STATE OF CALIFORNIA

DEPARTMENT OF MANAGED HEALTH CARE

FINANCIAL SOLVENCY STANDARDS BOARD (FSSB) MEETING

DEPARTMENT OF MANAGED HEALTH CARE

980 9th STREET

6th FLOOR

SACRAMENTO, CALIFORNIA

WEDNESDAY, FEBRUARY 28, 2023

10:00 A.M.

Reported by: Ramona Cota

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APPEARANCES

BOARD MEMBERS

Jeff Rideout, MD, Chair

Abbi Coursolle

Paul Durr

Mark Kogan, MD

David Seidenwurm, MD

Jessica Sellner

Mary Watanabe

DMHC STAFF

Erica Chan, Information Technology Supervisor II

Pritika Dutt, Deputy Director, Office of Financial Review

Sandy Phakonkham, Associate Governmental Program Analyst

Sarah Ream, General Counsel

Shaini Rodrigo, Associate Governmental Programs Analyst

Dan Southard, Chief Deputy Director

Jordan Stout, Staff Services Manager I

Michelle Yamanaka, Supervising Examiner, Office of Financial Review

ALSO PRESENTING/COMMENTING

Doug McKeever, Chief Deputy Executive Director, Programs
Covered California

Pamela Cleveland

William "Bill" Barcellona
America's Physician Groups

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PROCEEDINGS

10:00 a.m.

CHAIR RIDEOUT: Hi, this is Jeff Rideout, I am Chair of the Financial Solvency Standards Board for the Department of Managed Health Care and I would like to call the February 28 meeting to order. We will start with a few welcomes, including our newest Financial Solvency Board Member Jessica Sellner. Jessica, are you on? I think you are.

MEMBER SELLNER: I am on, yes. Hi.

CHAIR RIDEOUT: Would you mind giving everybody a few words of your background? We will go around then after that and introduce the rest of the Board Members that are here today.

MEMBER SELLNER: Yes, definitely. First off, thank you, super thrilled to be here, and thank you for electing me to be part of this board. I work at Health Net, I am the CFO of the California plan. I have been with Health Net for about 10 years now. Under my responsibility I have Medicaid, Medicare and Commercial insurance, so a little bit in each of the buckets. I also have commercial underwriting and then analytics and facilities, so a little well-rounded there. Before the health care space I was in the solar space, so that's a slightly different dynamic, but have been in the health care space for about 10 years now.

CHAIR RIDEOUT: Great. Thank you, Jessica, and great to have you on board.

I think we will go a quick introduction and then I have the housekeeping that I will need to go through before we start the meeting. Let's start with Paul Durr, if you want to introduce yourself briefly.

MEMBER DURR: Sure, thank you. Welcome, everybody. I am Paul Durr, CEO for Sharp Community Medical Group, an Independent Physician Association in San Diego.

CHAIR RIDEOUT: Great.

Abbi?

MEMBER COURSOLLE: Yes. Hi, everyone. My name is Abbi Coursolle, I use she/her pronouns. I am with the National Health Law Program in Los Angeles. Our mission is to protect and advance the health rights of low-income and underserved individuals and families.

CHAIR RIDEOUT: Great.

Mark?

MEMBER KOGAN: Hi, I am Mark Kogan. I am a gastroenterologist in private practice in Berkeley and San Pablo in Northern California.

CHAIR RIDEOUT: Great.

David?

MEMBER SEIDENWURM: Yes, hi. I am a neuroradiologist with Sutter Medical Group and I am the Chief Medical Officer for Sutter Physicians Alliance and duties as assigned. Nice to meet you.

CHAIR RIDEOUT: Thank you.

And is Jarrod McNaughton on yet? Don't think so, we will look for him.

I also want to have our first guest speaker introduce himself, Doug McKeever from Covered California.

MR. MCKEEVER: Well, good morning, everybody. Thank you,

Jeff. Doug McKeever, I am the Chief Deputy Executive Director for Covered California. I will go into a little bit more as to what that means when I get into the presentation. Thanks, Jeff.

CHAIR RIDEOUT: Thanks, Doug.

And Mary, your amazing staff. I just want to acknowledge them before we start. Anything you want to say before we jump into the housekeeping?

MEMBER WATANABE: Maybe just quickly I will introduce. Mary Watanabe, I am the Director of Department of Managed Health Care, hopefully, you know me. I have Sarah Ream, our General Counsel with me, Pritika Dutt our Deputy Director for the Office of Financial Review, Michelle Yamanaka also from our Office of Financial Review. And I will just acknowledge our amazing admin team that is supporting us, we have got Jordan, let's see, Shaini, Sandy and Erica here. I think that is our team.

CHAIR RIDEOUT: Great. And a big personal shout out to Jordan, who always keeps me on the straight and narrow.

Okay, so I am going to go through the housekeeping notes and then we will take up the minutes from the last time. These are rather long, but they are very important that we all understand sort of the conditions under which we are participating, so, I am going to just read them now as we go through them.

So, first of all, this meeting is being conducted in a hybrid format and there is an opportunity for public participation in-person or virtually through video conferencing or teleconferencing.

Please note the following items for those joining us in-person today.

There is a sanitation station located in the back of the room where you will find masks and hand sanitizer.

Participants are encouraged to follow the current CDPH guidance for use of face masks and face coverings will be provided by the DMHC upon request.

The restrooms on this floor are locked for those that are in the room. The bathroom badges are on the table at the back of the room. Please make sure to return them to the table.

Please remember to silence your cell phones, everyone.

For our Board Members here in person, please do not join the Zoom meeting with your computer audio, that will create some echoes. To ensure that you are heard online and in the room, please use your microphone in front of you and press the button on your microphone to turn it off. That is if you are in the room. The green light will indicate that it is on, the red light will indicate that it is off. Please remember to turn your microphone off when you have finished and please speak directly into the microphone and move it closer to you if necessary.

Questions and comments will be taken after each agenda item, first from the Board Members and then from the public. For those who wish to make a comment, please remember to state your name and the organization you are representing. If any Board Member has a question, please use the Raise Hand feature if you are using Zoom. All questions and comments from Board Members will be taken in the order in which the raised hands appear. Public comment will be taken from individuals attending in-person first. For those making public comment at the podium in the front of the room, please be sure to

leave your business card or write down your name and title and leave it on the podium so that our transcriber can accurately capture your information. For those making public comment virtually, please use the Raise Hand feature.

For those joining online or via telephone please note the following: For members of the public attending online, as a reminder, you can join the Zoom meeting on your phone should you experience a connection issue. For attendees on the phone, if you wish to ask a question or make a comment please dial *9 and state your name and the organization you are representing for the record. For attendees participating online with microphone capabilities, you may use the Raise Hand feature and you will be unmuted to ask your question or leave a comment. To raise your hand, click the icon labeled Participants on the bottom of your screen, then click the button labeled Raise Hand. Once you have asked your question or provided a comment, please click Lower Hand.

As a reminder, the FSSB is subject to the Bagley-Keene Open Meeting Act. The Bagley Keene Act requires the Board meetings be open to the public. As such, it is important that Board Members refrain from emailing, texting or otherwise communicating with each other off the record during Board meetings because such communications would not be open to the public and would violate the Act. We also ask that you not use the Zoom chat feature as these comments or questions may not be viewable by the public.

Likewise, the Bagley-Keene Act prohibits what are sometimes referred to as serial meetings. A serial meeting would occur if a majority of the Board Members emailed, texted or spoke with each other outside of a public FSSB meeting about matters within the Board's purview. Such communications would be impermissible, even if done asynchronously. For example, if member

one emails member two, who then emails member three. Accordingly, we ask that all members refrain from emailing or communicating with each other about Board matters outside the confines of the public Board meeting.

So I think that is it for the housekeeping. Mary or anybody, did I miss anything that needs to be stated?

MEMBER WATANABE: Note that we don't have anybody here in the room with us. I will let you know if that changes, but at least for now we don't need to go to the room for questions or comments. But thank you, I think that is it for housekeeping.

CHAIR RIDEOUT: Okay. We will move on to Agenda Item number 2, which is review and approval of both the transcript and the meeting summary or meeting minutes from November 15. First on the transcript, were there any comments or corrections from Board Members?

(No response.)

CHAIR RIDEOUT: Okay, hearing none I will ask for a motion to approve.

MEMBER DURR: Motion to approve.

CHAIR RIDEOUT: Thank you. A second?

MEMBER SEIDENWURM: Second.

CHAIR RIDEOUT: Okay. All those in favor? Aye.

(Ayes.)

CHAIR RIDEOUT: Okay. We will consider the transcript approved. The meeting summary or meeting minutes? Were there any corrections or edits to that?

(No response.)

CHAIR RIDEOUT: Okay, hearing none, I will take a motion to approve those.

MEMBER SEIDENWURM: So moved.

MEMBER DURR: So moved. Second.

CHAIR RIDEOUT: Okay, all those in favor please say aye/raise your hand.

(Ayes and raised hands.)

CHAIR RIDEOUT: All right. All right, those are approved. So, I think we are done and now moving on to Mary's Director's Remarks.

MEMBER WATANABE: All right. Thank you, Jeff. Good morning. So, I have just a few brief updates. I know we have got some exciting presentations we want to get to, but I wanted to start just quickly with an update on the governor's January budget. So, Governor Newsom released his proposed 24-25 state budget on January 10. The governor's budget projected a nearly $38 billion budget shortfall, primarily related to a substantial decline in the stock market and unprecedented delay in income tax collections. You have probably been reading about the most recent Legislative Analyst's Office projection that the budget shortfall may have risen to 73 billion, so we will be watching closely as the budget is revised in May based on actual revenue. But I am sure you all are tracking the significant deficit the state is facing.

To address the budget, the governor's budget reflects a balanced plan of funding delays, reductions, fund shifts and deferrals similar to what we saw last year. I will note that within our California Health and Human Services departments the governor's budget does propose to maintain many of the investments that were made in prior years, including the expansion of Medi-Cal

to all income-eligible Californians, as well as the significant investments that have been made in behavioral health and Cal-AIM, just to name a few.

You probably are aware of this, but the budget proposes to seek federal approval to increase the managed care organization or MCO tax that was approved in December of last year by the federal government. The proposal is to increase it, I believe, to about 20.9 billion in total funding to support the Medi-Cal program; so more to come on whether that moves forward.

The DMHC did not have any budget proposals in the governor's January budget so there is nothing exciting for me to share with you today. But we would be impacted by the proposed elimination of the telework stipend and savings from vacant positions that was proposed in the governor's January budget. So, again, more to come. I think we will all be watching closely to see what happens when the May revision comes out.

I want to note, if you haven't noticed, we have redesigned our public website. We launched that earlier this year so I would encourage you to check it out. If you are not on our listserv we now have a little box that says Join our mailing list. So, you can add your email address there to get any updates on any announcements we make or invitations to upcoming meetings.

One of the items that you will find on our website that we recently released is our Prescription Drug Cost Transparency Report for Measurement Year 2022. This was required by SB 17, I don't know, back in 2016, I think, if not earlier, so we have been doing this report for quite some time. But the report looks at the impact of the cost of prescription drugs on health plan premiums and there is comparison data that goes back to when we first collected this data in 2017. Among other findings, the report reveals that health plan spending on

prescription drugs has increased by $3.4 billion since 2017, including an increase of 1.3 billion in 2022. This is the report that also includes greater transparency on costs, including the 25 most frequently prescribed drugs, 25 most costly drugs, and the 25 drugs with the highest year-over-year increase in total annual spending and how that impacts premiums.

