STATE OF CALIFORNIA

DEPARTMENT OF MANAGED HEALTH CARE

FINANCIAL SOLVENCY STANDARDS BOARD (FSSB) MEETING

DEPARTMENT OF MANAGED HEALTH CARE

980 9th STREET, 5th FLOOR

SACRAMENTO, CALIFORNIA, 95814

WEDNESDAY, FEBRUARY 26, 2025

10:00 A.M.

Reported by: Ramona Cota

ALL AMERICAN REPORTING, INC.
(916) 362-2345

APPEARANCES

BOARD MEMBERS

Jeff Rideout, MD, Chair

Paul Durr (participated virtually)

Mark Kogan, MD (participated virtually)

David Seidenwurm, MD

Jessica Sellner (participated virtually)

Katrina Walters-White

Mary Watanabe

DMHC STAFF

Pritika Dutt, Deputy Director, Office of Financial Review

Derek Jang, Senior Examiner, Office of Financial Review

Sarah Ream, General Counsel

Jordan Stout, Staff Services Manager I

ALSO PRESENTING/COMMENTING

Sean Atha
Vivant Health

William "Bill" Barcellona
America’s Physician Groups

Derek Schneider
MedPoint

Jamie Currie, EdD-C, LMFT
Hope Counseling *and* San Gabriel/Pomona Regional Center

INDEX

PROCEEDINGS

10:05 a.m.

CHAIR RIDEOUT: Thanks. Paul, we are just doing a roll call. If you could introduce yourself and tell us your association.

MEMBER DURR: All right. Paul Durr, with Sharp Community Medical Group in San Diego.

CHAIR RIDEOUT: Thank you.

Mark?

MEMBER KOGAN: Yes. Mark Kogan, I am with Genesis Healthcare Partners, a private practice in Berkeley.

CHAIR RIDEOUT: Thank you.

Any other committee members on the phone or virtual? It looks like Jessica, you are joining us. You are on mute, I think. There you go.

MEMBER SELLNER: Can you hear me now?

CHAIR RIDEOUT: Yes.

MEMBER SELLNER: I am sorry, I was double-muted. Jessica Sellner, CFO for HealthNet.

CHAIR RIDEOUT: Great, thank you very much.

All right, so I will continue with the housekeeping and then we will get started. Please remember to silence your cell phones.

For Board Members here in person, please do not join the Zoom meeting with your computer audio. In fact, you don't need to join at all.

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 or just raise your real hand. All questions and comments from Board Members will be taken in the order in which the raised hands appear.

Public comment will take be taken from individuals attending the meeting in person first. For those making public comment at the podium here 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 would like 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. And yes, there is more.

To raise your hand, click on icon labeled Participants on the bottom of your screen, then click the button 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 to 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, Member 1 emails Member 2, who emails Member 3, et cetera. Accordingly, we ask that all Members refrain from emailing or communicating with each other about Board matters outside the confines of a public Board meeting.

Okay. Any comments at this point, and then we will go to the meeting minutes.

Okay. There are two approvals for committee members. One is the transcript, and the other is the meeting summary which functions as the meeting minutes. Can I get a motion from a committee member to approve both the transcript and the summary.

MEMBER KOGAN: So moved.

CHAIR RIDEOUT: Do we have a second?

MEMBER DURR: Second.

CHAIR RIDEOUT: All those in favor, aye.

(Ayes.)

CHAIR RIDEOUT: Any opposition?

MEMBER SEIDENWURM: One abstention, I was not in

attendance.

CHAIR RIDEOUT: Okay, sorry, David. So, I think that concludes the formal vote on that and I will turn it over to Mary to make her Director remarks.

MEMBER WATANABE: Great. Good morning. Hopefully you can hear me. Thank you for your patience as we get started here.

For those of you that did not hear, we welcomed Katrina Walters-White.

You also may have noticed that we have reappointed Jeff Rideout and Paul Durr to the Board, so thank you, Jeff and Paul, for your willingness to continue to serve. And Jeff has graciously agreed to continue as our Board Chair, although he may want someone else to take a turn at some point.

We also have three remaining vacancies on the Board. So, for anybody that has applied and you haven't heard from us, just don't worry, we will make some decisions before our next Board meeting. We did extend our solicitation through the end of this month, so if anybody is still interested you have a couple more days to submit your application or letter of interest.

