous meeting. So I will try to briefly go through the presentation again one more time. And again, Paul, we wanted to give you the opportunity to weigh in but also for the Board Members now that maybe you have had some time to think about this too, we will just have an opportunity for continued discussion.

So again, just as a reminder, the Board was established by SB 260 in 1999 in response to concerns about the financial solvency of RBOs, many of which were going bankrupt in the late '90s.

The purpose of the Board is to advise the Director on matters of financial solvency affecting the health care delivery services.

Develop and recommend to the Director financial solvency requirements and standards relating to plan operations, plan affiliate operations and transactions, plan provider contractual relationships and provider affiliate operations and transactions.

And to periodically monitor and report on the implementation and results of the financial solvency requirements and standards.

SB 260 also directed the Board to provide a study or report to the

Department on specified criteria related to risk sharing arrangements and RBOs by 2001. There is a lot of old information here.

And required DMHC to adopt regulations related to solvency standards and monitoring of RBOs as recommended by the Board.

The primary focus of the Board in the first four to five years was to develop these regulations and standards and then beginning in 2005 the agendas began to expand to include other topics. We have also used these forums to provide regular updates on other Department areas and at the Board's request to have the Department of Health Care Services provide regular updates on topics that impact the financial stability of the RBOs and health plans participating in the Medi-Cal program.

One of the last times the Board revisited kind of the priorities and the focus of the Board was back in 2012. At that time, obviously, the focus was on the implementation of the Affordable Care Act and Covered California, rate review, accountable care organizations and medical loss ratio, risk adjustment, risk adjustment transfers, reinsurance and risk corridors.

And again, as I mentioned, APG submitted a letter with a number of suggestions for future areas of focus from the Board. They also highlighted some of the history and performance related to the oversight of the Board along with current challenges. There were a number of suggestions that were made in that letter and at our last meeting we had a good discussion. It sounds like there is support for including some of those recommendations in our future meetings. We have already incorporated a couple of the suggestions into our ongoing reporting and it seemed like there was interest, and you heard some of this today, in continuing to look at quality and the information that IHA has, which we

will hear about more in a moment.

And again, a lot of consensus around recommendations related to looking at RBO performance and financial viability while also looking at the root causes of why RBOs are on a CAP.

We will we will take some of that feedback that we heard at the last meeting in addition to what we hear today. We are going to take a look to see what maybe we can incorporate into our future reporting as well as bring back recommendations to the Board if we think there are some new things that we need to flesh out.

We also shared this table on report frequency because we thought it would be helpful to share kind of the cadence of when we bring things to the Board. There are a number of items we present quarterly, others are twice a year and there's a few that we present either annually or less frequently. The feedback we heard last time was that generally we were presenting the right information at the right frequency and so our plan at this point will be to continue.

And with that, Paul, not to put you on the spot, but I do think we wanted to give you the opportunity to provide additional feedback today and obviously open it up to any of the other Board Members for additional input as well. So with that, I will turn it back to you, John.

CHAIR GRGURINA: Go ahead. Paul has got his hand up but we will put him on the spot. Paul, your thoughts and comments.

MEMBER DURR: Thank you, John. Thank you, Mary, a great overview. I did look at the transcript from last meeting and thought there was a good discussion. I agree and support the direction and I have seen that you have taken some of those recommendations in the material that we are

presenting today. I do think that the role of FSSB is still very vital. It's proven, and Jeff's data will prove that out, is that the delegated medical groups and the model that we have here in California does really provide value both on quality and cost for the citizens of California in making that decision to purchase insurance or have insurance so I do applaud the Department and the role of FSSB in managing that and monitoring that.

I think it is critical that we have a great model. It is up to us to continue to enhance that and further evolve as we have done over the years so I appreciate that and I appreciate the overview as well.

I do think in support the, the guidance to really look at this every once in a while. You know, ten years is a long time for us to reset as well as when we bring new people on to the Board to ground them in what our purpose and vision is for FSSB. I think that is, that is really important to really engage that dialogue with new members so we have a good foundation for what our role and responsibility is. I think what you are doing is great. I love your leadership, your perspective on it and the openness to hearing our suggestions for improvement and, and being open to them.

MEMBER WATANABE: Thank you, Paul.

CHAIR GRGURINA: All right, thank you, Paul.

Okay, Larry then Ted then Jeff.

MEMBER DEGHETALDI: So I love this, I love the history of this. Jackie Speier in 1999 did not anticipate the Affordable Care Act driving a third of Californians into Medi-Cal, didn't anticipate that today we would have half of Medicare beneficiaries in Medicare Advantage, didn't anticipate the explosion of Medicare fee-for-service value-based options that cross over into a sort of a

managed care world, didn't anticipate the huge dependency of those of us who serve government patients on the cost shift from commercial payers, and didn't anticipate a pandemic that would expose the health care disparity gaps. I guess my point is that DMHC with 28 million and FSSB with its scope creep that we are feeling is an important way to talk about all of these issues that affect all 40 million Californians, you know. So that that's just my point. I appreciate ,Mary, your team's willingness to put up with us who talk about things like amputations of the diabetic limb, et cetera, that don't have a lot to do with -- well, they do have a lot to do with health care financing. But thanks.

CHAIR GRGURINA: Thank you, Larry.

Ted.

MEMBER MAZER: Mary, thanks for the history there and to Paul. Yeah, I'm the new, I think I'm still the newest guy on this group and still trying to figure out that whole history, even in the second presentation it's kind of an interesting history having actually been present during those debates with Jackie Speier and yeah, could not have anticipated where we are today.

Just a couple of comments that I think there are some places we could go. We get lots of in-depth reporting, great reporting. We raise questions about some of the things like the ongoing CAPs on the same plans or the same management companies. I would like to see whether this group as part of its role in advising the Department can get a deeper dive into some of these issues of the same players month or quarter after quarter and have more firm ability to make recommendations of how to proceed. I am the curmudgeon every time saying okay, this is the sixth quarter that the same group is there and what are we doing about it, and I understand the potential repercussions. Now we have

Anthem and Dignity splitting and that is going to affect about 10,000 people but it is going to affect two RBOs as well and what are those impacts. So that is one recommendation of something I think we'd like to look at a little bit more closely and have a little bit more input on.

The other one is looking at these one-off events. It's got to be retrospective, obviously. But the events that tend to lead to the RBO difficulties, that lead to difficulty on access to care whether it's in managed care Medi-Cal or it's in a commercial program. We have COVID, we know that, but there are other events that come up and we need to look at what the trends are so that we can help predict the next problem before it becomes a problem. So I think there are other roles we could be taking on and I'd love more history, thanks.

MEMBER WATANABE: Thank you.

CHAIR GRGURINA: All right, thank you, Ted.

Paul. I apologize, Paul. Jeff.

MEMBER RIDEOUT: Yeah. Hey, Mary, thank you again and I do appreciate the history. I didn't live through as much of it as maybe some others but I think we abandon it at our peril so that's always part of it.

And I do realize we are constrained by legislation but I came around to like what's in a name, the Financial Solvency Standards Board. It's really hard to say and the word Financial Solvency really dictates sort of, kind of the scope and I think Ted mentioned scope creep. But I think in the end we can't abandon that but I think it would be interesting to think about a broader charter that institutionalizes some of what we talk about almost ad hoc. So whether we are going to talk about quality, health equity, whether it's IHA, whether it's DMHC, whether it's somebody else, I think it would be nice to say, you know, that's part

of our purview and part of our charter as well because that goes to so much of what we are talking about. And I know we have tried to connect the dots between those two but I think with some exceptions maybe more on the Medi-Cal provider side.

The solvency issue is not the burning platform as much as it needed to be in terms of sort of the review. So again, we are kind of back to what, what can we do under the legislation, versus what needs to be done in a forum like this to really pay attention to what is happening in the market, so to speak. So I know that's a tall order but as a committee member, you know, I would love to spend the time to do a refresh, you know, to really think about how can we make this even better. Because I think we are getting a lot of the information that we all crave and work in but maybe not quite as much focus on it on a consistent basis. So anyway, thank you.

CHAIR GRGURINA: All right, thank you, Jeff.

Any other comments or questions from the Board Members?

Okay, if not I will echo particularly Paul's comment early on of I think it would be great to do a refresh each time a new Board Member comes on. And we certainly also could just have right at the front, the mission, the drive of what we are just to remind ourselves, and quite frankly, because we have members of the public who are coming for the first time at each and every meeting, so I appreciated that comment.

And from Ted's comments about the risk-based organizations and we have the CAP reports where there are several who have been on again and again and again. I agree with Ted that we need to take a little closer look and we also need to look because it's one thing if it's a financial issue, it's another if are

they paying claims on time, do they have a TNE issue? What is it and why do they continue to be on and how do we make sure that not only are they going to be okay but that they are serving members well. So I am a big believer, as Jeff and others had said, of just trying to get a little bit better over time again and again and again in raising the bar and I am very appreciative to be part of this Board.

So with that, let's go ahead and see, Daniel, are there any members of the public who have any comments or questions for this item?

MR. RUBINSTEIN: There are no raised hands currently.

CHAIR GRGURINA: All right, thank you.

All right, Mary, well thank you. We will continue to work forward. I tried to see if I could slip a second comment in from Paul there. Ted, you have your hand up or is it still up from before?

MEMBER MAZER: No, I did put my hand up and this is more of a question of how we could proceed with what we are talking about and that is whether without violating open meeting acts, et cetera, is there a place in which the Board can do a mini-retreat to discuss what our purview is under law and what we can do to expand that, whether it requires legislative change, or is already covered. We would not discuss the business that comes before these meetings but maybe give us a little bit more time to hash out how we can move forward to expand, improve or make more relevant What this FSSB does.

MEMBER WATANABE: Yeah. And Sarah Ream our general counsel is on the line and I can ask her to weigh in maybe what we can and can't do, but we do need to be careful that our discussions are in a public forum. I will say for me in my mind the next steps are really for us as the Department to go

back and kind of summarize the feedback that we received at the prior meeting and today's meeting. In particular there were a number of recommendations at the last meeting about how we do that deeper dive on RBO financial solvency issues and why we have groups and some trends of why we have RBO to continue to be on CAPs. So I think there's some good feedback that we received that we can consolidate and maybe come back with a recommendation.

In terms of the scope and the very somewhat narrow focus of financial solvency that this Board has been charged with. We do have some constraints there. There's been a number of efforts over the years to potentially expand the scope of the Board but I believe in many cases to do, to formally expand the scope we would need the appropriate authority to do that. But that doesn't mean a lot of the things that we discuss here absolutely have an impact on the financial stability of both the plans and the RBOs and so we have tried to make that connection in the information that we have presented.

But Sarah Ream, I don't know if you are on the line, if you are able to jump in and give us any feedback on kind of our legal constraints about meetings.

MS. REAM: I am, yes, thanks, Mary. You can't meet without the public present, essentially. I think the idea of a retreat is, is really, it's intriguing and interesting and could probably result in some really great, you know, info, you just need to do it as a public meeting. So you could have a meeting potentially where that's the purpose of it is to discuss and really dig into the, you know, what the Board will look at, what the purpose is and so forth, but you do need to do so in a public setting.