We will be holding a public meeting on premium rates on March 13 from 1:00 to 4:00 o'clock. This will include information on that Prescription Drug Cost as well as reports we recently released on health plan premiums in the Individual, Small Group and Large Group market. This meeting similar to today's meeting will be in a hybrid format so you can join here in Sacramento or virtually. This is a public meeting we have done historically in San Francisco; we do this every other year. I am really excited about how we are going to change this up a little bit this year. We will have the Department of Insurance that will be joining us to share the information they have on premium rates for the plans under their authority. We will also have the Office of Health Care Affordability coming to talk about their work on setting spending growth targets and what that means in terms of the context we are presenting on premiums. And then I am really excited to have the UC Berkeley Labor Center join us to talk about how the increased cost of health care is impacting consumers and their overall health and financial well-being. So, look for the agenda that will go out later today. It will be posted on our website. And again, go to our listserv. So, that is March 13 from 1:00 to 4:00, so look forward to having folks join us for that.

I want to note that one of the reports that was included in the materials for this meeting is our Dental MLR report. Years ago we used to present this report every year at our Final Solvency Standards Board meetings.

The Board recommended a few years ago that we provide this as information only. It includes information on dental loss ratio and premiums for both our Dental HMOs and PPOs, it has trend data. And just a reminder, unlike in our health care setting, we do not have a required MLR or standardized benefits and the premiums are pretty low for our dental plans compared to health care so you can see that reflected in the report. Pritika is here with me, we are happy to take any questions if you have any, but that was really just an informational item.

And then lastly I wanted to share that we had our last meeting of the Transgender, Gender Diverse or Intersex Working Group last week. They have finalized their recommendations. I think we had final comments coming in today. And that report with their recommendations will be released probably sometime next month. I will provide probably a more detailed update on their recommendations around training curriculum and quality standards at our next meeting. But it was really -- it was an eye opening meeting. I think I really appreciate the working group members, their commitment to come to monthly meetings, but also for just their vulnerability in sharing their personal stories of navigating the health care system and I will probably -- I shared before I think we have a lot of work to do to make sure that they feel welcome and are receiving the care that they need. So, more to come on that.

And I think that concludes my updates. I am happy to take questions from the Board and then the public.

CHAIR RIDEOUT: Any questions from Board Members?

Okay. Any questions from the public in the room?

MEMBER WATANABE: No one here.

CHAIR RIDEOUT: Okay. I'll keep asking, I guess. Any questions

from the public on Zoom or by telephone?

MR. STOUT: None at this time.

CHAIR RIDEOUT: Okay, I think that concludes this section. We will move on to the Covered California update.

MR. MCKEEVER: Jeff, is that my intro?

CHAIR RIDEOUT: That is your intro. And we have the fabulous Senior Deputy Director from Covered California, Doug McKeever, who also is a Board Member for IHA, just in passing to say that. But Doug, the floor is yours.

MR. MCKEEVER: Thank you, Jeff. And again, good morning, everybody. It is a privilege to be with you today and hopefully I will be able to impart some information that you may already know about Covered California, but then again, some updated information that hopefully you will find interesting, especially as we get into some of our quality initiatives moving forward.

Jordan, I am guessing, are you going to control the slides? Because if you are, can we go to the next one that has some content on it, please. And then I will just prompt you all to move forward, if that is okay. And there we go, great.

So, before I get into what we are and who we are, let me just give you a little bit more background on myself. So, I have been with Covered California now, starting my eighth year in January. Prior to that, I was the Chief Benefits Officer over at CalPERS for all of their health benefits efforts and so I have worked -- in total at CalPERS I was probably there over 15 years, the last couple of years in the Deputy Executive Officer role over all of the CalPERS health benefits.

With Covered California, just to give you a sense of what my roles

and responsibilities are. We have an Executive Director Jessica Altman. Hopefully some of you will have the opportunity to meet her at some point in the future. Relatively new to the organization. You may know Peter Lee was the founder and ran the organization for the first 11 years. And Jessica joined us, which is almost hard to believe but it has almost been two years that she has been with us now. A dynamic leader who is taking the organization to the next level, so to speak.

We have four Chief Deputy Executive Directors, of which I am one. My colleagues, one of them is over all of the admin section. We have a Chief Medical Officer Dr. Monica Soni, and then our General Counsel, and then myself.

And then the areas that I oversee for Covered California include all of our marketing, which I will go into a little bit when I talk about our open enrollment activities. Our Policy Research and Eligibility Branch which does a host of data research, analytical research, peer reviewed articles that we take care of, and set the policy direction for Covered California. Communications and External Affairs, our Outreach and Sales division, which is essentially our link to all of our sales partners. To give you an example, we contract with over 14,000 certified agents who sell Covered California, as well as navigators and community assisters throughout California. Our service center, we have a now totally 100% virtual service center that provides direct access for our consumers for information including enrollment. And then the last area that I am responsible for is our plan management division. And our plan management division essentially is responsible for our contracts with our 12 health carriers and also our annual rate negotiation process. And they work with DMHC at the end of that process when our rates are submitted to DMHC for their review.

So, let me cover a little bit about what we are and who we are. Hopefully this is not overly repetitive.

But we are one of the few state-based marketplaces in the country. There's a few, there's a few of us that are out there that chose when we instituted the program to go at it on our own as opposed to having the federal government run the marketplace for us. It gives us the unique ability to be what we call ourselves an active purchaser, meaning we negotiate rates with the carriers every year. We have set our benefit designs, of which we have what's called our standard benefit designs, which allow each of our carriers to compete primarily on price and not on benefit offerings. And then for those of you who may not know, we have all of our metal tiers, bronze, silver, gold, and platinum, that are available to our consumers. Most of our consumers, 90% of them receive federal assistance, and that is all predicated upon where they fall on the federal income range. That will dictate then how much money they get from the federal government to help them pay for the premiums that are offered through each of those particular metal tiers.

I will say we have been extremely fortunate the last couple of years. The state of California passed legislation, the governor signed, the ability for us to use state monies that were collected through the penalty that is assessed for those individuals in California who are eligible for health care but choose not to enroll. Those penalties over the years have accumulated and in the current plan year for 2024 there is approximately $80 million that we are using to help make our plans even more affordable. And just to give you an idea of what that looks like, that $80 million was used to remove deductibles from one of our silver plans. And so the majority of our individuals are in silver plans and as a result some

who were paying thousands of dollars annually in deductibles, those deductibles in several areas in the benefit design program were actually removed and zeroed out. So, a huge, huge financial boost to those lower income individuals who use Covered California for their health benefits.

Some good news, starting in plan year 2025, that allocation actually doubles and we will be spending $160 million. We are currently in the development of what that looks like. How we are going to offset the payments to the consumers and where we are going to offset those payments for the 2025 plan year, that is going to be brought to the board for a final action in April and May. Can we go to the next slide, please. Thank you, Jordan, or whoever it is that's running the slides.

I want to spend a little bit of time here so that you all have a sense of where we started and where we are currently at today. When we opened our doors back in 2013, the uninsured rate in California was over 17%. You can see by this graph, as of the latest data we have in 2022, that now is down to 6.5. So, we have made tremendous strides and successes over the last few years, decade now, in reaching individuals in California who previously were uninsured and then of course now have insurance. And I do want to note this is not totally a Covered California issue. Clearly, we expanded Medi-Cal and Medi-Cal accounts for a large percentage of the uninsured rate going down. I would call out that in today's world where we are in 2024, we are really probably close to 4% uninsured, and most of those are going to be your undocumented who are ineligible to receive benefits through us at the current time. So, that gives you a sense of where we are and where we have come from. Next slide please.

I want to provide you with a little bit of information that shows who

we contract with; and as I mentioned, we have 12 health carriers that we currently contract with. They represent the big players of Blue Shield, Anthem, and Kaiser, who have a statewide footprint, meaning they cover all 19 regions in the state of California. And then we have some smaller, local, regional plans. CCHP in San Francisco, Valley down in the Santa Clara region, Sharp down in San Diego.

And then the one call out that I would like to make here, and I don't think Jarrod has joined the group yet, but IEHP is the newest addition to our stable. They are truly the first local initiative plan that we have brought into Covered California and we are extremely excited that IEHP has joined us and will be serving the individuals down in the Inland Empire. The beauty of them joining, particularly now in the time in which we are dealing with redeterminations for Medi-Cal is that there is hopefully a seamless transition now for individuals who are no longer eligible for Medi-Cal but are eligible for Covered California and could stay within the IEHP framework and network that they have down there in the Inland Empire. So, that is where we are with those. Next slide, please.

Some folks don't realize, but we do provide dental and vision. This provides you with the three plans that we current -- or the four -- the five plans that we currently contract with for dental health services. These are for adults and it is voluntary and the individuals do have to pay for the coverage. I will note that there are over 200,000 individuals that are currently enrolled in our dental program so is it is a pretty sizable program relative to the overall market, which currently has 1.8 million people. Can we go to the next slide, please. And one more.

Okay, so, let me spend a little bit of time speaking to our recently

completed open enrollment campaign. And before I launch into kind of what the campaign was, and where the numbers have landed for us I think it is important to note for context purposes the amount of energy effort that we put into our marketing on an annual basis. So, as I indicated earlier, we have a marketing department. For those of you during the months of November through January, if you watch any television, listen to the radio, I would be very surprised if you didn't see our particular ads that are out there constantly promoting the enrollment for individuals who are eligible for Covered California. We spend in the neighborhood of anywhere from $30-50 million on an annual basis on marketing so it is a big deal for us and it allows us to get out there into the local communities to allow folks to understand who we are, what services are available to them, and then how to access those services.

In addition, we have earned media efforts through our communications team and the earned media efforts are what are represented here in these pictures that you see. This year’s open enrollment theme was Bridging the Gap, a very appropriate campaign theme given the fact that redeterminations were taking place, and so Bridging the Gap between Medi-Cal and Covered California was an important message for us to get out there this year. What you see here are just pictures of events that we held. We held events all the way from Redding down to San Diego and in places all between throughout California. And we conducted these events, both in November, December and in January. It is a way for us to get our message out not only into local communities, but to have the local news stations, radio stations and others pick up our message and then communicate that out to the broader audiences that they serve.

One of the things that I will say that we are very proud of is in all of our efforts we use a robust campaign for multicultural media, in particular Spanish, AAPI, and our Black communities. This is something that is important to us given the number of enrollees that we have in those communities and the fact that we know based on the current uninsured who are in California, the majority of those right now at least fall into your AAPI and particularly Korean community. So, it is really important for us to make sure that we, that we go out into those local communities, reach those communities, and let them know that we are available to them. If we can go to the next slide, please.