I will just note, I don't think we have received any interest from someone who represents large group purchasers, so if there is anyone out there listening that is interested in joining that represents large group purchasers, we would encourage you to apply.

I am excited to share our personnel update. We have had a very stable leadership team. I feel incredibly blessed that all of our deputy directors and our chief deputy have stayed with me, but we did add a new deputy director to our Help Center Consumer Complaints Division. Given the Department's

growth and especially at our Help Center, so Rachel Long is the Deputy Director of the Call Center Provider Complaints and Information Division. She was over all of our Help Center previously.

And I am excited to announce that Kristene Mapile has joined the DMHC as the new deputy director over the -- over the -- let's see. It is called the Help Center Consumer Complaint Division. I know many of you probably know Kristene from some of her prior work. She was the principal consultant in the California State Assembly I think for the last eight years. Prior to working in the Assembly Kristene worked at the DMHC as an Assistant Chief Counsel in the Office of Plan Licensing and as an attorney in both the Office of Plan Licensing and the Help Center. So, I know many of you may miss working with her, but you will I think welcome the opportunity to work with her in her new role out at the Help Center.

We have been very busy this year, including responding to the devastating wildfires that occurred in Southern California. I think we hit the ground running in January with a lot of different things happening; but wanted to make sure we were supporting the response in Southern California. We issued an All Plan Letter on January 9 to make sure that the plans were doing a number of things to make sure their enrollees that were impacted by the fires can continue to get prescription drugs, see providers, encouraging a lot of flexibilities for the providers that were also impacted in that area. The plans are required to have a toll free number for those that are impacted to call to get information around refills, get a new ID card and other information about accessing care.

The plans also have a tremendous amount of information that they have posted on their websites. We put together a resource guide that

consolidates the information for that toll free number as well as the websites and information specific for plans. This has been included in a lot of the information the state is pushing out related to the fires, it is also on our website.

We also have a fact sheet specific to natural disasters that talks about the flexibilities that the plans need to provide when there's things like fires. And if you follow us on any of our social media channels you will probably notice that in January it was all about response to the fire. So, appreciate our communications team that has done a lot of work to push that information out.

I will just make a general note about kind of federal changes in the '25-26 budget. Normally, in our February meeting I give an update on the Governor's budget. But I think given a lot of the uncertainty with the state's budget as well as all of the changes coming out of the new federal administration, I think we will monitor that and bring more information back to you after the May revise on the state budget and our impact to our budget.

I will just say, you will notice Sarah is just doing a regulation update and not a federal update. There's, you know, a lot we are monitoring and keeping track of. Nothing really that we can share other than we are working very closely with the administration and our agency and sister departments.

Let's see. So, the other thing that has been keeping us very busy, and I talked about this at our August meeting, is California initiated a process last year to add new, what we call Essential Benefits to California's Benchmark Plan. Our Benchmark Plan has been in place for about a decade and so there's been some federal changes that allow us to add benefits on kind of like an a la carte basis, is what we call it. So, I think I talked about this in August. We had a public meeting last summer. We convened another public meeting in January to share

kind of the results of the analysis from Wakeley, which is the consultant we have hired, that included information on how much room we have to add, what we refer to as our budget to add benefits. So, we kind of have a menu of items that we can add, we had the cost of those, and then how much room we have to add.

So, there was also a legislative hearing in February. So, in early February it was a joint legislative hearing to provide additional information and opportunity for public dialog and for the legislature to have dialog about this as well.

The next step really is for us collectively to make some decisions about what benefits we want to move forward. We need to have a public comment process on the package that will get filed with CMS in May. And so we are anticipating the next step would be a public comment on that package in March.

So, follow us on our listserv. We will push out information about kind of the next step as that becomes available.

I will just note the other thing that we did earlier this year is we, I think we have talked a lot about the settlement, $200 million settlement agreement we had with Kaiser related to access to behavioral health services. One of the deliverables tied to that settlement agreement was submitting a corrective action work plan to the Department that really outlines the steps that Kaiser is taking to make transformative changes to their delivery of behavioral health services. We have posted that corrective action work plan, which we accepted earlier this year. It is posted on our website. We will start quarterly meetings with Kaiser and will post updates on those quarterly meetings as well on our website.

And then finally a couple of reports I will just give you a quick update on.

So, our Prescription Drug Cost Transparency Report for Measurement Year 2023 was released, I think is it January?