CHAIR GRGURINA: All right, thank you, Sarah. I figured that was,

that was what the answer was.

And then lastly on this topic is just a special thank you to Bill Barcellona who had raised this several meetings ago to say, hey, it might be time to go ahead and just take a refresh, take a look and let's discuss this. So Bill, thank you for raising that several meetings ago.

All right, so we are on to agenda item 7. The expectation is so large that one member who couldn't make it broke what was their other commitment to be able to be here to hear Jeff and the Health Care Cost and Quality Atlas; so, Jeff, I will turn it over to you. Jeff, you are on mute.

MEMBER RIDEOUT: Thanks very much, John. I hope we don't disappoint, I will do my best. I first of all want to thank Mary and all of the Board Members for giving us the chance to give our update on the Atlas results. And I will make some comments as we go but I guess the opening comment is, this is a great resource that California and the California health care industry has created voluntarily. We have refreshed the information on a regular basis. I really don't want people to imagine that we are trying to make a political point or a policy point, we are really trying to show capabilities and capabilities in anticipation of the state's own health care payments database that is coming online soon. I think the best way to think about this is understand that the industry has done this voluntarily and that we are moving toward institutionalizing something like this at the state level and maybe let your mind think, well, what's possible, what could we do with consolidated data and information on behalf of the consumers of California?

So I will, can everybody see my screen? I am going to try to be the sharer because there is some animation but I will turn it over to Jordan if that

doesn't work so we will go from here.

It is important that you understand some of the background, where this comes from and who IHA is. Again I want to thank everybody for their kind mentions along the way. We are an interesting organization. We are a 501(c)6 not for profit. Many of you have heard this before but I think it's important, especially for the public to understand, we are a not for profit but a 6 is a business League, by definition in the IRS. And what that means is we exist solely as a not for profit to find those few and maybe many things that our members can do together as a utility that will improve the state of health care in California.

So two things I'd say about this: It's a very unusual charter in the sense that we are here just for that purpose, to find things that can be turned into utilities or standard approaches.

And two, if you look at the logos, it is not so much the impression that you have of looking at all these really well-known, highly familiar brands; it's that think about them as organizations that compete like cat and dog all the time. So how do you find those few things that everybody wants to get together and do for the mutual benefit of the state of California. And I will point out that we do have health plans, we do have risk bearing provider organizations, we do have health systems, we do have regulators. DMHC at the director level is a member in a non-voting capacity. We do have pharma, we do have Covered California, we do have University of California, we do have CalPERS. So the goal here is a big tent. And sometimes a big tent can work if people have an opportunity to work together and I think some of what we will show you today suggests that that is possible. Not always easy but it is possible.

We have two major areas of focus, program focus. I will talk primarily about our performance measurement area. Most of you are most familiar with IHA in terms of its provider level measurement. So every year for over 15 years we have produced standardized quality, total cost of care, utilization reports on over 200 provider organizations that, again, voluntarily allow themselves to be rated publicly. It is a pretty amazing commitment to have that level of transparency. We also have another big part of the organization which is around provider directory improvement. I am not going to talk about that today; that's our Symphony program but it's very, very important.

Under the performance measurement area we also have some new work coming out through EDGE, that's Encounter Data Governance Entity that we were awarded recently through a HealthNet award that was part of an undertaking that started several years ago by DMHC related to the HealthNet-Centene merger. The reason I mention that is in our mind all of these things perfectly align, if we choose to make them align. If we don't choose to make them align all these things are kind of scattered efforts to create data, data lakes, as they call them, create information. Our goal, and it has been my goal for five years, six years, is to make sure we do everything we can at IHA to show what's possible, but also to make sure what we are doing is as aligned as possible. Because the one word I hear over and over again from our members, including this new health equity committee, is alignment, alignment, alignment. We want to be rated, we want to do better, we want to improve. What is really, really hard is when it is coming at us from every quarter, a variety of different ways. I am boringly and numbingly committed to standardization so I probably needed to be in the French civil service or something like that. But there is no way -- my first

real project was, if people remember, the HEDIS CCIH standardization of, count them, six quality measures; and that was a major, major undertaking to get everybody to align. So it's just kind of in my DNA and it's still necessary and I think there's a lot of good work to come.

So we are going to focus on this one wedge called Atlas. I do want to acknowledge that we can't do this alone. We are a committee of, an organization of collaborators, of conveners. But the work actually also includes some very important work, in this case, on the side of the ledger from Onpoint Health Data. This is not an advertisement for Onpoint, this is a statement about dependency and partnership that allows us to do this kind of work using a common database.

And that's another huge thing. It's kind of technical but I used to work in the tech industry. If you don't have common infrastructure, it's probably not going to work very well. So one of the goals that we have had is to develop a common infrastructure. And really the more recent beginnings of this infrastructure came from a CHCF grant so I'm acknowledging a lot of folks. But this was six or seven years ago when the state did not get a CalSIM grant at the federal level and the former deputy -- the former director of California Health and Human Services said, let's try to keep the pilot light on on a common infrastructure until and unless the state decides to do it itself.

And that day has come with the HPD. And what we have tried to do as stewards of this is keep the pilot light on for a common infrastructure for the state of California so that when the state is ready to take that on we can either participate, we can support, we can enable or we can give over that work, having had the plans and the providers essentially become used to things like

common data layouts, quarterly reporting, standard risk adjustment, standard wage adjustment. So all of the standardization that's under the hood that you'll never see is absolutely essential for this work and we have tried very hard over the last four or five years to make sure the industry is ready for what's coming now.

I am not going to go into much detail on this but, again, I talked about our Align, Measure and Perform side. That's really more about provider level measurement.

Today we are going to be talking about Atlas. Again, common infrastructure. Atlas is reporting that is, I will describe it in more detail, but we now on a voluntary basis have over 50% of the California population under management and I will describe what that means. And if you don't include Medi-Cal, which we want to, we have been anxious to include Medi-Cal data for a long time, it starts to approach 70%. So I think for this audience, it's really, we do have a good representative infrastructure sample and it's growing all the time.

So what is Atlas? Again, remember, common infrastructure. This all comes out of the same infrastructure. Atlas is a reporting program. And I think for many the best analogy to say is, this is like an all-payer claims database that a state might mandate like the HPD but it's done on a voluntary basis. And given the size and scale of California it represents, we think, the largest voluntary all-payer claims database in the country, or multi payer. It doesn't have everybody but we cover about 90 to 95% of the commercial and Medicare Advantage data in California on a voluntary basis, which is pretty outstanding.

We do standard measurements so over two dozen standard measures of quality, total cost of care, patient cost sharing utilization. A kind of

reference back to the health equity and quality discussion we have, we are using the measures that could become the core set for that work. We are using NCQA and NQF approved measures only; there's no sort of let's manufacture something on our own or let's do -- we have had to do that in the past because we have been ahead of a national curve. But everything that we measure is referenceable to national standards. You can argue with the results, you can argue with the quality of the data, but we are trying to do this in a way where at least how we are measuring is not something that everybody debates.

Mention again we have about 20 million Californians in this program now. All, you know, HIPAA-secure privacy, all of that.

We only look, we don't look at member level detail. We could, it's available, technically. But our charge with the plans and the providers that participate is really driven by the business rules. So I'd like for folks, and I'm sorry, this is kind of a long-winded introduction but think about the difference between capabilities technically and what you are allowed to do from a business rule and legal point of view. And remember, this is voluntary. So all of this is coming to you and to us through use agreements between our plans that provide the data, providers and IHA.

We have been doing this since 2015 and I referenced the CalSIM grant that we did not get as a state. I was at Covered California at the time. Really, really important to know that we have tried to make sure that the capability to do this reporting is there and we have supplied information through our business rules to the Healthy California Commission, to Covered California, to OSHPD. So what we are trying to do is say, look, to the extent we can we want to be good citizens and provide the information that helps keep this ball

rolling.

And what's improving, and this is again, under the hood, but we are now submitting quarterly. Think about that. The plans in this program are submitting all their data every quarter on a regular basis. And that's a really, really hard thing to do but it's necessary to get kind of the speed of the information going as fast as we can but also all the technical things that have to happen, common data formats, common risk adjusters, all of those things. That's what people are committing to and have committed to over the last four or five years so we are in this position.

This is a very selective list of the kinds of analysis that we have done already. I am not going to go into it other than to say this list could go on for pages and pages and pages. It's not about what you choose to report, it's about whether the infrastructure is capable of doing that, so I am going to give you a couple of tastes of that. My guess is you will have many more questions than we will answer. And the point here isn't to answer every possible question, it's really to help people understand the capabilities that we have currently but I believe the state will have in abundance with the HPD.

And you can see a lot of the kinds of things we are looking at. I am going to highlight just the primary care spend to show you a little bit of the nimbleness. We were asked to do a lot of that work on behalf of Covered California, which we have done, and that included a really good look at sort of how much different health plans and different organizations spend on primary care. I am not going to share the results, that's another discussion, but what I will say is that because the database is so large we could look at that for not just Covered California QHPs but the plans in general. So the benchmarking is really

quite enormously comprehensive given that we have so many records under our management.

All right, so this is a wonky slide but it's a fun one and I'll explain it. If you look at the vertical axis it's the colorectal screening cancer rates. If you look at the horizontal axis it's an individual physician organization contracting with more than one health plan. So this is not to point out, you know, if things are bad or good. What it is to point out is if you are a physician organization in this environment you might be rated very highly on colorectal cancer screening by one plan versus another plan that might rate you very low. So even if you are using the same measures it's really impossible for you to understand where you sit for your whole population and you might have your own data that says you sit somewhere else.

So the whole point of what we do, and we have been doing it for 16 years is, how do we get the reliability to a point where people can actually act on the information? And when you aggregate The data, in this case across providers but it could be across a geography, it could be across a line of business, you get something that looks more like this. So this is where you can actually start to take some measured action on what needs to improve or not improve.

So that's, you know, that's the tale of standardization and reliability if you are going to actually do things like regulate an organization based on performance. Because if the data is bad, and that's partly why we are pushing the encounter data program, or if the data is unreliable, we will spend endless amounts of time talking about data quality and whether it's reliable or not, we will not get to actually improving what we are trying to improve. If everybody had to

question whether the vaccine rate was right or wrong we would never improve the vaccine rate, is essentially the example.

So I am going to pause here just to catch my own breath but remember, we can do a lot of analyses. This is one we chose to do and it's only our choice. It may be not the one you are interested in, it maybe is one that you think, wow, why do you keep you know, pushing on integrated care? Well, look at our name, we are the Integrated Healthcare Association. So we are not trying to promote it to the exclusion of anything else, we are saying it's a very interesting and important fact for our members that we understand, you know, credibly and reliably where integrated care sits in the, in the, in the landscape of things.

Larry, I see your hand up, I'm fine taking questions if you'd like.

MEMBER DEGHETALDI: That colorectal chart is a thing of, it's ugly and beautiful at the same time and it shows disparity, Jeff. And I can guarantee you, you construct that for the Medi-Cal population, the Medicare Advantage population, the commercial HMO population and the orange lines are not going to be congruent. And that is -- that's a perfect example of, you know, advertisement, in quotes, for IHA so thank you.