So, these give you some numbers relative to where we were at through February the 9th and I am happy to report that we have reached a milestone in Covered California is history by having the most enrolled individuals since we opened our door. Almost 1.8 million individuals are currently enrolled with us, a 16% jump for new enrollment over last year. A lot of that is probably attributed to the redeterminations, those who are signing up who lost their Medi-Cal coverage. However, this is wonderful news for us that, again, we are continuing to reach individuals in the communities in which they live to ensure that they have affordable health care coverage through Covered California. Next slide, please.

Okay, I am going to spend a little bit of time on strategic planning. Can we go to the next one.

And I will say as I tee this particular one up, and again as I mentioned, having been at Covered for eight years, it is really a testament to Jessica's coming in as our new Executive Director to want to have a strategic plan in place for us over the next three years. We never had one up until the

point that she arrived. And it is not a matter of not wanting one, I think the first ten years, frankly, for Covered California, were spent, one, building the organizational structure to provide health benefits. And then you all recall, oh, about four or five years ago there were quite the, quite the antics coming out of the federal government relative to maybe the Affordable Care Act was going to be repealed and replaced and we were going through that situation and so we really never had the time to sit down and formulate a strategic plan. Under Jessica's leadership, we have done that. The news here is just to share the vision and the mission, which you all can read. That did not change, and that is a testament to the founders, our founding board members who developed in conjunction with advocates and stakeholders and others, what the vision and mission should be for Covered California. And as of today, 11, 12 years later, it still resonates. We can go to the next slide, please.

I just want to share a little bit of our core values; I'm sure all of your organizations have them. These are probably similar in nature to what your organizations may have. But what this does; it allows us to focus our energies and efforts into the five areas that you see here. Again, I am not going to read each one of those, you all have access to the slides. But clearly, the focus for us is around valuing people. Those include not only our Covered California team members, but the people that we serve in California.

The fact that we work together and build that culture of trust is extremely important.

Doing the right thing for the right reasons sounds kind of commonplace, but for us to call that out I think is a very good indication that we take accountability for the actions and the processes that we put in place.

We view ourselves as very innovative and we continue to do that.

And then we follow through on our commitments, which is also a strong indicator of our value system. Can we go to the next slide.

So, these are the strategic pillars that we developed and then from these we developed all of our initiatives over the next three years. Each one of these there is an appendix to the slide deck, you all have access, there is additional information for each one of these pillars. But just to run through the highlights of them.

Clearly, Affordable Choices has never been more important today than it has been. It has been one of the legs of the stool, so, to speak, since we opened our doors and that has not changed.

Quality Care, again another leg of that stool. And you will see in a moment when I go through our Quality Transformation Initiative, our emphasis on quality, our focus on quality is actually heightened, and you will see what I mean when we get to that section.

Organizational Excellence, again, how we look at ourselves internally and foster that.

Reaching everybody in California. We just don't view individuals who are eligible for us as our audience. We want everybody to have health care coverage and so our message is to get out the information for all Californians, what is available to them.

A Catalyst for Change again speaks to that innovation side.

And then Exceptional Service, an internal mantra, if you will, relative to our desire to be the best and the brightest and provide the best services possible to our consumers. We can go to the next slide.

And this again, just what does it mean to our consumers relative to how we perceive the care that we provide?

How does it resonate?

Making it easy.

And of course, being sustainable, which I think is important for individuals knowing that we are here for the long run. And next slide, please.

All right. So, if we can go, I want to spend a little bit more time on the Quality Transformation Initiative, if we can go to the next slide, please.

So, this particular area is a huge focus for Covered California. And I want to just provide a little bit of context relative to what got us to where we are today and let you know that before Peter left he actually started the process by which we began development of our Quality Transformation Initiative. It was born out of the fact that we had been looking at our quality scores, understanding whether we are moving the needle on quality or not. And frankly, the outcome of that review and analysis wasn't very positive; we weren't making a huge increase in the area of quality. We weren't seeing our scores going up dramatically. And this is going back 30, 40 years, looking over a horizon of what has tried to be done and what folks have tried to do and just we weren't making the headway that we were hoping for. So, what we did is we decided to vet this. It took us about two years, frankly, to vet the process, to vet the idea, and to come up with the framework that I am going to share with you this morning.

So, for us, we wanted to come up with some principles. And I will tell you, one of the biggest ones was Alignment. Alignment for us is huge. You can see here that we have alignment with DHCS and CalPERS. And why is that important? I mentioned to you earlier, we have 1.8 million members in California.

If you break that out by 12 health carriers, that then takes that number to something less than 1.8 total. I mean, so, Kaiser has about a half a million and then you go all the way down to the lowest common denominator, probably CCHP in the Bay Area. And then you localize it and regionalize it. Our ability to effectively make changes becomes much harder as you bring it down to the local level. Yes, we are big, but we are not that big. When you start to look at how we can align with CalPERS, CalPERS has about 1.4 to 1.5 million members; and of course, Medi-Cal is huge. In totality, about 42% of the covered lives in California that the three of our organizations are responsible for; 42% can now move the needle. We now know that we can, if we align our efforts and develop strategies and approaches, we can, in fact, working with our health carriers, make effective changes at the local level through the providers to move the needle on quality.

So, you will see here these are the focus areas for us that we are going to be focusing on and continue to focus on and these are through performance guarantees that we have in our contracts with all the carriers.

And Jeff, I don't, I can't see if people have questions so could you prompt me if someone has a question. And certainly please feel free to ask them as we are going through this.

CHAIR RIDEOUT: I can do that but I don't see any questions at the moment.

MR. MCKEEVER: All right, thank you. Okay, next slide, please.

So, again, looking at our contracts. Let me cover the first one. You know, our goal was to establish a floor and then aim high. So, we are shooting for the moon, so to speak. It doesn't mean we are going to get there but that is our lofty goal. And right now for existing carriers we have a process called

25/2/2, which essentially says, if you are at are below the 25th percentile in quality metrics, that we will go through in a minute. And you are in that place for two consecutive years, we are putting those individuals on a performance plan so they can indicate to us how it is they are going to raise that up above the 25th percentile. If they are unable to do that, that particular product is removed from the marketplace. And I say product because it could be an HMO, it could be a PPO, or it could be an EPO.

Now, where that won't happen is in regions in which there are fewer than three carriers. So, for example, Region 1 up north, right now we only have two carriers up there. Clearly, we don't want to remove one and only have one carrier and limit choice and opportunity for the individuals up there. So, we will have other measures that we will have to put in place to address that.

And then on the Quality Transformation Initiative, I will go through this in more detail. But essentially, we are looking at key measures that I will cover. And if they are not at or above the 66th percentile in national performance, then there are financial provisions in place that I will walk you through. So, if we can go to the next slide.

This gives you a little bit more of the information I just provided to you relative to the 25/2/2. What the monitoring period is and then the remediation period. And again, our goal here is, you know, we don't, we don't believe and I would hope that all of you who are specifically in the health care industry, I don't think any of us would want to go to a doctor or any provider that has a quality rating of 25 or less. And so we are looking at that as a means by which to raise all boats to get everybody above that 25th percentile. Can we go to the next slide, please.

So, let me get into the financial incentives relative to the quality efforts that we are undertaking. On the left are performance standards that we have with penalties and right now that equals .2% of premiums over the domains that are listed here.

The majority of our financial incentive goes into the Quality Transformation Initiative itself, the first year of which it is .8% of premium. That is at risk relative to four measures. And if we can go to the next slide I will share with you what those measures are.

Well, we are going to do this one first. So, before I get to the measures let me speak to the Initiative itself. And you can see, making quality count on the far left tied to .8% up to 4% of premium. That 4% of premium is over a graduated annual process that is going to take us three and a half to four years to get to. And I want to say this and I should have said this earlier. We have said this since day one when we developed this approach. We don't want any carrier to pay anything to us. We would love the fact that every one of our carriers was at a percentage that did not require them to provide us with any monetary amount. That is our goal.

So, we also want measures that matter. And as you all know, there has been a lot of, a lot of effort in measurement; and the term that has been used now is parsimonious. We want the measures that count in that matter and we want a small number. We don't want to inundate individuals and providers with 13 to 18 measures that just don't make sense to have them do that.

Equity is a quality, we are doing that.

And then I already mentioned alignment. Okay, so now can we go to the next one, please.

All right. So, here are the measures that we are putting focus and energy around. All of these measures have downstream implications. So, if you can't control your blood pressure, obviously, there are issues that lead to more severe complications. Diabetes, colorectal cancer screening, and then childhood immunizations. We do have two measures that are reporting only and that is just because there isn't enough data that is relevant enough for us to include them in the core measure set.

But you can see, we are only doing four. CalPERS has adopted the same four. I know DMHC in its quality measure efforts, these four are included in their overall quality set. And of course, Medi-Cal looking at these and adopting these as well. So, again, energy focus alignment around these four particular measures.

I will say that at the current we have been able to look at and measure where our current plans are using historical data and there is only a couple of plans that meet the 66th percentile or above. Everybody else falls below it in some category in some percentage. And so all the plans know that they have got some runway in which to work to try and get those up before we start assessing these performance metrics and that will be -- the first year that we do that is in 2025. Can we move to the next slide, please.

This just shows you the graduated payment structure that we put in place. If you are below the 25th percentile, you pay 100% of the penalty. And then as you graduate up to 66, that percentage goes down. So, depending upon the measure, depending upon where the particular carrier is with that measure, we then aggregate that in a manner in which it will then determine what the total payout is from the carrier to Covered California. Next slide, please.

So, the big question that has come up in recent months is, what are you going to do with all the money that you are collecting? And so, we have been in a massive undertaking relative to our engagement, not only with our current carriers but with advocates and stakeholders, academics, to figure out how best to administer and use the dollars to lift all boats, so to speak, which essentially has a positive net impact on the quality of care that is provided to Californians. And so, you can see here, this is where we look at providing our indications of our responsibilities for those payments, what Covered California will be responsible for as opposed to others, and what the money is going to be targeted for. And I think the best thing for me to do is just to call out that we are looking broader than a typical specific quality approach. We are looking at Population Health Investments. And those can be a range of things that are currently being discussed right now with an advisory group that has been formed that Dr. Soni is responsible for convening. And then ultimately coming up with what those dollars will be allocated to and for and how much. Can we go to the next slide, please.

For us it is really important to talk about what these -- what are the needs assessments that drove our investments and the early themes that we have found in talking with consumers in engagement are obviously financial. Affordability continues to resonate. We actually reached out to patients, our consumers. Again, their biggest thing was reducing the overall financial burden. And then you see here provider and practice engagement and population level geo-mapping that we looked at.

All of which is contributing to us understanding the broader map of how best to approach this and come up with a methodology that everybody, one,

can agree with; and number two, we will see outcomes that are measurable for us to understand if we are actually making positive strides in this area. Can we go to the next slide, please.

We wanted to land on principles relative to the use of the funds so that everybody understood there is a framework and a foundation for us to ensure that these funds are being used in a way that they should be and are intended to be. So, here you can see Equity First. Direct, meaning they go to measurable improvements in quality of outcomes for our consumers. That they are Evidence-based. And that they go to areas that really are currently underfunded in this particular area. So, those are the principles that guide our efforts right now and will dictate where those funds end up going. Next slide, please.

So, this just provides what the current thinking is relative to the thinking on how those investments will be selected. One, they have to meet the guiding principles. Two, they have to address population need. Three, they have got to be feasible to implement and measure. And then the Advisory Council will then take all that data and decide what is it that we believe are the best approaches that we ought to be pursuing moving forward and then they will roll that out. And next slide, please.