MS. DUTT: (Nodded).

MEMBER WATANABE: I don't know, it's a blur. It feels like we have already put in a year's worth of work this year. But yes. So, we recently released that report. I know this is sometimes still referred to as our SB 17 report, but we have been collecting data now from 2017. I think it is just actually a really interesting summary with a lot of trend data on just the cost of health care over the last seven years. Among the findings were really that the health plan spending on prescription drugs increased by 4.9 billion or 56% since 2017. This was significantly higher than the increase in medical trend. Prescription drugs accounted for 15.1% of total health plan premium in 2023, an increase from 14.3 in 2022. So, we are continuing to see prescription drugs having a significant impact on health care premiums.

And then finally, included in your packet is the Dental Medical Loss Ratio Report. For those of you that have been coming to these meetings for a long time you may remember we used to present this report; and the Board made some decisions years ago not to present it but just to share it for information only. So, I would encourage you to take a look at it. Pritika is here, happy to answer questions. I will just note that unlike on the health care side, there is no required medical loss ratio. We also have quite a bit of variance in premiums with some on the very low end. But Pritika is happy to answer questions. Sorry, Pritika, put you on the spot, if you have any about that report.

That concludes my updates. I am happy to take questions from the Board and the public.

CHAIR RIDEOUT: Thank you, Mary.

First, we will take questions from committee members in the room. Do I have any? David.

MEMBER SEIDENWURM: When we and the legislature discusses the menu of essential benefits are we going to take into account the costs relative to the 3% cap that's phasing in and its impact potentially on the solvency of our groups?

MEMBER WATANABE: Yes, it has been brought up by the health plans and so it is something that will need to be considered, I will say, in particular at the joint legislative hearing there was a presentation by CHBRP, the California Health Benefit Review Program, on the impact to premiums as well. There's been some discussions as part of these meetings just about the uncertainty at the federal level, the potential other impacts on the cost that consumers are paying for health care, the potential increased share of premium that consumers may need to pay, especially for Covered California. But I think the spending target is kind of the other thing.

CHAIR RIDEOUT: Other questions from committee members in the room?

Going to committee members on the Zoom, Paul, Mark or Jessica?

No questions.

I will make one comment and then we will go to public comment. The specialty drug costs that you noted, we have been tracking that for well over a decade.

MEMBER WATANABE: I will say, I think we see that in our report too. I mean, it is actually interesting to have so much data, you know, because we had been limited to just a few years. But to have seven years worth of data and see just the shifts over time, I think particularly we are seeing with the GLP-1s and biosimilars.

CHAIR RIDEOUT: Okay, we will go to questions from the public in the room. Anybody? Bill, of course, come on up.

MR. BARCELLONA: Hi, Bill Barcellona with America's Physician Groups. Welcome, Katrina, to the Board. Hope you enjoy your tenure.

Mary, I had a quick question for you. You had mentioned previously that there was a study, a labor study, I think it came out of Cal Berkeley, around deductibles and the kind of the prevalence. That something like 80% of a certain subset of coverage. But there was a quote at OHCA yesterday that all benefit designs in California are now -- that 80% of all benefit designs are deductibles, and I don't think that's correct. I think there was some kind of a differentiator in that report that it was a subset, like it was a certain type of coverage, maybe self-funded coverage. Do you know the answer to that? Do you remember?

MEMBER WATANABE: I would have to look it up. It is the UC Berkeley Labor Center. They actually presented at the meeting that we had last year on our -- just premium rates overall and the prescription drug impact on the large group market. It's in -- they have a report and it's in the report of who is included in that. And I forget. There is a nuance I believe to that, but I would either defer to them or have you look at that report.

MR. BARCELLONA: It is helpful to know if we can get public data

on how much of the market is still vested in in first dollar copay coverage, particularly so we can look at some of the analysis that IHA is working on in terms of cost relative to PPO plans.

CHAIR RIDEOUT: Bill, we do look pretty regularly at line of business and out-of-pocket, because that's how we calculate total cost of care, and there is a pretty marked difference between HMO lines of business under capitation and everything else. So, that is available in the data we have. We can probably tease out which of those are zero, but the kind of cut line for us is pretty broad, you know, HMO, PPO, EPO, kind of.

MR. BARCELLONA: Yes. I am just interested to see the difference in the spending trend in deductible coverage plans versus first dollar coverage copay plans to see if we have got some data that shows whether there is a difference in the trend increases.