MEMBER RIDEOUT: Yeah. And you are anticipating what I'm going to show and I want to assure everybody that nobody other than Mary saw this ahead of time and she got it late last night, because of the crunch so, but that's exactly where we want to go. So if you want to read to the end of the book it's, if you do this well with reliable data in a standardized way you can actually start to apply things like equity adjusters, which I will show you that, so that you can say, wow, is that difference just sort of bad performance on a, on the same

type of enrollment or is it actually something where we need to get under the covers on something as important as disparities, because we will never change that. So that's, that's kind of the preview.

Okay, so what we looked at in this analysis, and remember, it's one of several we could have done and I will show you two different things if I have time, is, let's look at what the impact of capitation is on performance, both quality and total cost of care, again, using standard metrics, nationally endorsed.

And we picked this, you know, because we are the Integrated Healthcare Association, but it is a material difference and we have seen this year over year in the state of California where it's not in the rest of the country, necessarily. So it's really important for people to understand the delivery system drives much to this and that makes sense. If you are -- I'm a doctor, I grew up in integrated care and trained in an academic medical center like many people did. The point is -- I believe, and this is a personal belief, you do better when you are surrounded with peers and colleagues that are there to help you and there to kind of keep track of you and you have access to systems of care that can help. That's my personal bias. I want to show you the data and you can judge for yourself but this is the kind of thing that we would look at.

I want to also point out this does not include Kaiser Permanente. And the reason it doesn't is because Kaiser is such a large part of this landscape it will swamp the results. And I will say on Kaiser's behalf just so people can anticipate, they do really, really well, so the results you will see would be even more dramatic if they were included. I want to say that so you understand because the first order question most people has is, what does it look like without Kaiser? This is what it looks like without Kaiser and it still looks really

dramatically different so I want to share that. So that's why we have the 12 million but we are looking at 7.5.

This is just kind of your overview. Integrated care. If capitation represents integrated care it's unequally distributed across the state. About half the enrollees, and this is commercial only, in Southern California have access to integrated care and are seen in integrated care communities, capitated environments, not so much in Central and not so much in Northern. So part of this is the lumpiness of how penetrated integrated care is. That's the kind of thing people have to account for in public reporting.

First measure, look at that quality composite. This is 12 different measures. A couple things I will say about 12 measures: Don't we need 100? Don't we need to measure everything? Answer: Probably no at this level. If you are measuring performance at a population level this measures preventive health, this measures the chronic care management; and it's a proxy for everything else and we know that from other analyses we do. It's also a proxy for other lines of business. People that do well in commercial do well in Medicare Advantage and actually do well in ACO work and PPO work. So it's, it's important to understand, we are not trying to boil the ocean, measure everything, we are not working at that level. We are working at where's the canary in the mine, what can we look for that will help us improve?

And the first story here is, when you take a capitated risk and therefore are part of an integrated care community you generally perform quite a bit better and the professional risk as opposed to full risk is enough to get you over that hump of performance. And our supposition, not proven, is that in order to take any risk, any financial risk, you have to have some systems of care

around data, care management, things like that, that actually help you monitor and measure a population. This is not to say, physicians as individuals don't do a great job, this is to say in aggregate, working in systems of care seems to have a beneficial effect.

So let's break the care down, the quality down to within those 12 measures.

First, you look at preventive health.

You know, it's not a dramatic difference. And again, this is where I could qualify everything. Well, it's because of encounter data and, you know, we are not measuring stuff that's hard because people aren't getting paid to do it. They're getting, you know, they're responsible for it but they don't always track it. But I think that's kind of the nature of what we have to deal with as a state. We have to account for things that push the numbers one way or another and how do we adjust for that? Ted, it looks like you have got a question.

MEMBER MAZER: Yeah, just quickly. These numbers are a little bit closer together than the previous chart. I'm curious, statistically is there that big a difference, particularly between the professional only and the full risk, because those numbers seem to be very close at this point?

MEMBER RIDEOUT: There is a statistical difference. But again, this is we're peeling back the onion. It's like, is it meaningful? Is it meaningful in a particular geography? I mean, if you are in a geography where there is no access to integrated care it's a different sort of puzzle to solve than if you are in a geography where you have that choice. So again, that's going to be one of the thousands of questions. But we believe it's meaningful. It's observational, though, Ted, I think is the right answer.

MEMBER MAZER: Yeah, okay. So it might be interesting at some other point to break it down by the different regions as those regions vary so greatly.

Thanks.

MEMBER RIDEOUT: Yeah. And I will show a version of that but I also think it's, you know, it begs more questions. So John, I will go to you and then Jen and I realize I'm probably busting through my time.

CHAIR GRGURINA: I would just say, again, this goes back to the comments you made earlier, that we have taken out the largest provider in the state, and how this would dramatically change these numbers under the full risk when Kaiser would be added to it. But I understand why you did it because they would just completely overwhelm the numbers. But we have to remember that as we are looking at this we are taking the largest provider and not including it. And there has to be some kind of recognition for all of us that these numbers would be even higher if Kaiser was included in these and even if we down-played Kaiser's overall emphasis. So I appreciate you sharing that but it's important for us to remember.

MEMBER RIDEOUT: Yep.

Jen, did you have a question?

MEMBER FLORY: Yeah, one is kind of a global question and one is more specific.

MEMBER RIDEOUT: Mm-hmm.

MEMBER FLORY: The more global question is, how do you think the voluntary nature of participation in this may or may not skew the data? And then the more specific on, in choosing the quality measures were there efforts

done to make sure that some of the quality measures were also capturing conditions where there are known health disparities?

MEMBER RIDEOUT: Great questions. First of all, the voluntary nature is data submission. Everything after that is done through our committee structure, consensus, conforming with standards, national standards. Personally I don't -- there's no cooking of the books in terms of oh, I can take this one off the list or something like that. In terms of the equity measures --

MEMBER FLORY: No, I meant by who would be able to participate.

MEMBER RIDEOUT: Oh, I'm sorry.

MEMBER FLORY: I meant by who would choose to voluntarily submit, yeah.

MEMBER RIDEOUT: This is a general statement but everyone that's of any scale, and that doesn't say that we don't want everyone in, but anyone that's of any scale in terms of enrollee participates, there's nobody not participating. Which is remarkable but there's a sense that it's important to do.

And then in terms of the measures that you are interested in. I think the challenge is what can we do either with new measures that are wholly dedicated to equity? Oftentimes very hard because data sources are not claims-based. Or what could we do with the data set that we already have? And if I have time, and I will make time, I want to get to that because the answer is, through an adjustment that RAND has developed and has been applied to national Medicare data. We can adjust our data set and the state HPD could adjust their data set based on claims. And so you can infer race/ethnicity for a population with a high degree of confidence without needing to collect that data

directly. And as I think most of us understand, there are very few organizations that do collect that data comprehensively on a direct basis, Kaiser happens to be one of them. So I'm sorry, this is not an advertisement for Kaiser but they do do that. Other plans do that but not consistently well. So we believe that there is a path here to use this data set, either ours or an equivalent one for the state, to start to do some of the work for equity adjustment on the measures that you are looking at now.

Larry.

MEMBER DEGHETALDI: Just real quickly. The two columns missing would be the Medi-Cal population here.

MEMBER RIDEOUT: Yes, uh-huh.

MEMBER DEGHETALDI: And the delta between the 75.2, the 65.9, on the chronic and the 6%, this leads to patient death. So, I mean, these look like numbers, and are they statistically significant?

MEMBER RIDEOUT: Yes.

MEMBER DEGHETALDI: The delta and gaps for colorectal screening leads to patient death so this is hugely important.

MEMBER RIDEOUT: Yeah. And again just to complete this discussion on this slide, this actually, if you start to look at the chronic care performance, it's dramatically better for integrated groups than non-integrated groups. And again, this does not include Kaiser and they are even better than this. So, you know, this, this starts to give you at least directionally What does integrated care add to the party? Now remember, there are lots of folks that are worried about consolidation, which is another concept, there are lots of areas where integrated care is not available, so all of that has to be taken into account.

But you know, the statement here is, there seems to be something of value in integrated care.

The same kind of picture with cost. This is total cost of care on average. And again, this is another commitment that the plans and the other participants have made to give us the information to do this. So it's actually in total, when you take what the plan pays and what the patient pays, on average, much less expensive to be in an integrated product. And we often talk about the cost of integrated care or patient cost share, but if you look at it on a patient basis it is dramatically different. And the story here is, most of the extra cost of a non-integrated product is being borne by the consumer and that's true, you know, whether it's Covered California options or commercial options, or self-funded employer options. All we are doing is revealing what I think everybody understands, that there is a burden for many, many consumers that's pretty significant and this becomes even more noticeable when you look at those with chronic conditions, which we have done.

So you know, if you need kind of to put it together, integrated care, assuming that capitation is a proxy for it, tends to get better in terms of quality the more risk that's taken and tends to be at lower cost. So, you know, these are relatively simple graphs but I think they tell a story that needs to be included in how -- and particularly the Office of Affordability needs to look at that option.

This is another way to look at it. I'm moving pretty fast because I want to get through this. But each of these represents a Covered California region. Not just Covered California members, a Covered California region. This is what it looks like for regions that don't accept risk. So, Ted, to kind of your comment, this is sort of for regions that don't have a lot of integrated care options

or regions where that is still a predominant delivery model.

This is what it starts to look like for professional risk and, shocker, you know, we are trying to get to the upper right green.

This is what it looks like for full risk. So a couple caveats to this. This is another way to look at the same information. It we were going to go to one of these, you know, purple diamond regions and say best practices, we better be darn sure the measures are accurate and that we are not missing things because best practices would say, let's make sure we are not sort of replicating something that isn't true.

And then I want to do a second analysis and I will pause. So now if you kind of take your head away from integrated care, I know I've sounded like a hammer looking for a nail. But if we just look at geographic what we did is we looked at all of the data we have by geography. And it includes integrated, non-integrated, any plan type, Covered California, non-Covered California. So this is sort of the big boiling pot of things. And I think the way to think about it is, yeah, it's lumpy, not every region has the same opportunities, but it's what the consumer faces. If I live in a certain area, this has sort of defined some of my available choice.

So what we did is we said, what is quality and total cost of care looked at by region. And any region that was above average in quality and/or below average in total cost of care was given a yellow; if you were better in both you were given a green, shocking; and if you were below average or below where you want to be it was given a red. So again, thousands of ways to look, is this the right way to do it? But this is all, remember, clinically risk-adjusted and wage-adjusted so some of the adjustments take some of that unevenness out.

These are the areas, some would be surprising some not, where you are either challenged -- where you are challenged by quality and challenged by cost.

These are the areas where you may be challenged by quality or you may be challenged by cost but not both.

And these are the areas where both the, versus average, the quality and costs are going in the right direction or what people would perceive in the value direction.

This, this is a hornet's nest. I know it's a hornet's nest. I'm putting it up there to say there's a million and one things to ask and answer. But I want to, again, emphasize that with a data set of this size and scale and standardization you can start to ask and answer these questions and what's driving that.