I think this might be the last one. One of the things that I want to note here is we are not rigid. We are innovative, we are adaptive and flexible. And so, therefore, if we try something and it doesn't work, we will pivot. And this is where we will rely upon the evidence-based opportunities and measurements that we get out of this process. We will continuously look at whether or not this is impacting quality and in what areas. And again if it is, great, maybe we expand

it; if it is not, let's pivot and do something different. So, we are going to be working closely with the health carriers to ensure that these dollars are going to ensure that not only our consumers but their members are actually receiving the best care that is possible for them. And ultimately, that the quality of care that is being provided translates to individuals having healthier lives in California.

So, with that, Jeff, I think that concludes my comments. I know that was a lot of information to cover in a short amount of time and certainly happy to address any questions that you or the Board may have.

CHAIR RIDEOUT: First of all, on behalf of the committee I would really like to thank you, Doug, for the information and also the hard work to get to this point.

I would like to entertain any questions or comments from Board Members. Paul.

MEMBER DURR: Yes, Doug, it was a great presentation so thank you for that. And great work that you have done with Covered California to make a difference in our state so I really appreciate that. My question had to do twofold. One was measures of success and how do you define measures of success as to what we are seeing as outcomes. One is enrollment, obviously. But anything else that you look at?

And then my other question has to do with regards to member satisfaction. So, where the members are satisfied.

And maybe a third one I would throw in there which is, how is this perceived on a national basis? You mentioned we are one of only a few states that have taken the burden on ourselves. And I am just curious as to how that is perceived nationally? And thank you.

MR. MCKEEVER: Thank you, Paul, appreciate the comments. First, success will be measured primarily upon those four core measures. Again, we picked those for a reason. They are small in number, they have -- if we increase the ability to impact individuals, reducing the number of those individuals that get diabetes, right, reducing high blood pressure, increasing immunizations, all of that should translate into positive success that we can measure at the back end so that is going to be the first indicator. There may be others, Paul, that we come up with, but again, we don't want to inundate the providers in particular with efforts that don't lead to positive outcomes. I have heard for years, you know, the administrative burden that many of us put on health plans and providers in particular and that they spend more time on paperwork than they do on patient care. We are not trying to amplify that, right, we want to remove some of the administrative burden, so hopefully, we will be able to do that.

As it relates to satisfaction, we do a lot of surveys in Covered California with our consumers, some of which speaks to satisfaction. I will tell you that the majority of the feedback that we have gotten to date on these surveys is fundamentally around affordability and not on health care outcomes. Which is a bit of a disappointment given that you would hope that more individuals would be focused on their health. (Coughed.) Excuse me. But affordability continues to resonate. And again, this is our population, so you have to remember it is a lower-income population that we serve and so affordability for them is paramount relative to their health care needs.

And then the last one on the national basis. You know, we had CMS, we have had multiple national entities, organizations, academics look at

our Quality Transformation Initiative. They helped form and shape it. Our hope is at some point somebody will look at this as a model for replication. And whether they do or they don't, we will have to wait and see. I think probably a lot of folks are waiting to see, as we implement, what are the successes, what are the outcomes, what is the evidence telling us? We are not there yet, obviously. But clearly, we have set the framework for others to just take this and import it into their own geographical areas. And they can adapt it to their needs, right. They don't have to do it exactly like we have formulated it. But certainly we think it is a model; and a model, frankly, that Medicare can be looking at as well at some point. So, I mean, I don't want to leave out the other big gorilla in the room, which is Medicare, Medicare can be using this just as much as the commercial side and the individual market.

CHAIR RIDEOUT: Mark, I believe you have a question?

MEMBER KOGAN: Yes, thank you. Thank you for that presentation. I just have a quick question. The 80 million and 160 million next year that is available from penalties, is that anticipated that that range of money will be available in years to come also, to utilize?

MR. MCKEEVER: Yes, Mark, we are hopeful. And given how much the state has been collecting annually with penalties, that that will be a sufficient revenue pool by which this will be an ongoing appropriation. The legislature will have to continue to include it in the budget, but it is our hope that they will continue to do so.

MEMBER KOGAN: Okay, thank you.

CHAIR RIDEOUT: Are there any other questions from committee members?

Okay, hearing none I will move on to public comment. We will start with folks on Zoom.

MR. STOUT: There are none at this time.

CHAIR RIDEOUT: Okay, anybody on the telephone, questions?

MR. STOUT: None at this time.

CHAIR RIDEOUT: Okay. Well, again I want to thank Doug. And my remarks, which will follow next, will reinforce a lot of what Doug is saying. So, thank you, Doug. Anything else for the good of the committee?

MR. MCKEEVER: All right, thank you all very much, appreciate it.

CHAIR RIDEOUT: Take care. All right.

Next, we move on to a presentation on IHA's Atlas and results that we have seen in a five year look back. I will let Jordan advance. A couple of things. I am the chair of this committee, but I am presenting this as the CEO of the Integrated Healthcare Association. Mary has afforded us the opportunity to present this data pretty much on an annual basis so that's what this is about. I will try to tie what you are going to see here to what Doug said because a lot of the work here is how to align the aligners and also how to align more than the measures, because a lot of this comes back to what are the incentives for not just plans. And as you heard a lot of the QTI incentives are downside financial incentives, but what are the incentives for the provider community to actually improve. Because that is where this is going to come home to roost because all the measures that are being focused on are clinical. So, I am going to start, Jordan, if you can advance.

First of all, just a primer on IHA, we have been around over 25 years. We are organized as a 501(c)(6) not-for-profit, which means we are a

business league, which is a little bit unusual but there are about 39 ways to be a not-for-profit in the US tax code. What this means is that we have the obligation to provide products and services to the majority of our members that benefit the membership as a whole, not any individual member. IHA's membership is an amazing cross section of health plans, health systems, capitated medical groups, or RBOs in the language of DMHC, non-voting regulators including DMHC and DHCS and CMS, we have some pharma companies as members, and we have purchasers. So, we are represented well by Covered California, CalPERS, and the University of California.

So, the goal here is to take all of the strange bedfellows and see if we can find something that makes sense to work on together and we really have two major areas. Maybe you have heard about the provider directory area that is essentially a utility for improving provider-related data and that is going great guns now. We have got over 500,000 unique providers under management and we are finding about 100,000 errors every month through the process. I won't talk more about that other than to say it is an important function of IHA's.

The kind of historic focus of IHA has been on performance measurement, that on the left. We have three major programs. Probably not necessarily to know the branding but one is around provider group performance measurement; one is around more geographic and line of business performance measurement, that is the Atlas; and then the third is a major initiative undertaken with Health Net to actually improve encounter data capture called EDGE. So, next slide. Next. Apologies, Jordan. Some of these build so I will just keep going next.

A little deep dive. Oh. Go back, if you would. Thanks. A little

deep dive on performance measurement. We have been doing provider capitated group performance measurement for over 20 years. We have about 200 physician groups that participate in that program every year. That goes under our AMP label. And that is the same information you might see on the OPA site or on the CalPERS Medical Group rating site. So, our data is what feeds both of those.

About 10 years ago, we are coming up on 10 years ago, we started doing broader measurement, called Atlas, which looked at not just HMO and MA lines of business, but also, PPO lines of business. We do have quite a bit of PPO data, we also have to Medi-Cal plans. So, I want to shout out to Blue Shield and IEHP for their participation in that way. This was actually an attempt to preserve a data infrastructure for the state of California when a CALSIM grant was not approved. When Diana Dooley was Secretary of Health and Human Services we were awarded this work in a competitive bid and we have been doing this work ever since. And it is a bit of a precursor or forerunner to what OHCA is doing now and I will try to draw those connections as we go.

And then since 2017 we have standardized all the measurement and we are combining the provider and the plan information so you will see some of that. And just as a preview, we will have this year's Atlas report coming out in a few weeks.

The other thing on this page in the lower right, we manage over 20 million member claims every quarter, so that makes us one of the largest claims databases in the country.

Fifteen health plans are submitting regularly and voluntarily, which is an interesting thing to kind of keep going every year.

Mentioned the 200 physician organizations that participate in one or more of our programs. We were actually the plan that brought Onpoint into California, which is now serving as the analytic vendor to OHCA's HPD.

And we do provide analytic information to both Covered California and CalPERS based on the size of the database and the number of participants. Okay, moving on.

So, what does the Atlas tell us? And this is sort of the data-focused or results-focused section. So, next let's look at cost of care first. Jordan, if you can advance. Thank you.

So, no huge shock here but when we do a five-year lookback on our data the total cost of care in California has increased by 20% over that period of time. Just so people know, this is Commercial data, it includes both HMO and PPO data. We also do this for Medicare Advantage data. The other thing that comes with this, this is risk adjusted for age, sex and clinical condition. And the other thing that is probably important to note is that this is the same kind of lookback that OHCA is now doing. But we are looking at total cost of care. So, this is where it gets a little bit technical. But that is where we actually calculate the cost on a per member basis, on an individual member basis, and then add it up. So, this does not include profit or margins, but it does include kind of a bottom-ups, calculation of the total cost of care, which includes copays, deductibles, and out-of-pocket expense. Next.

Because it is so topical, we can look at things like specialty drug spend. Drugs in general as a category of increased have increased by 15% but it is really in the specialty drug category we have seen this dramatic rise in both use and cost. So, this is just another indication of the kind of data that we can

look at and the kind of information that is available to us right now. Next.

It gets a little bit interesting when we start to segment the information by line of business and so this looks at HMO versus PPO. Standard measures for both so we are not, we are not looking at different apples and oranges. What we have seen, and this isn't surprising, but the heavily integrated product lines which typically go along with the HMO plan products have shown a rate of rise that is much lower than the non-integrated plan models. So, if you think about Doug McKeever's presentation, a number of the QHPs for Covered California are HMOs, but a number of them are EPOs or PPOs. And so some of the cost trend is driven by how integrated these organization networks are and much of that is driven by whether they accept capitation or not. So, this is essentially a proxy for capitation. Next.

So, trying to be useful and contributory. As many of you know, the Office of Health Care Affordability issued its target, statewide spending target of 3% for the years 2025 to 2029. That public comment period closed a couple of weeks ago and it received quite a bit of attention from multiple organizations. So, we looked at, first on the left and then I will go to the right, well, did our lookback match what the state was looking at? And it is pretty close. The state's years were a little bit different and a little behind ours. And they calculate total health care expenditure and then divide by the number of residents, we actually do it from the bottom up. But we were happy to see that the rate was about the same. Again, the striking difference was really the annual increase when you look at integrated products, product networks, versus non-integrated. And one of the things that we are trying to do is not necessarily challenge is 3% enough or not enough, a number of other organizations are doing that. What we are trying to

promote is can we segment the market so that we can look at these things on a more sophisticated and nuanced basis, such as whether people are taking capitation or not. There's a lot of other ways to segment geographically you can segment. But it is important to say, have those capabilities ready because a lot of the reporting will need to be by market segment or by line of business segment. Next.