MEMBER WATANABE: I will say, and Pritika, you can jump in here, we are working on finalizing it now. But even in the, I think, SB 17 report too there is also -- we have some data on deductibles and copays, but it's in like it's aggregated.

MS. DUTT: We are getting data on out-of-pocket cost, like percentages for individual and small group products right now under Assembly Bill 2118 reporting. We are trying to expand that requirement in SB 54 to capture in the template. Because large group covers the most enrollees so it makes sense to expand that data reporting requirement on the large group plan. So, we are working on that and we are working closely with UC Berkeley Labor Center to get their feedback on it also. Bill, I can provide you a copy of their report. I have the link so I can share that with you.

MR. BARCELLONA: Okay, thanks very much.

MS. DUTT: Of course.

CHAIR RIDEOUT: Aany other comments or questions from the public in the room?

All right, turning to the public that are virtual. Any comments or questions?

MR. STOUT: Yes, we have one. When prompted please state your name and organization.

MEMBER WATANABE: The name we have listed is Professor Currie, so if you are there you can unmute your mic and give your comment.

(No audible response.)

CHAIR RIDEOUT: Okay, we will circle back to that.

Any questions or comments on the phone?

None this time. Try Professor Curie again.

(No audible response.)

CHAIR RIDEOUT: All right, we will come back. Sorry about that.

Next we move to the regulation updates from Sarah Ream. Sarah, welcome.

MS. REAM: Great, thank you. I am happy to report that we have two regulation packages in formal rulemaking right now.

First, we have the provider directory regulation. The first comment period on this regulation closed on Monday and we are now reviewing all the comments we received; and we received a lot of comments as you would expect. We will likely be making edits to the regulation based on those comments, so I expect that we will have at least one more public comment period on this reg

before we finalize it. Once the regulation is in final form, we will submit it to the Office of Administrative Law for their review and hopefully their approval.

The second regulation we have in formal rulemaking is the regulation to implement Senate Bill 600 from 2019. This regulation concerns the scope of fertility preservation services the plans must cover. We have had four public comment periods on this regulation, with the fourth comment period closing last Friday. The clock is ticking on us to submit this regulation to the Office of Administrative Law, and we expect to do so within the next several weeks.

As an aside, we have been getting a lot of questions about the fertility preservation statute and regulations and how they will be impacted by the recently enacted Senate Bill 729. For background, SB 729 requires, or will require starting in July, large group health plan products to cover services to diagnose and treat infertility. With respect to small group products, SB 729 will require plans to offer coverage for the diagnosis and treatment of infertility. SB 729 does not apply to individual products.

We have started drafting regulations to implement SB 729 and will hopefully start formal rulemaking on these in the second half of this year. However, I can say that in the meantime we expect plans to comply with both SB 729 and SB 600. If there are cases where it is impossible for a plan to comply with both, or if the statutes are in conflict, which I don't anticipate there actually will be a conflict, but if there was we would expect the plans to follow the more consumer protective statute, like we would do in any other circumstances.

Finally, I want to talk briefly about two draft regulations we plan to share with stakeholders in the next couple of weeks. Actually, one of them we

are sharing today, so I am happy to report that. And that regulation is the draft of the SB 17 regs. SB 17 took effect what feels like a lifetime ago in 2018, and requires plans to report on their 25 most frequently prescribed drugs, their 25 most costly drugs by annual plan spending, and their top 25 drugs with the highest year-over-year increases in plan spending. The DMHC has been collecting this information since 2018; and the primary purpose of this regulation is simply to codify our current instructions and reporting form. Accordingly, we don't anticipate that stakeholders will see anything surprising in this draft regulation.

The second draft regulation we intend to share soon is the regulation to implement SB 368 from 2021. This bill requires plans to track and report to enrollees the amounts the enrollees have spent toward their out-of-pocket maximums. So, we anticipate -- we are excited about this regulation. The law and the reg are very consumer protective. And we anticipate we will share a draft regulation with stakeholders hopefully mid-March, early April.

We have lots of other regs in the works, like we always do, but these are the ones that are furthest along in that pipeline.

CHAIR RIDEOUT: Thank you, Sarah.

Start with questions or comments from committee members in the room. I have one question. I believe you do not comment on pending legislation, but with the regs -- AB 280 at this point or do you wait until that works its way through?