The last thing I want to do, and I know I'm running out of time but this is probably the conclusion. We actually then said, is there a way to use the data set with a standardized adjuster for health equity. And RAND, as many of us know, it's a huge resource and treasure to have that in our state. And RAND and Cheryl Damberg who sits on our board and she was also the chair of the HPD Advisory Commission; so, you know, why not tap the people that we have close at hand. They developed through a statistician named Marc Elliott, in part, who worked on this, an adjuster that was applied to the Medicare data set nationally that would essentially try to impute the race/ethnicity, could be of individuals, but of a population based on a geo code. So it's a little bit wonky but zip code, surname, things like that, and it is incredibly accurate. So it's not a good place if you have direct information. If I say I am of a certain race or ethnicity that's much more important than if I impute that. But look at the bottom

statistic, 90 to 96% accuracy for those four racial and ethnic groups. So if you can't get to it quickly this is a way to at least say, can we start the conversation?

And I am going to put this California map back on. Here is what I want you to think about: Maybe that yellow region is yellow because it is dominated by individuals of color. Maybe it's not about integrated care and maybe that's part of the picture but maybe we need to focus on those areas where we know something like this adjuster says, this is a problem for under-served communities so let's go there first or let's spend more time investigating.

And when we put that on our data, and again, all due respect and support from Onpoint and also RAND to help us do this. We just wanted to say, will this work? And the answer bottom line, the implication is, yes, it will work. If as a state we need to move in this direction as a first step in the absence of direct information there is a lot of reliability to do that. And there's a lot of questions, there's a lot of probably concerns, we are not talking about individuals, we are talking about communities. This could be applied to a health plan, this could be applied to a provider group. But statistically it will work on this data set, which is good news because something like this data set is what the state will be working with through the HPD very quickly.

So these are just some next steps. And I will just point out the third one in the interest of time. We have offered the Director our support for the equity and quality measures, both in terms of what a core measure set would look like because that's kind of the business we are in, but also, is there an opportunity to adjust that for equity as a starting point for their work in terms of regulating based on equity and quality?

So I'm going to stop and, John, I really apologize if I've gone too

long.

CHAIR GRGURINA: No, no.

MEMBER RIDEOUT: I think I'm kind of within my half an hour but, anyway.

CHAIR GRGURINA: No problem at all, Jeff. I see actually Mary has her hand up. Mary, go ahead.

MEMBER WATANABE: Thank you.

MEMBER RIDEOUT: I'm going to the woodshed on this one.

MEMBER WATANABE: No. And I never know how to jump in so I'm just going to raise my hand. Jeff, thank you, I really appreciate, again, the time that went into putting this together and I know it was some late-breaking information that you were trying to share with us. I will just say as it relates to the quality and equity work that we do, I appreciate IHA and many others that have offered to help us. And we, we want to be respectful that we convene the committee with diverse representation and give them the opportunity to weigh in. But I think in particular the RAND information on looking at equity is really helpful as we think of some of the challenges of collecting some of the demographic data. So this is really helpful, both for our ongoing discussions about risk-sharing and the quality differences but also as we look into getting our health equity committee established. So I just wanted to say more to come on that but we also want to make sure that we have another public forum to have those discussions as well, but thank you, Jeff.

MEMBER RIDEOUT: Of course. We are here to help if we can.

CHAIR GRGURINA: Larry than Ted.

MEMBER DEGHETALDI: Two quick points, Jeff. And again, thank

you. I like RAND's creativity in back-filling the race/ethnicity data but it just screams that we need that data at the patient level in California. It's just, we can't address disparities without that.

And the other thing is, there's a difference between equality and equity. I just want to keep saying it. For instance, with COVID vaccination if Fauci says get to 70%, we probably need to get to 85% for Latino patients. So there's -- the first P70 would be an equality measure but ultimately we are looking for outcomes, equity and outcomes.

MEMBER RIDEOUT: Yes.

MEMBER DEGHETALDI: And just to remind folks of that because there is a difference between equality and equity.

MEMBER RIDEOUT: Yeah. And, Larry, I don't, I certainly in no way want to speak for RAND. What I will say is, it is highly accurate at imputing race/ethnicity. And I think you have to couple that with the fact that in our data set, and we have asked this, most of the submitters are well below 20 or 25% in collecting that information at all and comprehensively, because it's hard to do. Now, Covered California maybe can do some of that on an enrollment. Certainly you can back into it with income. But I think, just this is me talking personally, if we are going to get started down this road in a meaningful, data driven way, we -- it can't -- that hurdle has to be reduced or at least. And I think what RAND would say, and again I am not speaking to them other than what they have said, if we do both, you know. We need to validate that self-reported is -- and it is preferred and I'm sure that's why Kaiser does it the way they do. But we need to confirm that the two things do track together in the way that we think makes sense.

CHAIR GRGURINA: All right, Ted.

MEMBER MAZER: Yeah, Jeff, outstanding presentation. And like you expect it brings up more questions and more requests for deeper dives than it answers questions. I think there's other avenues to look here. Obviously, we need to know the accuracy of using proxies for race and distributions. But I think even looking at health plan formats and which health plans with their groups are performing better than others. I think all of that information would be invaluable as you go forward and I would look forward to the next presentations, either at this meeting or at some, some broader meetings to see where we can improve our efforts in organizing how we deliver care. So thank you for that presentation.

MEMBER RIDEOUT: Yeah, thank you, Ted. And what I will say, and this will sound like, you know, that I'm passing around the hat. This is a labor of love. I think it was John Locke but it's the tragedy of the commons. I mean, this is a public good and we see it that way and we want to continue to promote it and see it become even more robust, hopefully through the HPD but it's hard because people don't pay for this unless it's a slice of information. Like doing every one of those analyses that you just listed off, which all makes sense, that's where we would have trouble responding, you know, we do the best we can. So it's -- again, I'm not asking for anything other than just sort of maybe sympathy and maybe a little understanding that this is a treasure that we are stewards of and we really want to see it live and become even more robust through the HPD.

CHAIR GRGURINA: All right, thank you. And then, Jeff, my comments again, thank you so much. Amazing to be able to see the results. Absolutely agree with the comment of RAND's creativity and I think we need that

in order to get the data to be able to stratify and be able to get to health and equity and outcomes.

I would also say I appreciate from the very beginning you describing why you removed Kaiser from it and showed us the statistics. I think it would be good to see it with Kaiser, reason being is, what you are showing is there's a real difference between just fee-for-service, partial risk, and full risk. And if you are looking at California as a state, everyone included, it would be good to see all of that. Even though Kaiser would overwhelm it because they're as large as they are, but it would be good, it would be good to see the differences between those three categories given that Kaiser would fill up the bucket over on the full risk side.

But you very much for the presentation and the time and here let's go ahead and turn, Daniel, do we have members of the public who have comments and questions? It looks like I see at least one.

MR. RUBINSTEIN: We do, it is Bill Barcellona; I have granted him access to unmute.

MR. BARCELLONA: Thank you. Hey, Jeff, one quick question. I was just a little surprised that San Diego ended up in the intermediate category and Sacramento in the best category.

MEMBER RIDEOUT: Mm-hmm.

MR. BARCELLONA: Do you have any thoughts on why the data played out that way?

MEMBER RIDEOUT: I do. I think it's the unevenness of the data sources. I think in other analysis, and again, I want to be respectful of what we can make public or not, San Diego in particular has been a shining star in terms

of integrated care performance on both quality and cost.

MR. BARCELLONA: Right.

MEMBER RIDEOUT: This data merged PPO data and HMO data and may have been out of proportion to one another so it's not a fair fight in that sense.

MR. BARCELLONA: Ah.

MEMBER RIDEOUT: And again, this is the, what we chose to do, especially under the time constraints. So again, I would like to emphasize this is about capabilities, not about anything else. And, you know, for San Diego and Sacramento you'd have to say, oh, if we thought they were green or we thought they should have been higher, what's driving that? And maybe it's sort of product mix? Maybe it's -- but I don't think it's the accuracy of the measures. This is how it would feel to potentially a consumer, you know, or what they would experience.

MR. BARCELLONA: Okay, thanks. Great report.

MEMBER RIDEOUT: Thank you.

CHAIR GRGURINA: Thank you, Bill.

Daniel, do we have anyone else who would like to make a comment or question?

MR. RUBINSTEIN: No, that is it.

CHAIR GRGURINA: All right. Well, thank you very much, Jeff. And as you could see, Board Members, when we get to the end and talk about future items we'd like to have you will be called back again. And Larry, you have a --

MEMBER DEGHETALDI: Yes, one last question. When is this public, Jeff?

MEMBER RIDEOUT: So, Larry, that's a really interesting question. Again, I said, there's no kind of client for this and it's the control of sort of performance presentations are made based on the business rules. So this presentation we will make public. Beyond that it would actually be, you know, what do you mean by public? So, do you access the tool? Do you, you know, self-help your way through it? We have had to let go of some of that because of cost constraints but we didn't let go of the capability to produce this. So I don't want to say this is a one-off but until we know exactly how people are using the data and whether it conforms to our business use agreements it is pretty hard to say, oh, yeah, just go and look for yourself, we have to be real careful about that.

CHAIR GRGURINA: All right. Well, thank you very much, Jeff.

Let's go ahead and move on to the 2020 federal medical loss ratio summary and, Pritika, you are up.

MS. DUTT: Thank you, John. Good morning, I am Pritika Dutt, Deputy Director of the Office of Financial Review. I will provide you an overview of the 2020 annual federal medical loss ratio reports. There has been a lot of interest in the 2022 MLR data and we just the received information last week so my team is still reviewing the information, but we wanted to share the data with you. And then, as part of our review, and CMS's review, if plans end up refiling the information we will share an updated summary with you at the November FSSB meeting. For the details related to this presentation please refer to the federal medical loss ratio or MLR summary for reporting year 2020 and that report is included as part of the meeting handout.

So federal laws require health plans that sell health care products directly to enrollees and employer groups to spend a certain percentage of their

premium dollars on health care or medical expenses. The medical loss ratio requirement went into effect for reporting year 2011. Health plans in the small group and individual market have to spend 80% of their premium revenue on medical services. So for every dollar that the individual and the small group plans receive in premiums they have to spend 80 cents on providing medical services to enrollees. And for large group the requirement is 85%; so 85 cents of every dollar needs to be spent on provision of medical services.

If the plans fail to meet this requirement they have to pay a rebate to the enrollees. The MLR calculation is based on a three year average. For the federal MLR reporting year for 2020 the MLR and rebate calculation is based on the average of 2018, 2019 and 2020 premium and medical expenses.

Page two of the report shows the MLR for the plans in the individual market. As I mentioned earlier, the Federal MLR requirements for the individual market is 80%. The MLR for the 12 plans in the individual market range from 77.8% to 95.6%. Two plans in the individual market reported MLR of below 80% and paid rebates totaling $13.1 million. The first time one was LA Care and they paid $9.7 million and Molina paid $3.4 million. We haven't had many instances of rebate payments in the individual market so most of the years that plans have reported they were able to meet that 80% requirement except for in 2014 when Blue Shield had reported an MLR of 96.7% and paid rebates of $64 million.

For the 2019 federal MLR reporting year we had the same 12 plans in the individual market and the MLR back then ranged from 80.1% to 97.2% with no rebates paid.