And then finally, this is just sort of an all-in comparison of out-of-pocket costs for consumers. As I said the way, we calculate total cost of care allows us to do it. And this is an average across all members. So, imagine if you are a chronic care member, the difference is here. And Doug mentioned that in his remarks as well, trying to reduce the deductibles in particular that consumers experience depending on the product that they choose. Next.

Okay, what do we know about quality? And this is really IHA's historic focus, but we have moved into measuring total cost of care as well 10 or 15 years ago. We are one of the few states where we are transparent with total cost of care at both the plan and the provider group level.

But as you have heard, there is a fairly noticeable shift back to quality as a marker for performance. The QTI program will exclusively focus on four measures of quality and I will go through the other major programs to share. But that is the general theme. Race and ethnicity-adjusted quality of care and performance improvement are really the order the day. So, next.

First of all, if you look at claims only information, the good news is that this is a composite of eight measures, many of them are in the Core 4. Over the last five years, which this was the lookback for, quality has generally improved in all lines of business. That's good. The non-integrated lines of

business, or those that do not take capitation of any type, are still below a level of where the capitated provider organizations and products were five years ago so there is room to move. The big thing I want to highlight here isn't that. It is that claims are a very limited way to look at quality and we will show some data on that. But, if you are relying only on claims information and you are relying on it once a year, there are a lot of challenges in terms of the completeness of that information and the ability to change. Because a lot of these programs, including ours, measure this annually. We are moving toward a much more regular process with a new partner where we can actually provide information on literally a monthly basis.

But the QRS program for Covered California, not to be critical of it, but it is a once a year submission of largely claims driven information to determine who is, in this case, eligible for a financial penalty or not. And there is some kind of kludgy things that still happen. A lot of the plans actually supplement those claims information with a one-time chart review on a sample and submit that as a combined rate. That is great to get the rates maybe closer to where they really are, but it is a big burden for provider organizations, and it really has no impact on performance improvement because you are looking at a sample and you are looking at it for one year. So, there’s a lot of ways that we have done this kind of work that have persisted out of necessity, but I think the Quality Transformation Initiative and what CalPERS are doing can really jumpstart a different way to approach this. Next.

This is really technical, but I wanted to highlight it. This is that results from our Edge program. And I mentioned that is a very large grant program from Health Net and DMHC to try to improve encounter data. This looks

at 200 or so medical groups, again, all risk-bearing. And this spans actually Medicare and Commercial. And we correlated the performance of those groups on the Core 4, those same core clinical measures, with their submission of encounter data. So, for those of you that aren't as familiar with that, encounter data is a form of a claim but it isn't paid. It is essentially an activity report for activities that occur at the clinician level. What you see here is there is a high correlation, not surprisingly, between better encounter data submission and Core 4 scores. And each of those red dots are actually potential physician organizations or IPAs that can be targeted for performance improvement because these are the ones that need the help the most. So, even if you are working in a claims-only world, this is an important piece of whether you are getting all the information you need. Next.

Okay, this one is a little bit dense, but I think it is really important for people to kind of walk through it with me. So, on the horizontal axis are those same four Core 4 measures controlling high blood pressure, hemoglobin A1c level, colorectal cancer screening, and childhood immunizations. These are all standard methodology in terms of the metrics. The red bars are what we see in our data from claims-only for those four measures. The blue bars are what we see when we supplement that with clinical data, either from submitted by the provider organizations or potentially from their EMRs. And what you see is a dramatic increase in the performance for most of these measures.

The thing I would like to leave you with is if we are doing any of these performance activities as an industry with just claims data, we are going to be missing a lot of what is actually going on, and capturing that is a really, really important process. Then you may say, well, why is that one, the hemoglobin A1c

only 6%? Well, in that case, plans are collecting laboratory data directly from LabCorp, Quest and others. They can supplement their claims data themselves. On most other measures that we are looking at that is not possible. So, again, closing both the encounter data gap from the last slide and the absence of clinical data is really, really important for any of these programs that are going to start penalizing folks for poor performance. Next.

Here is another interesting kind of finding across our 12 or 13 or 15 health plans. Every plan is a little different. So, one of the things that is really risky is to ask every health plan to submit their information themselves. Not because they are trying to cheat, not because they don't/can't interpret the methodologies, it is because everybody does it slightly differently. And in some cases, that has pretty dramatic differences on rates. So, these are the same four core measures. And what you see in the blue bars going horizontally, the plan in the lowest end only gets a 2% boost from clinical data. The plan on the right at 73%, their score improved by 73% from getting the clinical data. What that tells you and what it tells us is there is there are data gaps, and those data gaps are different depending on the plan and how they are organized. So, some organizations are really tightly integrated with their clinical providers, others less so. So, this is one of those things where the argument here is, if you want to promote performance improvement for the enrollees, you have to get, you have to start at the right place because otherwise people are essentially just trying to close data gaps. They are not as focused on the performance improvement as they are on getting their scores up. Next slide.

This has dramatic importance on race and ethnicity stratification. So, we also looked at all of our plans that are in our data group across race and

ethnicity information. The blue bars represent that information that is collected directly from the consumer or the enrollee and that is the preferred way to get it. There are ways to impute it, there are secondary sources that can supplement it. But by and large when we stratify these performance measures by race and ethnicity, we are also dealing with a lot of variability across different plans. And if you go to the next slide and build it out, there you go.

And what this means right now is if you stratify, and this is what -- these are actual results. If you stratify the results that we collect through the Atlas program, of the 15 plans, there are only 3 or 4 that meet even the Medicaid 50th percentile on this particular measure, which is controlling blood pressure. That is not surprising because blood pressure is a metric that is measured at the clinician level, it is in the EMR, it doesn't get paid for, it is an E&M visit that gets paid for. So, even if you are reimbursing you are reimbursing for the visit, not necessarily the detection of the blood pressure itself. So, this is a problem for the industry, if we are going to stratify by race and race and ethnicity, not only because everybody is doing poorly, but because the results then don't have much impact when you do split it down by race and ethnicity. Next.

Here is another view from the Atlas. This is primary care span. So, this is another focus area for OHCA coming up. We have been doing measurement in support of primary care for the last several years in partnership with PBGH and Covered California and our participating health plans. And the long and the short of this is there is a wide range of how much people spend on primary care. And so, is that a problem? Probably. How do we correlate that with performance? And what can we do, more importantly, to drive better spending and use of primary care? And the other part of the analysis that we --

and I am a primary care physician so, obviously I am biased. But the other part of the analysis that we have done is that spending is highly correlated to outcomes like patient satisfaction, lower emergency room use, lower hospitalization and higher quality. So, it is hitting a lot of the high points when you invest in primary care. Next.

And I am coming to an end. Okay. So, this is where I wanted to kind of bring it back to what Doug McKeever said from Covered California. So, there is a lot of very positive movement across regulators and purchasers in California to really focus the energy on a few measures that actually can make a difference for patients and enrollees. So, next. So, you can just build this out all the way. Okay.

So, there is a lot on this slide but a few points I want to make. There are, depending on how you count, four or five or even six programs trying to align performance. So, DMHC, and I verified this with Mary and her staff, 13 measures. There are 96 plans that will be affected by this in terms of potential sanctions for poor performance. Those are both Commercial plans and Medi-Cal plans. So, one way to think about DMHC's role in this, and I am kind of talking to Mary as well, is just, you know, this is where most of the enrollees will be impacted or potentially impacted. So, whatever DMHC rolls out, it will have the broadest reach.

Then go to the Covered California QTI Initiative. This is the one that is furthest along and Doug mentioned that. Six measures, four incented, the Core 4. Thirteen QHPs affected, but not necessarily 13 separate organizations. There are plans that have multiple products on the Exchange.

CalPERS is not far behind, they have a program called QAMS.

Eight measures, so slightly more measures, we are creeping up a little bit. Twelve to 13 plans affected.

And then DHCS has had its Managed Care Accountability program, MCAS, for several years and it has many, many programs that incent both positively and negatively for certain performance characteristics of the health plans that are under contract. In this case, the Managed Care Accountability Set includes 18 measures for incentive, there are another 23 that are recorded, and there are 25 MCOs that are affected by it.

And then I mentioned primary care. There is a voluntary initiative called California Advanced Primary Care Initiative. Twelve measures, four plans to date, all of them are PPO, and it is an upside only incentive.

The last things I will mention, all of this requires clinical data for accuracy. As I mentioned, all of these include the Core 4. So, Doug talked a little bit about trying to get the focus. So, they all include the Core 4, that is true, but they also, include other measures. Now, those other measurements are pretty standardized. But from a provider point of view, managing 13 measures or 18 measures effectively may be harder than managing 4. So, you know, that is a point of alignment that still could be tuned a little bit more. These will all include stratification for race and ethnicity, but it isn't clear whether that will be done the same way, so, there is another opportunity for alignment. And obviously, encounter data, as I mentioned, is another opportunity where the impact of getting better encounter data can help this.

On the bottom are the financial penalties. I know Covered California is very cautious about calling them penalties but there is no upside in this for health plans. They either meet that 66 percentile and don't pay into the

fund, or they will pay into the fund, and they will pay in more if they perform poorly. And as you heard, below the 25th percentile, they may even go into a remediation phase. So, for a plan that is offering a QHP that is a pretty serious thing to look at.

DMHC has not set its penalty amounts or its sanction amounts yet, that would have to go through regulation, as I understand it.

CalPERS has contemplated a program of the same magnitude as Covered California, but they are still deciding kind of both what the benchmarks will be and what the penalties will be.

And then DHCS. In the last cycle, there were 3.4 million in penalties. All of those were subject to appeal by the individual plans.

So, I think the takeaway from this one is more, there is still alignment work to do and the more of these things can get really strictly aligned the better. And some programs will probably get more attention than others just because of the magnitude of the financial risk.

The other thing I would say and I really, really want to stress this, this will not work very well if there is not something in it for providers. And this is hopefully not too self-interested a plug, but we have had a provider incentive program for over 20 years that is an upside program for both achievement and improvement. And what we are doing is redesigning that program to strictly reflect the measures and the benchmarks that Covered California, DMHC and CalPERS are coming up with. And the reason we are doing that is because this push from purchasers to plans will eventually go from plans to providers, and the provider community needs not only the alignment and the parsimony, as Doug mentioned, but also, the incentive to actually improve. So, I think it is really

important that we think about kind of the mirror effect at the provider level if we want these measures to get better. And then the last slide.

Where does this fit with OHCA? This is kind of a word salad, but there are some differences. They are not differences that can't be reconciled or brought together or aligned. But just so people know, OHCA is pursuing Total Healthcare Expenditure, we have been pursuing Total Cost of Care. They are highly related. One can serve the other. But right now that is a difference and so what that means is that plans are being asked to submit data and the measurement is against THE, not against Total Cost of Care. Maybe it is better to let it go. So, those are the kinds of things we can decide.

Risk Adjustment, huge issue. Because right now OHCA is considering certainly age and sex, but not necessarily a clinical condition and there is an infinite number of things you can adjust for. But in our experience, clinical condition is really, really important. We also do wage adjustment for north versus south and Central Valley in our reporting.

Sector specific, I mentioned already plans that are capitated or plans that are integrated care models. They track with the RBOs, but RBOs are kind of a superset of these organizations. We were pleased to see that OHCA plans to accelerate the segmentation effort in regulation and also its data submission guide. So, hopefully, that will give them the opportunity to do more segmented results. Capitation is part of that.