MS. REAM: It seems like every year there is legislation regarding provider directories. And we have --and the reason why we haven't moved forward yet with provider directory regs is because we keep anticipating that

there will be a leg fix, so we are always tracking, always following the leg world. I think that we are just going to move forward with -- we are going to move forward with this reg. And then if the reg and the statute conflict then we can issue guidance, but we want to get this one going.

CHAIR RIDEOUT: That was a welcome gift to Katrina. Anything else?

Any comments from committee members virtually?

Hearing, none we will move to the public. Any comments or questions from the public in the room?

MR. BARCELLONA: Hello again, Bill Barcellona, with APG. A quick question on the AB 3275 All Plan Letter. When are comments due on that Letter?

MS. DUTT: The comments are due this Friday.

MR. BARCELLONA: This Friday, okay, all right.

On pending regulations. Very glad that you issued the SB 137 regulatory update. I think it is long overdue and I think the form of the regulation is very satisfactory. Just want to make a polite nudge that we would really like to see the general licensure regulation issued in draft this year. It is very important to get that clarified so we can clear up those 500 pending exemptions that are out there on shared risk pools. So, hope to see that. Thank you.

MS. REAM: Bill, that is definitely on our to-do list for this year.

MR. BARCELLONA (OFF-MIC): Thanks.

CHAIR RIDEOUT: Any other comments or questions in the room?

Moving to the virtual public. Any comments or questions virtually?

MR. STOUT: Yes, we have one. Professor Currie, when prompted

please unmute your microphone.

DR. CURRIE: Hi, good morning. I am so sorry about that. This is Jamie Currie. Can you hear me?

CHAIR RIDEOUT: Yes.

DR. CURRIE: Oh, perfect, okay. So, I am with Hope Counseling and I am also the Chair of the Vendor Committee at San Gabriel/Pomona Regional Center for Behavioral Health.

And I had a question regarding the 200 million that you discussed for Kaiser on that settlement. I guess I have two questions.

One, where can we find more information on that? Because down here we have a lot of problems with the behavioral health on the Easter Seal side where board certified behavior analysts cannot provide services and there is over a year waiting list for, at least in our regional center district, to receive behavioral health. So, I am trying to find more information on that settlement you were referring to.

MEMBER WATANABE: Yes. So, so Kaiser settlement agreement is actually posted on our website. I will just say in terms of there's 150 million that is a community investment that will be forthcoming -- will be discussed as part of our quarterly meetings.

I will just note that if you have specific issues you want to raise with the Department, please reach out to us. Is it public comments with an S? Tell me an email address that would be the right one.

Okay. We will get an email address that I can share with you shortly if you just want to reach out to us and we can follow up on the issues you are having because I think we would be interested to hear more about that.

DR. CURRIE: Thank you so much.

CHAIR RIDEOUT: Okay, any other questions or comments from the virtual public?

Any questions or comments from anyone on the telephone?

None, okay. I think we will move on to Item 5, Pritika, the financial summary of Medi-Cal. A very nicely put together report, by the way, so.

MS. DUTT: Good morning. I am Pritika, Deputy Director of the Office of Financial Review. I will provide you a quick update on the financial summary of Medi-Cal Managed Care Report for quarter end September 30, 2024. A copy of the report is available on our public website under the Financial Solvency Standards Board section.

This report is presented to the board on a biannual basis, so twice a year, and highlights enrollment and financial information for Local Plans and Non-Governmental Medi-Cal Plans. And you will notice throughout the report we are now referring to both the Local Initiatives and County Organized Health Systems as Local Plans.

The NGM Plans are plans that report greater than 50% Medi-Cal enrollment but are not a Local Plan.

NGM plans provide and administer health care services to Medi-Cal beneficiaries either as a direct contractor to DHCS, which is Department of Health Care Services, or as a subcontractor to other health plans that contract with DHCS. For example, L.A. Care has subcontracted with Blue Shield of California Promise Health Plan and Health Net Community Solutions has subcontracted with Molina for services in L.A. County.

And the report is divided into two distinct areas, first focusing on

Local Plans and next is the Non-Governmental Medi-Cal Plans.