Page three of the report shows the MLR of the health plans in the small group market. For the small group market the MLR requirement is 80%.

For the 13 plans in the small group market MLR ranged from 77.3% to 102.4%. Two plans, Anthem Blue Cross and Health Net reported MLR below 80% and were required to pay rebates to the enrollees totaling $74.3 million. Anthem paid rebate of $66.7 million and Health Net paid almost $7.6 million.

For reporting year 2019 there were 12 plans in the small group market and MLR ranged from 77.7% to 105.4%. And back in 2019 we had four plans that reported MLR below 80% and paid rebates. Back then Aetna paid a rebate of $2.3 million, Anthem paid rebates of $53 million, Blue Shield paid rebate of $34.9 million and Health Net paid almost $10 million.

The table on page four shows the MLR for full service plans in the large group market. Twenty-two health plans offered products in the large group market and all of them met the MLR requirement of 85%. The MLR ranged from 85.4% to 115.2%. Since all plans met the MLR requirement no rebate was required.

There are four plans that reported MLR of 100%. These are local plans that offer health care services to in-home support service workers through contracts with the counties. For the IHSS products the health plans work with the counties to set the rates.

In 2019 the MLR in the large group market for full service plans range from 82.6% to 119.5%. One plan was required to pay a rebate. Community Care Health Plan reported MLR of 82.6% and paid rebate of $1.3 million.

Table 4 on page five shows the MLR for four specialized plans subject to federal MLR reporting requirement for their large group products. Holman Professional Counseling Center and OptumHealth Behavioral Solutions

of California did not meet the MLR requirement of 85%. Holman reported MLR of 84.6% so they barely missed the 85% mark and paid rebates of $20,000; and OptumHealth Behavioral Solutions of California reported an MLR 65.8% and paid rebate of $2.4 million.

And this chart shows the total rebates paid since 2011. Since 2011, $545 million was paid out in rebates to enrollees. The health plans have to issue the rebate checks by September 30, 2021 if they did not meet the MLR requirement for 2020 reporting year. And then rebates may be issued in a number of ways so enrollees could get a rebate check in the mail, a deposit paid into the account used to pay the premium or a direct reduction in future premium.

So we are currently, as Mary mentioned earlier, we are currently reviewing the health plans proposed rate changes for individual and small group market for 2022. And one of the things we are looking at is the MLR information that we have just received so we will consider that as part of our rate review.

And that wraps up my presentation. Any questions?

CHAIR GRGURINA: Ted, why don't you go ahead.

MEMBER MAZER: Yeah, two quick questions. Thanks for the presentation.

The overall chart that you have from 2011 to 2020 shows sort of a growth if you take out 2019, there's a little decline in 2020. Is there a trend of any specific health plans that keep on showing up there? You have given us 2019, 2020 and there's no real overlap but is there any pattern into that?

And the second question quickly would be that the 2020 rebates seem surprisingly low to me because of we know that there was less health care generated and there were greater profits shown. Is that because of the three

year averaging or was there really not that much of an overage on the profit side?

MS. DUTT: So one of -- you are correct that it is a three year average so it includes the 2018, 2019 numbers as well, those MLR might have been higher. The other thing is we heard from plans that they were investing in PPE, also giving premium credits to employers and enrollees, so those things helped with the MLR for 2020.

And as far as trends go, we see a lot of rebates payment in the small group market. And again, like I said earlier, that's something that we are looking at as part of our rate review. A couple of plans have been showing up as rebate payers year over year so we will be working with those plans directly. Thank you for the question.

CHAIR GRGURINA: All right, Larry.

MEMBER DEGHETALDI: Yeah, yeah, Pritika. And I know this is for the next meeting. Risk adjustment transfers, it's 8% of the total premium. I know Anthem got a check for -- not to pick on Anthem but they benefited in the small group, they got $240 million. Does that factor in to the MLR calculation? Is that revenue, you know, or is it excluded and the plans kind of take it and run with it?

MS. DUTT: Larry, I would have to check with my team and get back to you on that.

CHAIR GRGURINA: And actually, Pritika, if you can do that at least for the next meeting because that makes a huge difference, as we have seen, in those reports. Huge payments coming generally to the folks who have PPO products and payments coming from Kaiser Permanente. I would imagine

that if at our plan if we were there and we were given money we'd be counting it as part of the MLR and lowering the overall revenue. So let's just get the answer to that but that's a good question.

Paul, you have a comment or question?

MEMBER DURR: Yeah. Pritika, a great presentation. Question, this is based on audited financials or -- I know the plans have to report the information but what oversight do we have on ensuring the accuracy of the numbers reported?

MS. DUTT: Sure. So it's part of the Affordable Care Act so we went into effect in 2011; we also have a state statute that codified the MLR requirement into state law. It differs from the audited of the gap requirements, it's purely like a statutory requirement reporting for premium and medical expense purposes, Paul. And then as far as reporting goes, we do review the report. I know that CMS is looking at it right now. We go back and verify the reporting for the previous years as represented in the reports, we also do some audits to verify the accuracy of the information.

CHAIR GRGURINA: All right, thank you. And, Pritika, thank you very much for the presentation and let's go ahead and move on to the regulation update.

MR. RUBINSTEIN: We do have one (overlap) --

CHAIR GRGURINA: Oh, I apologize. Thank you so much. Yes, thank you, Daniel, you reminded me. Comments from members of the public and I see we do have one. Why don't you go ahead and go ahead and I apologize.

MR. RUBINSTEIN: Thank you. Bill, you are clear to unmute and

speak.

MR. BARCELLONA: Thanks, Dan. Just real quick. I testified as an expert witness recently in an arbitration along with former director Cindy Ehnes and I was surprised to learn that when a health plan takes the hit under risk adjustment transfer as opposed to taking the bonus, the federal MLR rules require the plan to log the hit on the medical loss side of the MLR calculation. So I don't know if that answers your question or not but I've actually seen reports to that effect and I've seen the MLR filing forms and, and discussed that at length. It's a very strange situation. That's it, that's all I have to say, thank you.

CHAIR GRGURINA: All right, thank you, Bill.

We will leave this to Pritika and her folks to be able to come back to us next time and give us the answer and I'm sure we will all be surprised at exactly how the machinations of this work with the math behind the scenes.

All right. I apologize, Bill, for not giving you that opportunity. Thank you for stepping in and correcting me. All right, let's go ahead and now let's move on to the regulations update and Sarah.

MS. REAM: Hi, good afternoon. I am Sarah Ream; I am the Chief Counsel with the Department of Managed Health Care. Next slide, please.

Great. So I am going to be talking about a number of regulations that I am happy to say we are either -- we have enacted or are in formal rulemaking regarding, and then I will also be talking about a number of regulations that we have in development at various stages in the pipeline.

So first I am thrilled to report that we have submitted our timely access/network reporting regulation to the Office of Administrative Law. We did that last week. We have gone through -- we went through three comment

periods on this regulation. A tremendous amount of work has gone into this reg both from DMHC and from all the stakeholders who were essential in helping us draft this regulation. So we submitted it to OAH. They have 150 days to review the regulation and to hopefully approve it so we will provide updates at the next meeting if we have any regarding this reg. We anticipate OAL may take -- because of the extra time they have been given because of executive orders due to COVID we anticipate they may take longer than they normally would to review this reg but I know that they, they are diligently working on it.

The next one I wanted to mention is the summary of dental benefits and coverage disclosure matrix. So we adopted this regulation as allowed by statute, or required by statute, and it became effective in January. we are now in formal rulemaking. We started a comment period back in late July and that comment period closes in September of this year, in early September, so we are looking forward to receiving comments regarding that reg.

Finally, and I don't know if it have made it onto the next slide or not. Yes it did, great. We had, we promulgated a regulation in January during the, I guess, the second or third surge of COVID, I am not sure, one of the surges of COVID when hospitals were being particularly impacted, that allowed the expeditious transfer of patients from highly impacted hospitals to hospitals that had more available capacity when that transfer was made pursuant to a public order. This reg also prevents health plan prior authorization requirements from causing unnecessary delays in effectuating those transfers and it requires health plans to reimburse the hospitals for the cost of the transfer of the enrollees and specifies how the plan has to reimburse the hospital. So this regulation expires in November just as a matter of course. We are really hoping we don't have to

amend or reengage with this reg but more to come on that. We are hoping that the surge does not impact the hospitals in the same way it did in November.

So that is, that is what's going on in the formal rulemaking arena. Let me pause there if you don't mind for a moment to see if there's any questions on those before I move on to what we have in the, in the queue.

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

All right, seeing none you can go ahead and move, Sarah.

MS. REAM: Okay, great. So we have lots of regulations in the works and I am just going to run through them all.

So, we are updating a section in Health and Safety Code Section 1384's financial reporting requirements. We are updating the forms and instructions the plans have to use in submitting their financial statements and making some other tweaks to this, to these requirements. We previously shared a draft of the regulation with stakeholders and we actually didn't receive any substantive comments so I either take that as good news or take that as people just weren't paying attention, hopefully it's the former. We are finalizing This package and should have it to the Office of Administrative Law within the next month or so to start that formal rulemaking process so you will be seeing that one coming out fairly soon.

We are also working on regulations to implement AB 731, this is in the large group rate review context. So implementing AB 731 from 2019 and SB 546 from 2015. We have shared a draft of this regulation with stakeholders and received some very, very helpful feedback. We plan to start the formal rulemaking process for this reg hopefully by the end of the year and we are

targeting to submit the final regulation to the Office of Administrative Law in the first or second quarter of 2022.

Next regarding rate review are the individual and small group aggregate rate reporting. So as you heard earlier today, AB 2118 requires full service plans to annually report information on premiums, cost sharing, benefits, enrollment trend factors, all sorts of information for their products in the individual and small group markets.

We have an Administrative Procedure Act waiver through 2023, which allows us to promulgate guidance to health plans with respect to what they need to file without having to go through the formal rulemaking process to do that. So on July 13 the DMHC issued an APL, it was APL 21-019, that provides plans with guidance regarding what they do need to file with us in their annual aggregate rate filings for the small group and individual markets.

Those filings are due in October so we are waiting to finalize the draft regulation until we receive the filings from the plans and assess what they filed. That will allow us to tweak our guidance to make sure that when we promulgate the regulation we are getting meaningful, accurate and thorough data. So we will be seeing, we will probably be tweaking the guidance a couple more times before 2023 I would assume based on what we learn as we receive those filings and then that will allow us to put together a really robust, comprehensive regulation.

Next I want to talk about the general licensure, also known as the risk regulation. So in 2019 we promulgated a regulation that did a number of things: It defined some terms that we had all been using but had not actually been defined in the Knox-Keene Act or the regs, those terms included

professional risk, global risk, and we also codified the process through which a health plan -- an entity could file to become a restricted licensee. We also developed an exemption process for entities that were accepting a fairly nominal amount of risk, of global risk, and wanted to be able to continue to do so without having to become a licensed health plan. So we promulgated the regulation. And then we implemented what we call a sort of a phase-in period for a year to allow entities that had accepted global risk to determine, okay, do they need to come in for a license or can they file for an exemption, so we wanted to give them some time for that.