And then there is a laundry list. Defining APMs consistently.

The definition of primary care and definition of spending. Many of these things we have worked out over the last 20 years.

I would raise a question. What is quality’s role in OHCA’s efforts?

It is very, very focused on affordability, by design. There are in the enabling regulations some pretty heavy mention of quality, but they are not front and center. So, again, just need to make sure we are not causing any harm to the quality of care as we try to manage the cost.

Health Equity has not been defined within the OHCA world yet. Obviously, they are aware of it and they will try to incorporate that, but that is another area.

And then the last thing I will say is just sourcing the information. There's lots of pitfalls if it is all sourced independently versus from a central area. Our thought was that the HPD would be the central source. That that is not how OHCA has organized it. Obviously IHA can be a central source for much of this, we cover about 50% of the enrollees in the state now. But again, making sure the data end is of high quality and is standardized as much as possible is an important step. So, I will stop there.

As Chair I guess I will ask if there are questions from other Committee Members. Paul.

MEMBER DURR: Jeff, it is always great to have this presentation. I think it says a lot about the great work that you are able to accumulate all of that data and present a story, which is really helpful, so I appreciate that.

Two things I had. One was thinking about, I know ethnicity is a factor. Is there a plan to do income with ethnicity as an adjustment factor in thinking about that?

And then the other piece I will ask is about the data sharing. Your point is, that is a critical component that is lost is that we lose that data that is in those provider offices that really aren't able to submit that as supplemental data.

So, that is a big, big concern there. And I want to reinforce your support for the impact to the providers on having lots of different measures sets, because it just overburdens the providers, as you know as the primary care physician. Their time is so fragmented right now with a lot of the easy cases being taken away from all these virtual care visit options that you can get through Amazon and Costco and all that. What is left for the provider is all the more complicated patients, so, I want to reinforce that. So, thank you.

CHAIR RIDEOUT: Yes. So, on the first question, there are ways to -- about income versus race and ethnicity. There are ways to impute race and ethnicity. RAND has a tool. We piloted that with our dataset. It would work but it comes back to four major races, not the maybe dozens that we have in this state. And it also is really, really hard for people to accept information that wasn't collected directly from the enrollee. So, another proxy for that has been income, so that is the connection there, where if you match income, and you can do first and last name matching, that is part of the RAND process. You can get better. Zip Code is another way to do it. But I think -- I don't want to speak for any of the regulators or purchasers, but I think people are pretty committed to doing this with just directly collected data. Now the income adjustment, you heard some of what Covered California can do to reduce the deductibles and whatnot. This could be income adjusted. I always say be careful what you adjust for because you may mask what you are trying to fix. So, if all of these results are income-adjusted you are just putting people with lower income in a different bucket. And I think we see some of that when we look at Medi-Cal versus Commercial.

And then the second question, Paul, if you can refresh?

MEMBER DURR: It was data sharing.

CHAIR RIDEOUT: Yes. So, this is a really tough one because what has happened, at least in California up to now is, oh, we will share and add and supplement clinical data once a year, if that; or we will do it at the point where we have to submit a result to QRS. That doesn't really do anything for the provider community or the plans that want to actually see things get better. So, the good news is there are some options with analytic organizations in California where upwards of two-thirds of the EMR data is already in their data environment. So, matching that to the plan information from claims then puts the kind of two pieces of the puzzle together. So, I think there is some hope there. I would caution that we are still in the last century on a lot of this stuff, but I think there is some opportunity to take some steps.

Abbi.

MEMBER COURSOLLE: I want to echo Paul's thanks for the presentation. It is really helpful and very interesting, so I really appreciate all the information, even though it was a lot. I was really struck by, you know, the gap between the claims and clinical data, particularly for the high blood pressure measure; and that was also the measure where there was the biggest range across plans. So, I was just wondering, you spoke to this a little bit, but if you could talk a little bit more about the inclusion of that as one of the four core measures, given the huge amount of variability we see with respect to that measure?

CHAIR RIDEOUT: Well, from a clinical point of view, and any of the other clinicians can jump in on this, managing high blood pressure is essential to avoiding stroke and heart disease. So, clearly it is an upstream thing that we need to do. The challenge is that in the coding world, you don't get paid

for managing blood pressure, you get paid for a visit where it is measured. So, that is a lot of the problem with claims is they are activity but they don't give you the results. And the same problem with hemoglobin A1c. Yes, you can get a lab test for A1c. But what really matters is if it is elevated, are you managing it? So, I think the difference here, and again, I would encourage Paul or anybody else to comment is, we are missing a lot of the information that is only going to be found in the electronic health record now or in the chart.

And if you are going to emphasize a measure like controlling blood pressure, which affects a lot of people, you have to be willing to go grab that too. Because even if you think about it, let's say, it is really, really low. Okay, I am going to go out and try to improve that with a plan and their provider network and it is 15%. Well, the first comment they are going to say is, you are missing data. I can guarantee it. So, once you get the missing data then it is like, oh, that is actually much better. So, I think it is a matter of how aggressive to be on the front end to make sure where you are starting from is accurate.

Are there other questions from Committee Members?

Okay, seeing none, I will ask for questions from anybody on the Zoom.

MR. STOUT: There are none at this time.

CHAIR RIDEOUT: All right. Well, hopefully I did well enough to be asked back next year to do this. Anyway, I will now turn it over to Mary to continue the meeting.

MEMBER WATANABE: Thank you, Jeff. And I just want to note, I think we are -- so for the DMHC, we will have our first set of data here probably this summer and our first report at the beginning of next year. So, we are excited

to kind of dip our toe into this world. We are learning a lot, lots of challenges of course, but, Jeff, I think I appreciate your perspective on the quality data.

So, with that I am going to turn it over to Sarah Ream for our Regulations and Federal Update.

MS. REAM: Thank you, Mary. Good morning, everybody. Jordan, if we could go to the next slide, please, or whoever is --

SPEAKER: Shaini and Sandy.

MS. REAM: Whoever is driving, thank you.

So, first off, I am thrilled to report that the Office of Administrative Law last month in January has approved our SB 855 regulation. Just as a reminder, this bill, SB 855, which was enacted in 2020, is intended to make it easier for enrollees to access behavioral health care services. It also requires plans to use specifically identified UM criteria and guidelines when they are making their UM decisions regarding behavioral health care. So, this reg will take effect on April 1, April Fool's Day, and we are just very excited about this reg. It has been a long process, a good process, working with stakeholders to get the reg where it needs to be, so we are very excited that this one is across the finish line.

I always say at every meeting that we have a lot of regulations in process and it is still true. I am going to touch upon four here.

So first, we are working on the prescription drug reporting requirements regulation. This regulation will provide clarity regarding Senate Bill 17, which was actually enacted in 2018. That bill requires plans to report to the DMHC information about their prescription drugs, including the plans most prescribed drugs, their most costly drugs and their drugs with the highest year-

over-year increases. So, plans have been reporting this information to the Department since 2018 and this regulation will largely codify what the plans are already doing. We plan to hopefully share the draft regulation with stakeholders in March and start the formal rulemaking pretty quickly thereafter.

The next that we are working on is provider directories. Again, we have been talking about this reg for a long time. But I am happy to report we are getting close to moving into formal rulemaking. As a reminder, this regulation will put into formal regulation many of the processes and the requirements the DMHC's guidance has required plans to follow for a number of years. So, we are hoping to start formal rulemaking on this by the spring.

Next, another real success here with fertility preservation reg. I am thrilled to report that yesterday my team submitted the regulation package to the Office of Administrative Law. That submission starts the formal rulemaking for this regulation. So, the public comment period for the reg will open on, I believe it is March 8, and will run through April 23. Just for folks who aren't tracking, this reg will implement Senate Bill 600 from 2019. That bill requires health plans to cover fertility preservation treatments when a covered health care service may cause infertility for the enrollee. So, again, look for this. Notice should be going out very soon that the public comment period for the formal rulemaking has begun. So, excited that is underway.

Finally, I want to touch upon our general licensure regulation. So, as a refresher, the current version of this reg, which is section 130049, requires an entity that accepts any amount of global risk to either obtain a health plan license or get an exemption from licensure. After we adopted that reg in 2019 we provided a phase-in period for compliance. During that time, we implemented an

expedited exemption application process. After learning a little more, learning what we didn't know, we decided to make some tweaks to the regulation. So, the Department has extended that expedited exemption process until such time as we promulgate an updated regulation.

The revisions that we anticipate making to the reg will specify what types and levels of risk will qualify an entity to receive an exemption on an expedited basis. And also what types of levels of risk may require a more thorough review of an exemption request; or even what types of risks may trigger a requirement that the entity get licensed as a health plan. We are also really closely following what HCAI is doing regarding risk to make sure that our regulation aligns with where they go with respect to professional and institutional risk, we don't want to get sideways there.

So, at this point, I don't have a timeline for this regulation. But we want to keep stakeholders informed as we are moving through this regulation into formal rulemaking at some point. So, you will hear me at future FSSB meetings I'm sure bring this one up again just because I know it is of particular interest to folks who are either on the FSSB or come to the meetings.

So, with that, before I turn to the federal updates, let me pause for questions.

MEMBER WATANABE: Just really quickly, I should have noted, Jeff had to hop off. He is juggling many, many meetings today. So, I will be facilitating the rest of the meeting. And I think Jessica had to jump off as well.

Paul, go ahead with your question.

MEMBER DURR: Yes, just a general question, Sarah. Will the OHCA have an impact on those regulations that you were just talking about with

how that would impact your coming out with a general licensure?

MS. REAM: So, we are -- I don't want to say that we are coordinating with them at this point, but we are tracking. We have frequent conversations with OHCA about numerous topics. But what we want to make sure is that they don't impose a requirement or a standard that conflicts with what we may do with our general licensure reg. So to your point, we are definitely following what they are doing, tracking that, and want to make sure that we are in alignment with where. So, it could impact. Want to make sure that if it does impact it is not a negative impact but a positive impact.

MEMBER DURR: Thank you.

MEMBER WATANABE: And maybe just a reminder for those that are joining as member of the public, you can raise your hand, click on Raise Hand at the bottom of your screen, I believe, if you have a question. If you are on the phone you could dial *9 and that will let us know you have a question and we'll unmute you.

I am not seeing any other questions from the Board Members. Actually, we do have a member of the public, thank you. So, Pamela Cleveland, I believe we have unmuted you. If you unmute yourself, you should be able to ask your question.

MS. CLEVELAND: Yes. I just wanted to ask about like the prescription drug reporting requirements and provider directories, if that is applicable to Medicare Advantage plans?

MS. REAM: Thank you for that question. So, the answer is no, they are not. Just as sort of some background. The DMHC has limited jurisdiction over Medicare Advantage health plans, those are primarily governed

by federal law, by CMS. So, no, neither of those regs will impact MA plans.

MS. CLEVELAND: Thank you.

MS. REAM: You're welcome.

MEMBER WATANABE: All right. I am not seeing any other questions so why don't you go on to the federal update.