There are 15 Local Plans that served over 9 million Medi-Cal beneficiaries in 49 counties. Gold Coast had only Medi-Cal line of business and no Knox-Keen license at quarter end September 30, 2024. So, therefore, the report does not include information for Gold Coast. However, Gold Coast filed an application and was issued a Knox-Keene license on February 7, 2025 for their Medicare Advantage Dual Special Needs Plan. And that is a requirement for all Medi-Cal plans to get a DSNP license to start offering that benefit effective January 1, 2026.

In the first quarter of 2024 the majority of the Medi-Cal managed care plans reported an increase in enrollment due to expansion of Medi-Cal to income-eligible adults, regardless of immigration status. However, most Medi-Cal plans experienced decreases in enrollment in the second and third quarter of 2024, largely attributed to unwinding of continuous coverage effective May 31, 2024.

For September 2024 the Local Plans report a total net loss of 217 million. And half of the Medi-Cal plans reported net income in the third quarter of 2024 -- a net loss due to decrease in enrollment and increase in Medi-Cal utilization, retro rate adjustment, et cetera. All Local Plans met the DMHC's reserve requirement, or Tangible Net Equity requirement, TNE, in the range of 315% to 1878% of required TNE.

There are five Non-Governmental Medi-Cal plans that served 3.5 million Medi-Cal beneficiaries in 21 counties. So, you will notice in the report Aetna Better Health and California Health and Wellness exited the Medi-Cal managed care business effective January 2024, so they are not included in the

report any longer. Similar to Local Plans, NGM plans experienced a slight decrease in enrollment.

And then for the third quarter, NGM plans reported total net income of 98 million.

TNE to required TNE ranged from 238% to 1,592%.

Changes in the Medi-Cal program, including rates. We continue to work closely with DHCS and the plans. We saw changes in enrollment and profitability through 2024 with unwinding of continuous coverage effective May 31, 2024 and expansion of Medi-Cal to income-eligible adults regardless of immigration status starting January 1, 2024.

We also worked on licensing the Medi-Cal plans for a Medicare Advantage DSNP product, for which plans will begin offering the coverage January 1, 2026. So, they are going through that application process with CMS right now.

And then we saw some of the plans reported net losses for, you know, the second half of 2024, so we have been working with some of the plans. And then they have informed us that they were able to get rate adjustments, so we will see -- they are projecting breakeven for 2025, but they had substantial, substantial losses.

We placed Alameda Alliance on monthly reporting. We saw a decline in their -- we saw a decline in their profitability. The plan was placed on monthly reporting starting with November monthlies. But we will continue -- like I said, we will continue to discuss with the plan and monitor their TNE and profitability through monthly reportings. That's all, thank you. Questions?

CHAIR RIDEOUT: Taking questions or comments from committee

members in the room. David.

MEMBER SEIDENWURM: So, it seems like this is kind of a tough business to be in right now with a general trend to a decrease in TNE and some net losses. Is there anything that we can do to, let's say, modify that trend?

MEMBER WATANABE: I don't know that there is necessarily anything specifically for you to do. I think historically we have brought this report to the board every other month, and we are going to start to bring this to you monthly. I think part of what we will be monitoring very closely is if this changes. I think we were encouraged by the changes in the DHCS adjustments to the rates that seemed to help some of the plans, because we had some concerns. So, I think part of it is just advising us on what we should continue to monitor, I think to Pritika and her -- credit to her and her team moving quickly to put a plan on monthly monitoring and reporting when we see a quick downward trend. So, I think just continuing to advise us on things we should be looking at and having more of a transparent discussion at these meetings on a more frequent basis on the trends we are seeing.

CHAIR RIDEOUT: I have got a couple of questions, Pritika, on the monthly monitoring. Was that triggered, I think you said by profitability. Were there any other metrics that alerted you to that need? You know, we have talked a lot about cash-to-claims and other things.

MS. DUTT: So, the main trigger for us is like when we saw the decline of TNE was going down very quick. The plan has been very engaged with us. They have met with Mary and I and informed us of their declining trend. They have been working with DHCS along the way. So, we were looking at -- that's the main thing we were looking at, just the decline in TNE and then the net

loss. And the plan engaged with us early on, so we knew what was coming in the subsequent months prior to -- you know, prior to them filing those financials we knew what was coming. So, if the plan let's us know what is going on, it is really helpful so we can put a plan in place quickly and move on any remediation, corrective action plans quickly.