Through that phase-in period we learned all the things that we, we learned all the things we didn't know before we did the regulation. We learned a lot and we discovered that it would really probably behoove the DMHC and our stakeholders to make some amendments to the regulation to make the exemption process a bit more streamlined and provide some more guidance regarding when an exemption process, when an exemption would be granted, when it wouldn't be and what we would need through that exemption filing. So then we extended the phase-in period, then COVID occurred and threw everything sort of into -- it became the COVID, all-COVID world all the time.

So we have now extended the phase-in period until the time that we amend the regulation and that amendment takes effect. So we have been studying the info that we received, we have been talking with stakeholders about the regulation. We anticipate starting the informal rulemaking process, the sharing with stakeholders, getting feedback and responses to draft language, in early 2022, with the goal of finalizing and promulgating this regulation in 2022. So a lot of work there but we are hopeful that we can, we can make the process

a bit more streamlined for folks who are asking for an exemption. Next slide, please.

So SB 855. This is one I believe that was meant, Dan may have mentioned previously in his remarks. But this bill enacted in 2020 expands mental health parity in California and among other things requires health plans to use the most recent criteria and behavioral health guidelines developed by the nonprofit associations for the relevant behavioral health clinical specialty involved.

We are working with CDI very closely on drafting implementing regulations to implement for SB 855. The regs will update the existing mental health parity regulation we already have on the books and will also clarify and implement the provisions of the law regarding the use of this nonprofit specialty association standards.

We really appreciate all the stakeholders who have met with us thus far to give us guidance and information about the clinical specialty guidelines and just the so much information that's been very helpful in developing this regulation. We intend to start the formal rulemaking process in the next several months with the goal of submitting the reg to the Office of Administrative Law by the end of this year. And we are shooting to have a draft of the reg to share with stakeholders by the end of August so be on the lookout for that one.

The next reg that we are working on is iatrogenic fertility preservation. So this is a regulation that will implement SB 600 from 2019. We had -- and just as a quick recap, iatrogenic fertility preservation is, refers to preserving an individual's fertility prior to that individual undergoing a medical treatment that could have the side effect of making the individual infertile. So, for

example, someone has been diagnosed with cancer, they are going to be undergoing chemotherapy which could impact their ability to have children later on down the road. So there are services that they can avail themselves of that can help preserve the fertility that they have in case they decide to have a child later on.

So we have had some, again, very -- I keep thanking our stakeholders but we have had some very robust, fascinating meetings with stakeholders regarding this topic and we have learned a lot more about the state of medicine in this area and it helped us identify open issues that the regulation, we need the reg to address. So we will be sharing an outline of the reg by the end of this month and look forward to receiving feedback on that and then we plan to start the formal rulemaking process by the end of October for this one so moving, moving quickly ahead on that one.

Then the final three I will mention briefly here. So provider directories: SB 137, Senate Bill 137 from 2015 required the DMHC to establish provider directory standards and gave the DMHC a number of years to do so before we had to adopt formal regs. So again, it allowed us a chance to obtain information, provide guidance and work on finalizing a more robust, inclusive reg that we might not otherwise have been able to do. So we adopted standards in 2015 and now we are working to codify those, those standards into a regulation. We plan to share the draft reg with stakeholders by mid to late-September. And then after we get informal feedback from stakeholders and then make any changes to the reg as are appropriate we will start the formal rulemaking process which should hopefully begin in the fourth quarter of this year.

The grievance and appeals regs. We also kind of call this

informally the Help Center cleanup regs. So this reg will mostly make non-substantive changes to the DMHC's grievance forms and notices, just really modernize those a bit; and it will also clarify what it means for a claim from a Medi-Cal enrollee to have been quote/unquote, presented for a fair hearing through the DHCS process. So we plan to start informal rulemaking -- informal stakeholder review for this reg also by the end of the year.

And then finally we have the prescription drug tiering/anti-discrimination regulation. So existing law prohibits a health plan from having a formulary that discourages enrollment by individuals with health conditions. It also prohibits a health plan from reducing the generosity of benefits, including prescription drug benefits, for enrollees with any particular condition. This regulation will help us ensure that plans do not organize their formularies or tier their drugs on those formularies in such a way as to discourage enrollees with health conditions from enrolling with the plan. And we start, we hope to start the informal stakeholder process on this reg by the end of this year as well.

And with that I have just given you a whole lot of info and I will take some, take any questions you have.

CHAIR GRGURINA: Boy, Sarah, when you said you had a lot of regulations to go through you weren't kidding.

MS. REAM: We have a lot going on.

CHAIR GRGURINA: Yes, you certainly do.

All right, Board Members, any questions or comments for Sarah?

No, you have obviously explained it very well, Sarah.

MS. REAM: (Indiscernible - audio breaking up).

CHAIR GRGURINA: Daniel, do we have any comments or

questions from members of the public? I see at least one.

MEMBER DURR: Yes, we do, we have Jadie Mayes. Please state your full name and your affiliation for the record.

MS. MAYES: Hi, sure. This is Jadie Mayes from Magellan Health and Human Affairs International. I had a question about the 1384 financial reporting change. I don't see that listed out on the open pending regulations list. Is there somewhere else on the website that I can find the details of that change?

MS. REAM: No, thank you for, thank you for that question and let me clarify. So we have not started the formal rulemaking process yet, it has been just an informal stakeholder process thus far. Once we start the formal rulemaking process then we will be posting the draft language, the various documents including the Statement of Reasons why the Department is promulgating the regulation and other information like that. You will you will see that on our, on our website. So thank you for that clarifying question.

CHAIR GRGURINA: All right, thank you, Jadie.

Daniel, are there any other comments, questions from members of the public?

MR. RUBINSTEIN: No, that is it at this time.

CHAIR GRGURINA: All right, thank you.

And actually I see Jen, you have your head up.

MEMBER FLORY: This is Jen, I've had my hand raised for a while. I just had a comment on the Help Center update regarding when there is form language in the regulations themselves. And, you know, I know that you are planning on doing, reaching out to the stakeholders, but sometimes it might be helpful to have like a readability analysis of that form prior to even putting it in

regulation form. That's kind of a tricky thing to deal with once there's already proposed regulations out there and it's tricky when it's in the regulation. We just notice from a lot of Departments in general that there is more that can be done to put things in even plainer English.

MS. REAM: No, appreciate that, thank you. We will take that back. That's a terrific suggestion, thank you for that.

CHAIR GRGURINA: All right, thank you, Jen, I apologize for missing your raised hand. Now I see Ted has his hand up.

MEMBER MAZER: Yeah. Actually I was going to go there but I thought on time I wouldn't, however, I am going to back up what Jen just said. Having gone through this process personally, and you can talk to Pritika about the experience, and worked with the Department, I think you probably need to get some people who have actively tried to use the forms to see whether the minor changes that you are suggesting are enough and did they actually clarify or maybe further confuse inadvertently. It is a very difficult system to navigate as is. I am happy to hear that you are going to modify it but maybe before you promulgate the regs try it out for a couple of, a couple of neophytes. Thanks.

MS. REAM: Thank you for that, thank you for that feedback.

CHAIR GRGURINA: All right. Thank you, Ted, and thank you, Jen.

Okay, well, Sarah, thank you very much and we are going to move on to the federal update and Jessica.

MS. PETERSEN: Good afternoon, everyone. I am Jessica Petersen with the Department of Managed Health Care's Office of Legal Services; I will be giving a really brief federal update. Next slide.

Specifically on the No Surprises Act, or NSA, which was a federal statute passed late last year. The NSA sets a new federal floor that protects consumers from some surprise balance bills and excessive cost-sharing in both emergency and non-emergency contexts, including air ambulance services.

Just as a general table-setting comment, a surprise balance bill happens when an enrollee gets an unexpected bill from an out of network provider that bills the enrollee the balance between the billed charge and the amount the health plan pays. And the classic example is where an enrollee received services at an in-network facility such as a hospital, but receives those services from an out-of-network provider such as an anesthesiologist who is not contracted with the health plan. Next slide.

So drilling down a little bit on this balance billing prohibition. The NSA removes consumers from disputes between those non-contracting providers and health plans by largely prohibiting plans and providers from balance billing those enrollees as specified in the law. It establishes some rules regarding reimbursement of those non-contracting providers and it limits an enrollee's cost-sharing to the in-network level. It also requires that cost-sharing to count toward any in-network deductibles and out-of-pocket maximums. The NSA also provides an independent dispute resolution process, or IDRP, for when providers and health plans or insurers cannot agree on a reimbursement amount.

And speaking in very broad strokes, the NSA provisions apply to health plans that the DMHC regulates, to insurers under the authority of the Department of Insurance in California as well as to self-insured plans. It binds health plans and in some cases providers and facilities as well.

So for those of you who have been following the issue of balance

billing some of these issues and provisions sound familiar. That is because California has comparable laws on the books for many of these purposes and I will touch on those in a later slide. So moving on, next slide.

Beyond balance billing the NSA also includes a myriad other protections that I will touch on very briefly just as a quick list.

The first is a new price comparison tool that will allow enrollees to compare their cost-sharing for a specific item or service from a provider.

Also cost estimates that disclose the estimated costs of treatment before that treatment is scheduled to be furnished.

With the removal of certain gag clauses in contracts with providers, including clauses that bar a plan from providing provider-specific cost or quality of care info or data as specified.

As well as a new federal requirement to ensure continuity of care when a provider's contract with a health plan ends. Next slide.

So continuing on with these additional consumer protections under the NSA:

The federal requirements include new requirements for enrollee ID cards including that they provide information on applicable deductible and out-of-pocket maximums on the card.

Certain disclosures for broker compensation as well as new federal requirements for provider directories.

So as you can see or as you have heard this rule, or rather, this statute is very broad, very comprehensive, and it does require regulations on the federal side to clarify, specify and implement its provisions.

The first of these federal rules was jointly released last month in

July of 2021 by the Department of Health and Human Services, Treasury, Labor and Office of Personnel Management and is called the Interim Final Rule, or IFR, Requirements Related to Surprise Billing Part I. Most of these provisions will go into effect under the IFR January 1st of next year, 2022, or for health plans for policy years beginning on or after January 1, 2022.

The IFR is lengthy and detailed and complex so I am just going to touch on a couple of key topics. One is for consumer consent. Under the NSA enrollees can consent in some circumstances to forego the protections of the NSA and agree to be charged higher rates. But the NSA and IFR detail what that process means including how much advance notice is required, in general 72 hours, and which providers are or not able -- are or are not able to seek that consent. In general the NSA and IFR do not provide an opportunity to consent to certain ancillary hospitals services.

Secondly, the IFR details the methodology for determining the qualifying payment amount, or QPA. And this definition is quite a mouthful so please stick with me while I attempt to recite it. It is the median of the contracted rates recognized by the plan or issuer on January 31st of 2019 for the same or similar item or services provided by a provider in the same or similar specialty and provided in a geographic region in which the item or service is furnished, increased for inflation. So that's quite a definition. And you will notice if you are familiar with the California law regarding surprise balance billing, it is different from our default rate construct based on average contracted rates but we will touch on that again later.