MS. REAM: All right. All right, so, federal updates. Things have been a little bit quiet at the federal level, amazingly. I'm sure there's lots of things percolating along. But two things I want to talk about here regard reproductive health and things that are happening at the fed level regarding reproductive health.

So, first, we have the HIPAA Privacy Rule to Support Reproductive Health Care Privacy. The federal rule, proposed rule, the comment period closed last June. But given all the action that is going on in different states regarding reproductive health I thought it would be helpful to mention this rule, and also how, the things that California is doing or has done to protect reproductive rights. So, the rule in a nutshell is designed to ensure that private health insurance information can't be used against people who obtain reproductive health care services.

In the past few years, California has also adopted some very strong protections for reproductive rights. Those laws include a number of bills including Assembly Bill 2091, and all of these are from 2022. But Assembly Bill 2091, which protects abortion records in California from access by out-of-state law enforcement agencies and other third-party entities that are trying to enforce the states', the other, Texas or whoever the state is, the other states' anti-abortion or abortion restrictions. So, California cannot share information with

those entities.

We also have Assembly Bill 1242 that ensures that law enforcement and the tech industry won't cooperate with other states that have criminalized abortion care in their states.

And then finally, we have Assembly Bill 1666. That bars enforcement of out-of-state civil, so it is civil anti-abortion actions against anyone who receives an abortion, or anyone who helps someone get an abortion. So, this bill is targeted at people who come from another state into California to receive an abortion. It bars someone from a different state suing somebody in California based on the provision of the abortion care. So, important bills that California has implemented and that sort of go hand in hand with the HIPAA Privacy Rule.

Next, I want to mention the FDA approval of Opill. So, back in July, the FDA approved Opill, which is the first FDA approved over-the-counter birth control pill. It isn't, the pill isn't available yet to consumers, as far as I am aware, but it should become available soon. I had heard that FDA and other consumer advocate groups have been saying that they expect it to be available to consumers over the counter within the first half of this year. So, in California effective this past January 1, health plans must cover over-the-counter contraceptives without a prescription and without cost-sharing, assuming the enrollee goes in-network. So, network requirements are still there. But an enrollee to get an over-the-counter contraceptive does not need a prescription anymore in California. Accordingly, once Opill is available to consumers, health plans will need to cover it when the enrollee obtains it from an in-network source, in-network provider.

We have heard, though, that there are some concerns that two federal administrative requirements could impede access to Opill. So, the first is that we understand there is a transaction standard for submission of pharmacy claims that requires a prescription and a prescriber ID. The problem is that with something like Opill but don't need a prescription, there is no prescription, and as a result there is no prescriber ID. We have heard that some pharmacies will do a workaround, but these workarounds aren't standardized. Also, some pharmacies may be concerned that using a workaround could result in state or federal audits. So, we are tracking this, seeing what happens with this, trying to see where DMHC might be able to provide some guidance or assistance where we can.

The second administrative burden really impacts Medi-Cal enrollees primarily. Specifically, it is our understanding that CMS requires Medicaid beneficiaries to have a prescription as a condition of coverage for outpatient covered drugs. But again, here with Opill you don't need a prescription so there is some conflict there between CMS' requirements and what is allowed under the law.

So, we have been talking internally and with the administration about this issue. We have also had conversations with plans and providers trying to see what they anticipate doing with respect to coverage for Opill. So, more to come on this. Just wanted to let you know that it is on our radar and we are definitely tracking this one. We want to make sure that enrollees can get the, can get the coverage that they are entitled to under California law when Opill becomes available. So, with that, let me pause and see if there's any questions from the Board.

MEMBER WATANABE: Maybe I will just really quickly note that on

I think it was February 22 the governor issued I think it is a press release with a number of actions the state is taking to really kind of reaffirm the rights to contraceptive care, and it included a link to an alert from the Board of Pharmacy, our All Plan Letter reminding plans of their obligation. There is an alert for minors and consumers. So, you obviously can find that on the governor's website. But also, there is a link if you go to dmhc.ca.gov and scroll all the way down to the end under What's New. The top link under What's New will take you to that document. Abbi, go ahead.

MEMBER COURSOLLE: Thanks So, much for the presentation. I just had a clarification question on the Opill update. I just wondered if the DMHC is working with DHCS specifically on the Medi-Cal barrier that was identified?

MS. REAM: We have been talking with DHCS about coverage for Opill, so, yes.

MEMBER WATANABE: Paul.

MEMBER DURR: I don't know if this is the right time to bring this up but I thought it would since Sarah is on. You know, we are as provider groups getting significant pushback on SB 510 on getting paid appropriately, so we will be notifying the Department formerly of that inability for plans to meet those requirements as outlined and just wanted to make you aware that you probably will hear from a number of us, unfortunately.

MS. REAM: Thank you, Paul.

MEMBER WATANABE: Thank you, Paul. And Paul, I will just say, I think you may already have looped me into something, but if not, if you can make sure Sarah and Pritika are included in any of the correspondence. We are tracking some of the challenges there as well.

Any other questions from the Board?

All right, going to members of the public. Again, raise your hand or *9 if you are on the phone.

All right. Seeing none, we will move on to Michelle Yamanaka and our provider solvency quarterly update.

MS. YAMANAKA: Hi, thank you, Mary. Michelle Yamanaka, Supervising Examiner in the Office of Financial Review. Today I will provide you with an update regarding the September 30, 2023 quarterly financial submissions from RBOs. We have made some changes to our slides. We are presenting three of the slides, which are the status of the RBOs, the CAP information, and the enrollment information on a year-by-year basis instead of a quarterly basis, to show the changes over time.

So, let's start with the status of RBOs. We have 211 RBOs that were required to file their financial survey reports with the Department. There is one new RBO that began reporting this quarter, and two RBO accounts that were deactivated. One RBO had less than 10,000 lives, the second RBO had less than 20,000 lives. Both RBOs were compliant with all grading criteria and were not on a CAP when the accounts were deactivated.

Of the 211 RBOs, 193 RBOs or 91% of the RBOs reported compliance with all grading criteria. This includes 8 RBOs on our monitor closely list. There are 18 RBOs or 9% of the RBOs that were reported noncompliance with one or more grading criteria. We have 16 RBOs that file annual survey reports for the fiscal year end 2023. And we receive monthly financial statements from seven RBOs as a requirement of their corrective action plan or CAP. Over the past three years there has been a net increase of 12 RBOs.

Also, an average of 91% of the RBOs reported compliance with all grading criteria. To provide some additional information on the RBOs, there is a handout titled RBO Enrollment and Grading Criteria. We compiled the relative TNE, Relative Working Capital, Cash-to-Claims ratio and Claims Timeliness percentage for the past five quarters. In the handout, the enrollment is presented in ranges, the relative TNE is presented as a ratio of tangible assets divided by total liabilities. The Relative Working Capital is presented as a ratio of Current Assets divided by Current Liabilities, also, known as the Current Ratio. The Cash-to-Claims ratio is presented as Met or Not Met. The ratio of .75 or higher is compliance or Met. And the Claims Timeliness percentage is presented as a percentage of claims processed timely; 95% or higher represents compliance. Next slide, please.

Moving on to the corrective action plans. As of quarter ended September 30, we had 18 active corrective action plans or CAPs filed with the Department. Of those, 8 are continuing from the previous quarter and 10 are new based on the September 30, 9/30 filings. Of the 8 continuing CAPs, 7 are improving from the previous quarter and are meeting their approved projections. One RBO did not meet its CAP projections, however, we reviewed the quarter end December 31 filing and that RBO is meeting all grading criteria. Of the new 10 new corrective action plans, 3 RBOs did not meet the claims timeliness requirement, 7 of these RBOs did not meet financial metrics, TNE, Working Capital and/or Cash-to-Claims. Of the 18 CAPs, 13 are approved, 5 are in review. And to provide additional information we have another handout regarding the RBOs that are on corrective action plan and it is sorted by management services organization or MSO and it includes additional information

such as the RBOs contracting health plan enrollment, the quarter the CAP was initiated, the compliance status of the approved CAP, and the grading criteria deficiencies. After our September 30 review, 4 of the 18 CAPs were completed where those 4 RBOs met all grading criteria.

Moving on to the grading criteria. Next slide please.

We have compiled the TNE data for September 30 and used the TNE and required TNE to calculate this ratio. RBOs that reported less than 100% were noncompliant with TNE. The data shows that 156 or 74% of the RBOs reported TNE of more than 500%, 6 RBOs reported non-compliant. Of those, 4 RBOs had less than 10,000 lives, 2 RBOs had more than 100,000 lives.

Moving on to relative working capital, again, also known as the current ratio. We took the current assets divided by the current liabilities, which are if an RBO can meet its short-term obligations that are due within a year. The data shows that 97% of the RBOs were able to cover their current liabilities with a ratio of over one; and there were 6 RBOs that did not meet the working capital criteria.

Next is cash-to-claims. For this ratio we take the cash, short-term investments, and health plan capitation receivables collectable within 30 days, and divide that by the total claims liability. The data shows that 5 RBOs were not compliant with this ratio and on a corrective action plan. A majority of the RBOs are reporting compliance, meeting the minimum of .75 or higher.

Next is the claims timeliness ratio. Again 95% represents compliance and we have 3 RBOs that did not meet this requirement.

Moving on to enrollment. RBOs are required to report enrollment with their financial survey reports. As of quarter ended September 30, we have

approximately 9.5 million enrollees assigned to all RBOs. This is an increase of approximately 62,000 enrollees from the Quarter 2 period. And the increase is mainly in the Medi-Cal lines of business with decreases in Commercial and Medi-Cal. Next slide please.

Additional information on enrollment. We took the RBOs that had Medi-Cal lives assigned to them. There were 81 RBOs, and approximately 5.5 million enrollees were assigned to those 81 RBOs. This represents 58% of the total lives assigned to the 211 RBOs. Of the 81 RBOs, 69 of those RBOs had no financial concerns, 3 were on our monitor closely list, and 9 RBOs were on corrective action plans. Of those 9 RBOs, 4 were on a corrective action plan for claims timeliness, 5 were on a CAP for solvency criteria that did not include claims timeliness.

And then taking our top 20, next slide, please. Top 20 RBOs that had more than 50% of Medi-Cal lives assigned to them. There were approximately 4.2 million Medi-Cal enrollees assigned to the 20 RBOs; and this represents approximately 44% of the total lives assigned to all RBOs. And of those, 16 of those 20 had no financial concerns, 4 of those RBOs were on corrective action plans.

And with that, that concludes my presentation and open to questions.

MEMBER WATANABE: Go ahead, Paul, sorry.

MEMBER DURR: That's okay. Michelle, great job, I just applaud you on the presentation and the additional information. I love the additional information which lists all the groups in there so that is fabulous. I also wanted to publicly comment on the fact that this is probably the best report that I have seen

since I have been on the Financial Solvency Board with so few people in our CAP program. Disappointing that we had a number of new ones on there. But this is really fabulous in knowing that the impact is with smaller groups for the vast majority. It leads to my one question because I notice that there is one provider group in particular that is the largest 300,000 to 400,000 in there that the last two quarters have had TNE, working capital and cash-to-claims deficiency. Are you concerned about that one? I don't know that I can say it publicly but I think you know which one I am referring to.