In general, the NSA's qualifying payment amount, or QPA, comes up in two contexts under the NSA; one is cost-sharing and the other is

determining the out-of-network amount.

For cost-sharing there is a sort of hierarchy in what is the basis for determining cost-sharing. The first alternative is if a state has an all-payer model agreement, that applies; secondly, if a state has a specified state law as defined, that applies; or third, if an enrollee's cost- sharing is based on not one of those first two alternatives and it is based on the lesser of the QPA or the amount billed by the provider for the item or service.

The second context in which the QPA comes up under the NSA is in regard to payments from plans to providers. Again there is a similar hierarchy. The reimbursement is either based on an all-payer model agreement for the state; or if there is none, a specified state law; or if there is one, an agreed-upon amount between the plan and the provider; or the amount determined through the federal IDRP and the QPA is a factor considered in that IDRP.

You have heard me say specified state law a few times and it is important under the NSA. The IFR Part I does define specified state law and provides some examples but, in general, it is a state law that provides a method for determining the total amount payable under a group plan or group or individual health insurance coverage to the extent that law applies. Further is a specified state law, that state law can be used to determine enrollee cost-sharing, to determine the provider reimbursement or to determine the dispute resolution.

You have probably noticed the IFR is termed Part I; that is because more parts are forthcoming. We expect to see other parts this year but the federal regulators do acknowledge it is unlikely that they will be able to get everything out before that January 1st, 2022 date when many of the NSA

provisions are in effect, so the federal regulators direct stakeholders to use a good faith, reasonable interpretation of the NSA statutes until those federal rules are developed. Next slide.

So, the NSA and the IFR raise some really important questions about whether those federal laws and rules overwrite comparable state laws.

The NSA overlaps with several Knox-Keene provisions regarding balance billing but it allows state law to determine cost-sharing and the rate paid to providers and the dispute resolution process if it meets certain criteria. So the Department is currently analyzing both our state laws that I will discuss in a minute as well as the federal counterparts, for lack of a better term, to determine how and whether they differ and what will be the rules of the road in California going forward.

But as a general reminder, the 2016 California statute, which was enacted through AB 72 addresses a lot of the same surprise balance billing circumstances that the NSA would address as the three core components say, a ban on surprise bills or the in-network facility/out-of-network provider circumstance that I mentioned at the beginning of my presentation.

The second core component of our state law is a default rate, which is absent an agreement between the plan and provider, the greater of the average contracted rate or 125% of a Medicare rate as specified. And you will notice that average contracted rate is quite different from the QPA under the IFR.

And third, the AB 72 construct also has an IDRP to help determine the appropriate reimbursement amount while preserving access to other legal remedies, which again is different than the version under the NSA. Next slide.

Additionally, effective at the beginning of last year 2020, California

state law includes protection from balance billing for certain out-of-network air ambulance services. This is another area of overlap with the NSA. And finally, by virtue or as described in the *Prospect* case from 2009, the Knox-Keene Act prohibits emergency balance billing.

Again, the Department is looking at all of these very carefully to determine these areas of overlap and how this is going to play out and we may have further comment at a future date. So this is just a high level overview. I am happy to take any questions you guys have.

CHAIR GRGURINA: All right, thank you, Jessica.

Are there any comments, questions from Board Members?

Okay, seeing none. Jen, you got in there, you have a question or comment?

MEMBER FLORY: Yes. Just on the other related balance billing laws. There's also the related Medi-Cal balance billing in the WIC and I just want to make sure that that's taken into consideration. Because sometimes even when it doesn't directly apply there is the impression that Medi-Cal beneficiaries don't have the protections when they in fact have greater protections.

MS. PETERSEN: Thank you, I take your point.

CHAIR GRGURINA: All right, thank you, Jen.

Okay, Daniel, do we have any comments or questions from members of the public? And it looks like I can see one.

MR. RUBINSTEIN: Yes, we do, just one. Bill, you are good to go.

MR. BARCELLONA: Thanks, Daniel. Hey, Jessica, do you anticipate the Department will submit a comment letter in the Interim Final Rule process?

MS. PETERSEN: Hi, Bill. Comments would be due to the federal regulators for the IFR by September 7th and the Department is still in internal discussions on how or whether to publicly respond.

MR. BARCELLONA: Okay, thanks.

MS. PETERSEN: No (overlapping).

MR. BARCELLONA: A short time frame.

MS. PETERSEN: Yes.

CHAIR GRGURINA: All right, thank you, Bill.

Daniel, any other comments or questions from members of the public?

MR. RUBINSTEIN: No, that would be it at this time.

CHAIR GRGURINA: All right, Jessica, thank you very much.

Let's go ahead and move on to the provider solvency quarterly update. Michelle, you are up.

MS. YAMANAKA: Thanks, John. Hi, Michelle Yamanaka, supervising examiner with the Office of Financial Review. Today I am going to give you an update on risk-bearing organization or RBO financial reporting for the quarter ended March 31st, 2021. Next slide, thank you.

So we have 210 RBOs filing, who are required to file with the Department. This is an increase of 7 RBOs from the previous reporting period. And there were no RBOs that ceased operations in the first quarter. For annual reporting, we have 200 RBOs that have filed their annual survey reports and for monthly reporting we have received 6 financial filings -- financial filings from 6 RBOs as a requirement of their corrective action plan. For quarter ended March 31st we also had 23 RBOs on corrective action plans or CAPs. Next slide,

please.

So we also track the RBOs that cease operations. As I mentioned, as of March 31st there were no RBOs so the number stayed the same as the quarter ended December 31st. And here we show that, we capture the RBOs in categories, either financial or no financial concerns at the time that the account is inactivated. Financial Concerns are the RBO was on a corrective action plan or there were, they were in some type of financial distress. Whereas No Financial Concerns is exactly what it is. We also have a Other category which is, which is a catch-all for, for example, duplicate accounts or accounts that were issued that shouldn't have been. Next slide, please.

We also capture the enrollment assigned to the RBOs that ceased operations. Since 2005 we have 114 RBOs that ceased operations. Approximately 69% or 79 of the RBOs have less than 10,000 lives assigned to them. Next slide, please. Next. Thank you.

The RBOs submit financial, that file financial statements also file enrollment information. This slide captures the enrollment information filed with their survey reports. As of quarter ended March 31st there were approximately 8.8 million enrollees assigned to the RBOs reporting. This is a 2% increase or 178,000 enrollees from the previous reporting period. The largest increase was in Medi-Cal, which was 94,000 Medi-Cal enrollees, followed by 48,000 Medicare, an increase in Medicare enrollees, and an increase of 36,000 enrollees, approximately 36,000 enrollees in commercial enrollees. Next slide, please.

Going on to the financial survey reports. The reporting results for March 31st are located in the last column which shows that 183 RBOs or 87% of the RBOs are in our compliant category and are meeting all solvency

requirements. This includes 10 RBOs on our monitor closely list. And we have 23 RBOs that are reporting non-compliance and are on a CAP. When we compiled the information to produce to produce the slides there were 4 RBOs, non-filing RBOs. To date we have received three of those financial filings and those RBOs are in our compliant category.

Next slide, please.

Moving on to corrective action plans. I mentioned that we have 23 RBOs that are on CAPs. Those 23 RBOs are filing 27 corrective action plans. We have two RBOs that have two corrective action plans and one RBO that has three corrective action plans. So of the 27 CAPs, 20 are continuing from the previous reporting period and 7 are new. For those 20 RBOs that are continuing, 16 RBOs or 17 CAPs are meeting their approved projections and 3 or not.

Subsequent to the March 31st filings we have been monitoring those 3 RBOs for April, May and June and happy to present that they are all meeting the timeliness requirements and it looks like we will be able to review, approve and complete once we received the quarter two filings. For the 7 new CAPs, 6 are approved and 1 is currently in progress. And we are working with the health plan and the -- health plans and the RBO to obtain an approvable CAP. Next slide please.

Oh, before I go to the Medi-Cal enrollment, we also have an attachment with a CAP summary which has the 27 CAPs listed and that table includes the RBOs, the management services organization or MSO name if the RBO has contracted with one, the contracted health plans, enrollment in ranges, the quarter the CAP was initiated, and a visual duration of the CAP using a lower case X as an indicator of the compliance status with the approved CAP and the

grading criteria deficiency or deficiencies. Moving on to the next slide.

We also look at the RBOs that have Medi-Cal lives assigned to them. At the quarter ended March 31 2021 there are approximately 4.9 million Medi-Cal lives assigned to 87 RBOs. This represents approximately 56% of the total lives assigned to the reporting RBOs. Of those 87 RBOs, 68 have no financial concerns, 4 RBOs are on our monitor closely list and 15 RBOs were on a CAP.

We took the top 20 RBOs that had more than 50% Medi-Cal lives assigned to them. Next slide please. At least 20 RBOs had approximately 77% of the Medi-Cal lives assigned to them. Of these top 20 RBOs, 11 of them had no financial concerns, 2 were on our monitor closely list and 7 are on corrective action plans.

And then the remaining 1.2 Medi-Cal lives assigned to 68 RBOs, 57 of those RBOs had no financial concerns, 2 RBOs were on our monitor closely list and 8 RBOs are on a CAP.

And that concludes my presentation. Be happy to answer any questions.

CHAIR GRGURINA: All right, thank you, Michelle.

Comments and questions from Board Members? Ted, you are first.

MEMBER MAZER: Thanks, John, and thank you for that presentation. A couple of concerns. If you go back to your slide 47 there is a significant increase in the number of new RBOs in the last two quarters that are on CAP compared to the previous two quarters. Is there a trend that we are needing to take a look at more closely, any commonalities there?

And then second part on slide 49, one-third of the RBOs with over

50% of Medi-Cal lives are on CAP. That's kind of concerning. Is that because of the Medi-Cal payments to the medical group, to the plan? Are we looking again at what's the trend there and what's the danger to those RBOs coming on board on new CAPs?

MS. YAMANAKA: Okay, let me, let me start with your first question. So when we are looking at the number of CAPs, yes, there has been an increase in the previous two quarters. Looking at the CAP summary, you will be able to see that approximately half of those CAPs have to do with claims timeliness. Looking at those, a majority of those CAPs, it has, they don't have financial concerns related so there could be issues where there was implementation of a new claims processing system and such. So that's what were the trends that we are mainly seeing in the previous two quarters with the RBOs that are submitting CAPs.

Regarding the CAPs, the RBOs that had Medi-Cal lives assigned to them. Again, many of these RBOs that have claims timeliness issues also have Medi-Cal lives assigned to them. For those that have may have financial concerns, we are monitoring those RBOs on a monthly basis to ensure that they are meeting their metrics and in the case if they are not, we will need to step in and may need to take administrative action. So we are monitoring these RBOs on a monthly basis using claims timeliness, monthly timeliness reports. And if there are financial concerns we will be reviewing, we review their, the financial trends and the monthly financial statements on a monthly basis.

MEMBER MAZER: Thank you.

CHAIR GRGURINA: All right, Paul.

MEMBER DURR: It is a quick question. Michelle, always a great

presentation. You said you got 3 out of the 4 non-filers. Do you have any concern with the one that did not respond?

MS. YAMANAKA: You know, this isn't, this last non-filer is a new RBO at March 31. So I can tell you that the enrollment is small. They are receiving sub-delegated enrollment and they are just waiting on some additional information before they can, they can file; but we anticipate that that filing will be coming in in the next week.

MEMBER DURR: Thank you.

MS. YAMANAKA: Sure.

CHAIR GRGURINA: All right. Daniel, do you have any comments or questions from members of the public?

MR. RUBINSTEIN: Yes, we have one. It is Bill and he is good to talk as soon as he unmutes.

MR. BARCELLONA: No, I meant to lower my hand, sorry.

CHAIR GRGURINA: All right, thank you.

MR. RUBINSTEIN: Never mind.

CHAIR GRGURINA: Okay. Thank you very much, Michelle, we appreciate it.

MS. YAMANAKA: Thank you.

CHAIR GRGURINA: Let's go ahead and move on to the health plan quarterly update with Pritika. Pritika, just note the time, we are at 12:43.

MS. DUTT: Thank you, John. So before I jump into my presentation, I want to go back to the MLR question that Larry had on risk adjustment transfers and the impact of that to MLR. So, if a plan -- the risk adjustment transfer does, is an adjustment to the MLR numerator. So if a plan

ends up paying money that is, that reduces their numerator, their Medi-Cal expenses get reduced by that amount. And if, if a plan is receiving money that adds to their MLR. So if that makes sense. So for example, the Blue Cross example was used. So Blue Cross received money in the small group market for June 30th, 2020. Results from CMS showed that they got $240 million. So that is an adjustment to their medical expenses so their medical expenses got reduced by $240 million, because they received that money.

CHAIR GRGURINA: All right, thank you, Pritika. We are going to note the time on how quickly you got that for us and remember that in the future when we ask questions; we won't be asking for next meeting but in the next hour or so.

Well thank you for doing that and why don't you go ahead and take us through the health plan quarterly update.

MS. DUTT: Thank you. The purpose of this presentation is to provide you an update on the financial status of health plans at quarter ended March 31st, 2021. We have been tracking the health plan financials and enrollment trends very closely and working with the plans if we see any unusual trends that would raise concerns. We also included the handout that shows the enrollment at March 31st, 2021 and TNE for five consecutive quarters, which includes March 31st, 2020 through March 31st, 2021 for all licensed health plans. The information is broken into three categories, looking at full service first then restricted full service and then specialized health plans.

Currently we have 140 licensed health plans and we are reviewing 6 applications for licensure which includes 4 full service and 2 specialized. Of the 4 full service, 3 are seeking license for restricted Medicare Advantage and 1

for restricted Medi-Cal. For the 2 specialized plans, 1 is looking to get licensed for employee assistance program and 1 for dental. Last year on the same time period we had 131 licensed plans.

At March 31st, 2021 there were 27.68 million enrollees in full service plans licensed with the DMHC. Total commercial enrollment includes HMO, PPO, EPO and Medicare supplement. We had an adjustment in the commercial enrollment at March 31st, 2021 because there were 2 health plans that were reporting almost a half-million enrollees that are federal exempt, in the federal exempt program under large group PPO enrollment. So therefore, commercial enrollment for quarters 12/31/2020 and prior are overstated by about half a million lives and we will make the adjustment for the prior quarters in future presentations.

This slide shows the make-up of HMO enrollment by market type. Large group and individual markets saw slight increases in enrollment while small group lost about 20,000 lives. Overall, HMO enrollment increased slightly when compared to previous quarter; HMO enrollment increased by 220,000 lives.

This slide shows the make-up of PPO/EPO enrollment. The decrease in the large group was due to the reporting error, as I mentioned earlier, and we will be working with the two plans to fix their reporting and then report corrected information at the next FSSB meeting.

This table shows government enrollment, which is Medi-Cal and Medicare. Overall, the government enrollment increased. Medi-Cal enrollment increased by 230,000 lives from previous quarter, an increase by almost 1.3 million lives when compared to the same period last year.

We are currently monitoring 30 health plans for various reasons; 27

full service and 3 specialized plans. There are 4.7 million enrollees in the 27 closely monitored full service plans. Of the 27 closely monitored full service plans, 14 are restricted licensees and had less than 1.2 million enrollees. The total enrollment for the three specialized plans was 90,000 lives, which included one vision plan and two dental plans.

This slide shows our TNE deficient plans as of March 31st, 2021. We had three health plans that did not report compliance with their tangible net equity or the federal -- I mean the state reserve requirement. For your benefit, Golden State Medicare Health Plan and Vitality Health Plan of California did not meet the Department's minimum financial reserve requirement.

For Your Benefit reported TNE of 73% of the required TNE. The plan corrected the TNE deficiency on May 11, 2021. The plan is being monitored closely and we will continue to work with them to make sure that they keep the TNE compliance above the required levels.

Both Golden State and Vitality remain TNE deficient. And since both are Medicare Advantage plans we are working with CMS closely. For Golden State the DMHC issued a cease and desist order on April 27, 2021 that prohibits Golden State from accepting new members effective May 1st, 2021. CMS has enforced a similar sanction on their end so they are not adding any more lives to Golden State. The DMHC issued an accusation on July 1st, 2021 to revoke Golden State's license. Golden State had 15 days to request a hearing, which it did, and we are working with Golden State and the Office of Administrative Hearings to set a hearing date for that.

And then for Vitality, we had issued a cease and desist on June 30th, 2020. Again, the plan cannot add any more enrollees; and that went into

effect July 2nd of 2020. And due to the severity of Vitality's TNE deficiency and financial viability concerns we issued an accusation last year on July 31st to revoke Vitality's license and then since then, in December, Vitality notified DMHC that it filed for Chapter 11 bankruptcy. Our Office of Enforcement has been in communication with Vitality's bankruptcy attorney. We also continue our discussions with CMS. And at August 6, 2021 Vitality's enrollment has further dropped to 571 Medicare enrollees. We continue to be in communications with Vitality's bankruptcy representatives who are working with interested buyers looking to purchase Vitality from bankruptcy court.

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 lower for specialized plans compared to full service health plans.

This chart shows the TNE of specialized service plans by enrollment category. Thirty-seven health plans, or over half of the total specialist plans, reported TNE of over 500% of required TNE.

This chart shows the TNE of full service plans by enrollment category. Fifty-nine health plans, or over half of the total licensed full service plans, reported TNE of over 250% of require TNE.

And this chart here shows a breakdown of 23 full service plans in the 130% to 250% range. And as a reminder, if a health plan's TNE falls below 130% we place the plan on monthly reporting and then we start monitoring the plan closely. And even before they hit the 130% mark if we see a declining trend in the plan's financial performance, the TNE going down, net income issues, if we see the enrollment declining, we start working with the plan closely before they

hit the 130% mark.

And this chart here shows the TNE by line of business for plans that are being monitored closely.

This chart pretty much summarizes the handout that was provided with the presentation, so it shows the TNE comparison for full service plans from March 31st, 2020 to March 31st, 2021. As I mentioned earlier, we had three plans that were TNE deficient for quarter ended March 31st, 2021. There are some plans that have other non-Knox-Keene Act business, so non-health plan business, or report combined financial statements with their affiliated entities. For example, Kaiser's financial statement includes financial information for Kaiser hospitals as well as Kaiser's out-of-state health plans. The TNE to required TNE levels for health plans tend to fluctuate due to changes in their profits, if they have losses, if there are any dividend payouts, required TNE increasing due to higher medical expenses or premium revenues, and then changes to their enrollment.

And that brings me to the end of my presentation. I will take any questions.

CHAIR GRGURINA: All right, thank you Pritika.

Comments or questions for members of the Board? Ted.

MEMBER MAZER: One quick one if you can flip back to slide 57. It has to do with the number of restricted plans that are closely monitored right now. That's 59. Yeah. So you've got 14 plans. I don't know what the total number of plans is off the top of my head but that just seems rather high on the restricted side. Is there a trend there? Is there any concern about the restricted plans with over a million lives?

MS. DUTT: Sure. So a majority of them, Ted, are newly licensed plans so we watch them closely. And then some of them have small enrollment and lower revenues, lower reserves, so that's why we are watching them closely. But the majority of them are newly licensed plans.

MEMBER MAZER: So no specific concerns at this point, just normal course of events?

MS. DUTT: We do have concerns if we see lower reserves; so some of them have lower reserves, others are newly licensed. So there are concerns there, right, because we continue to watch them. The revenues, how many enrollees they are adding. So in that respect there are concerns with them but we are working with those plans through them.

MEMBER MAZER: Thank you, Pritika.

CHAIR GRGURINA: And then, Pritika, I would say thank you. We see the slide on TNE deficient plans, which were 3. You are clearly on top of it. It was good to hear one of them has pulled themselves out and the two that are remaining are working through with about 6,000 members in Medicare with obviously plenty of other options that are available. So, I mean, this is the critical part of what the Financial Solvency Standards Board is supposed to be taking a look at because we don't want to be going back in those situations where DMHC has to close a plan down and you have the difficulty for the members and the providers, so thank you very much.

So if there are no other comments or questions from the Board Members let's go ahead, Daniel, and turn, are there members from the public who have any comments or questions?

MR. RUBINSTEIN: There are none.

CHAIR GRGURINA: All right, thank you.

Well, Pritika, thank you very much. That will take us to, once again, Daniel, are there any members of the public who have any comments or questions on matters that were not on the agenda today?

MR. RUBINSTEIN: There are no raised hands at this time.

CHAIR GRGURINA: All right, thank you, Daniel.

All right, now the next agenda item is agenda items for future meetings. This is to the Board Members. Are there specific things you want to see in addition to the multiple pages that Mary went over earlier that we have annually, quarterly, twice a year. Is there anything else anyone would like to bring forward, particularly for our November meeting, which remind yourself, Mary already told us, is jam packed. And I am not seeing anything other than smiles so all right, great.

So that leads us to our agenda for the -- no, I apologize, the closing remarks. Mary, you are up.

MEMBER WATANABE: Thank you, John. I will just say that we will take back the feedback on kind of the purpose of the Board and some of the other feedback on just our oversight and we will come back, if not in November, in the early 2022 meeting with some of our recommendations in response to that. We will certainly be responsive to all of the feedback we received.

But thank you to the Board and to all of the DMHC staff and Jeff for another great meeting that goes right up to the wire again, but just appreciate everybody's continued engagement.

CHAIR GRGURINA: All right, thank you. And Daniel, Jordan and Ramona from DMHC, thank you for all your help behind the scenes. Everything

went well and smoothly so we appreciate that. And we will look forward to seeing you in November and we'll see, is it in-person or is it online?

MEMBER WATANABE: Yes.

CHAIR GRGURINA: And Mary will get back to us.

MEMBER WATANABE: We'll let you know.

CHAIR GRGURINA: All right, thank you, everyone, have a good rest of your day.

(The meeting was adjourned at 12:56 p.m.)

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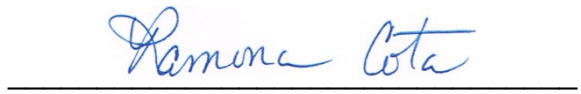
CERTIFICATE OF REPORTER

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 31st day of August, 2021.



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