MS. YAMANAKA: You know, for each RBO that is on a corrective action plan, we monitor them on a monthly basis, so we are monitoring them. Right now there are no concerns at this time. But, again, they are part of the monthly monitoring and so we are monitoring them on a monthly basis. In the event that we do see a downturn we will, we will contact the RBO, ask additional questions, where they are at, what they are doing, in order to determine if a new corrective action plan or a revised corrective action plan needs to be filed.

MEMBER DURR: Okay. I appreciate it because they obviously represent a number of people in their network, so thank you.

MS. YAMANAKA: Yes, mm-hmm.

MEMBER WATANABE: Thank you, Paul. Abbi.

MEMBER COURSOLLE: Yes, I echo again the thanks for the presentation, it was really helpful and interesting. As Paul noted, it is a little concerning to see the uptick in the new CAPs for RBOs. And you spoke to this a little bit already, Michelle, but I was just wondering if there is anything else, you know, sort of a systemic or trend issue that we should be thinking about with respect to that, that increase?

MS. YAMANAKA: You know, we looked at each and every corrective action plan that was filed in the new ones to see what the root causes were for those corrective action plans and right now there just is not a pattern that that we are concerned about. Each RBO is their own RBO and has their own, you know, if there's any things that they need to implement or fix. So, it is different, there is not a pattern at this time. But again, we are watching them very carefully.

MEMBER WATANABE: All right. And I see we have a member of the public. Bill Barcellona, I think you should be able to unmute yourself.

MR. BARCELLONA: Can you hear me now?

MEMBER WATANABE: Yes.

MR. BARCELLONA: Hey, thank you. Sorry to miss the meeting but I am just enjoying my day over here at the OHCA meeting today. I did want to make a comment. Thank you so much again, Michelle, for the report.

There is another issue, though, that has arisen here in the last couple of weeks regarding the increased payment rates for Medi-Cal providers under a new TRI fee schedule that was implemented on January 1, 2024. This concerns the 81 RBOs that Michelle just mentioned who participate in the Medi-Cal program. As we understand it, DHCS is requiring that payments be made downstream to these providers commencing January 1, but our RBOs will not see any increased capitation rates to make up for the 20 to 25% increase in payment rates until probably Q1 of 2025. This presents some very significant problems for RBO compliance under the Knox-Keene Act, which starts of course with IBNR spiking and leading to claims payment violations, interest accruals. This is a very significant conflict between two departments that we need help in

terms of resolving. And we have reached out to the DHCS but have not yet had the opportunity to hold a meeting with them. But I did want to make you aware of this today and to raise this issue publicly because this policy is in direct conflict to how RBOs are paid on a prospective basis, and yet would be required to pay increased rates without any sustainable increase in capitated rates. Thank you.

MEMBER WATANABE: Thank you, Bill.

Other questions or comments from the Board or the public?

All right. Seeing none I think we will move on to our health plan quarterly update. Pritika.

MS. DUTT: Thank you, Mary. Good afternoon. I am Pritika Dutt, the Deputy Director of the Office of Financial Review. The purpose of this presentation is to provide you an update of the financial status of health plans at quarter ended September 30, 2023. All licensed health plans are required to submit quarterly and annual financial statements to the DMHC. Additionally, we get monthly financial statements from plans who are newly licensed and also from plans whose TNE falls below under 50% of required TNE. Also, we place plans on monthly reporting if we have concerns with the health plan's financial solvency. We also included a handout that shows the enrollment at September 30, 2023, and TNE for five consecutive quarters starting from September 30, 2022, to September 30, 2023 for all licensed health plans. The information is broken into three categories, full service, restricted full service and specialized.

As of February 15, 2024, we had 138 licensed health plans. We are currently reviewing 10 applications for licensure, 5 full service and 5 specialized. Of the 5 full service, 4 of those applicants are seeking a license to offer restricted Medicare Advantage products and one for Medicare Advantage

where they will contract directly with CMS. For the 5 specialized, 3 are looking to get licensed for EAP for behavioral health services and 2 for dental.

Since the last meeting, we licensed one health plan, which was Imperial County Health Authority, which was licensed on December 15, 2023 as a Medi-Cal managed care plan and they are already operational as of 1/1/2024.

Since the last meeting, the following plans surrendered their license, so we had heavy surrender activity going on. So, we had 5 surrenders. The first one was Managed Health Network. The plan surrendered its license on November 17 of 2023. Medical Eye Services, Inc. surrendered its license on December 19, 2023. Brandman Health Plan surrendered its license on January 30, 2024. Essence Healthcare of California surrendered its license on February 1, 2024, and Golden West Health Plan surrendered its license on February 15, 2024.

At September 30, 2023, there were 30.4 million enrollees in full service plans licensed with the DMHC. Total commercial enrollment includes HMO, PPO and EPO, and Medicare Supplement. As you can see on the table, compared to the previous quarter, our total full service enrollment decreased slightly; so there was about a 30,000 lives decrease there. And then for the full service enrollment, the decrease was mainly driven by Medi-Cal. So, Medi-Cal enrollment, as you will see in a further slide, had their highest decrease and that was due to Medi-Cal redetermination.

This slide shows, this slide shows the makeup of HMO enrollment by market type. HMO enrollment in all markets remains stable compared to previous quarters. Next slide.

This slide shows the makeup of PPO/EPO enrollment. Similar to

HMO, PPO/ EPO Large Group and Individual experienced slight decreases in enrollment.

And this table shows the government enrollment, which is Medi-Cal and Medicare. Enrollment for both Medi-Cal and MA have experienced consistent growth in the past years. But however, at September 30, Medi-Cal enrollment decreased by about 245,000 lives. And MA continued to increase and experienced 25,000 lives.

We have 32 plans that that we are monitoring closely, which includes 26 full service plans and six specialized plans. For the 26 full service plans they had about 3.6 million lives. So, about a little over 10% of the full service enrollment were in the plans that we are watching closely for the full service plans. There are various reasons why we monitor health plans closely, which may include but not limited to they are newly licensed, low enrollment, financial solvency concerns, concerns with parent entity, claims processing issues, et cetera. A majority of the plans that are monitored closely do not have large, they are not very large plans in terms of enrollment. And some of the activities that we do is we would put those plans on monthly reporting, have weekly/monthly meetings with those plans. So, we have taken extra effort to monitor these plans closely.

So, 6 health plans did not meet the Department's minimum financial reserve or tangible net equity requirement, so I think that is probably the most we have had this year. The first one is Central Health Plan of California. Central Health Plan of California reported TNE deficiency at December 31, 2003. The plan received a contribution of $16 million from its new parent Molina Healthcare in January so we will continue to monitor Central Health Plan. The plan was

recently acquired from Bright Health so Molina Healthcare just acquired the plan. So, we continue to work with Molina on overseeing Central Health Plan's compliance.

The next plan is Central Valley Health Plan. So, as a result of audit adjustments, Central Valley Health Plan reported TNE deficiency for March 31, 2022 through April 30, 2023. The plan filed revised monthly, quarterly and annual financial statements to align with their audit findings. We continue to work with the plan to ensure accurate financial reporting. So, my team has been working with the plan to ensure that information they submit with the Department is accurate and timely.

The next plan is Holman Professional Counseling Centers. Holman reported TNE deficiency at March 31, 2023 and all the way through December 31, 2023. We are working with the plan to address the plan's TNE deficiency. Next slide. Thank you.

MedCore HP is the other plan that is TNE deficient for month ended December 31, 2023. This was due to their audit adjustments. So, the plan received a cash infusion from its parent entity in February 2024 and was able to correct its TNE deficiency.

Next, we have TELUS Health Limited. So, TELUS is an EAP plan and they reported TNE deficiency for the month ending October 31, 2023. And they received a cash infusion from its parent entity in November and the TNE deficiency has been cured.

And the last one on this list is Universal Care, Inc. Universal Care reported TNE deficiency for months ending November 30, 2023 and December 31, 2023. Again, this plan was owned by Bright and was acquired by Molina on

January 1, 2024. So, Molina has contributed additional capital, and we continue to work with Molina to ensure that the TNE requirement is taken care of and the plan achieves compliance. So, both for Central Health Plan and Universal Care, like I said, they were acquired by Molina on January 1. As a condition of the Department's approval, we have placed Universal Care and Central Health Plan on a TNE requirement, so they will be required to maintain TNE levels of 200% on a going forward basis.

This chart shows the TNE of health plans by line of business. A majority of the health plans, as we have previously shared, have TNE over 500%. Those are specialized plans. Because the TNE requirements for specialized plans compared to full service plans is significantly lower.

This chart shows the TNE of full service plans by enrollment category. Sixty-six health plans, or over half of the total licensed health plans, report a TNE of over 250% of required TNE. The plans that report TNE below 150% are placed on monthly financial reporting.

And this chart shows a breakdown of the 25 full service plans in 150% to 250% range. So, like I said previously for health plans, if TNE falls below 150% of required TNE, those plans are placed on monthly reporting. We also monitor health plans closely if we observe a declining trend in their financial performance, which is TNE, net income, enrollment, anything we find in news, any information that we receive from either the plans or outside regarding any concerns with the plans' operations on a going forward basis.

And this chart here shows the TNE of full service plans by quarter. So, this summarizes the handout that was provided as part of the presentation. So, for detailed information on the health plan TNE and enrollment, please refer

to the handout that was provided with the meeting materials. You can see the enrollment for each health plan. And like I said previously, the information is broken down by full service, by restricted full service and specialized plans.

This slide shows working capital for full service health plans by enrollment as of September 30, 2023. Working capital measures the plan's ability to cover its obligations that come due within the year.

And this chart shows the cash-to-claims ratio for full service health plans by enrollment. Again, this measures the plan's ability to cover its claims liability. And as you can see, 22 plans have less than one as the ratio for their cash-to-claims ratio. So, we continue to monitor the plans to ensure that, you know, claims are processed timely.

Okay, that brings me to the end of the presentation, I will take any questions.

MEMBER WATANABE: Any questions from Board Members first?

All right, I will check and see if we have any questions from members of the public.

All right. Seeing none, that concludes our formal agenda items and now we will move on to public comment on matters not on the agenda. I will see if any of the Board Members have anything to add.

Seeing none, are there any public comments from members of the public? Again, you can raise your hand or *9 for comments or questions.

All right, moving on to agenda items for future meetings. I will just maybe note that I think we are hoping to have the Department of Health Care Services join us at the next meeting and probably the Department of Health Care Access and Information and OHCA in our fall or later summer meeting. I know

we have a lot of updates and changes that have happened at the Medi-Cal program, so we are looking forward to having DHCS hopefully join us at the next meeting. But are there other items for the agenda for either our next meeting on May 8 I believe it is, May 8, or for future meetings this year? Any ideas from the Board Members first?

Not hearing any, anything from our public about future agenda items?

All right. Well, I think that will give you all back some time in your day. Appreciate your participation and all of the great engagement and questions for us. We look forward to seeing you again in this hybrid format when we meet in May on May 8. Have a great rest of your day. Thank you.

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

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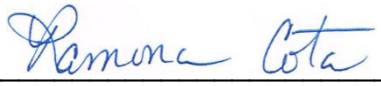
CERTIFICATE OF REPORTER

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 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 21st day of March, 2024.



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