CHAIR RIDEOUT: Okay. And second question, if I have got the math right, there was a decline in Medi-Cal enrollment between the Local Plans and the NGMs by almost 800,000. Was any of that offset by Kaiser enrollment or is that a true, true drop?

MS. DUTT: I am not sure, let me take that one back. I think so, because Kaiser did get the direct contract. But let us take that one back so I can --

CHAIR RIDEOUT: And then last for me. On page 10 there is a number of comments about for-profit NGMs dividend payments. Can you explain the significance of that to the work we do here?

MS. DUTT: So, the reason we included it here was to kind of show sometimes when we look at the government plans, we see high TNEs because they cannot make those distributions. When you compare the NGM plans to Local Plans you will see the NGM plans have lower reserves. It is not because they are having losses, they paid out dividends, right. So, that's, that's the explanation we tried to provide.

CHAIR RIDEOUT: Thank you. And I am actually getting input from both sides, which is good, that it looks like the Kaiser Medi-Cal enrollment offset the overall declines on the Local Initiative and plan side.

MEMBER WATANABE: We are jumping ahead to the health plan

report that has the trends in Medi-Cal data overall, so, sorry, Pritika.

MS. DUTT: It's like a phone a friend moment.

MEMBER WATANABE: I know, I know. I think we had the data. We have been tracking the trends with the redeterminations over time. Okay.

CHAIR RIDEOUT: I will fall back to my Chair role. Any questions or comments from committee members on virtually? Paul, anything from you?

MEMBER DURR: Since you did ask, Jeff, I would say that your comment about the dividend is something that we should always keep in mind because of the fact that those dollars -- they are not built into the TNE they are paid out as dividends. So, when times get tough, you know, they need to remember the revenue that they have generated for that book business and keep in mind that some years are lean and that they need to continue to pay the providers on that.

The other comment I do have is with regards to DHCS funding. There's been significant challenges from the provider side to get that money from various health plans. So, Mary, anything you can do to influence the DHCS to holding the plans accountable to a plan to pay the providers appropriately as they are entitled, would be helpful. Thank you.

MEMBER WATANABE: Yes, thank you, Paul. And obviously, I think, you know, Pritika and her team in particular work very closely with DHCS. We actually were hoping to have DHCS here today with us to have some conversation around this report. Unfortunately, they have had some staffing changes and that didn't, didn't work out. But we look forward to having them in the future as well.

CHAIR RIDEOUT: Thanks, Paul.

Okay, taking questions or comments from the public in the room. Bill.

MR. BARCELLONA: Okay, Bill Barcellona, APG. Thank you for the report.

I wanted to raise an issue concerning Medi-Cal managed care plan solvency and how it is impacting the eighty-plus risk bearing organizations that serve the Medi-Cal managed care population of 6 million lives in California. What we have experienced over the past year with respect to the targeted rate increase implementation has been extremely confusing, extremely threatening to the financial solvency of the RBOs that are involved in this process. With the exception of four Medi-Cal managed care plans, IEHP, CalOptima, Alameda Alliance and San Francisco Health Plan, all other MCPs have failed to transparently establish a sustainable process with the implementation of the targeted rate increase funding for RBOs, and this is impacting the downstream street level providers in the Medi-Cal program.

As we reach the December 31st deadline for the 2024 TRI implementation. With the exception of the four plans I mentioned, those other plans did not have signed addendums as required by the All Plan Letter issued by DHCS, and had not moved sufficient funds down to the groups so that they could move it out to their networks. This is a massive failure of what was promised under the TRI process.

As we sit here today, we are moving toward the end of first quarter. We still don’t have a reconciliation from all those other plans on 2024 payments. In 2025 because of the passage of Prop 35 there will be even more significant changes, namely greater funding need for FQ clinics in the TRI process. And it is

still very confusing and uncertain how the money will flow. And so the way it breaks down is that it is hard to know exactly at the association level because we don't have access to everybody's rates. But what we hear generally is that the assessed impact of the TRI rate increases for 2024 would require an RBO to increase its downstream payments by 20 to 25% over 2023 rates. The cap rates that were being discussed across the MCPs were in the range of 3 to 6%. It is -- well, a nice way to say it is it is unsustainable to manage an RBO in those circumstances when you have a 17% differential in the obligation that you have to pay downstream rates.

If this is a problem between DHCS and the MCPs in terms of inadequate funding, it would be great if we had more transparency. And it is unfortunate that no one from DHCS could make it today so we could have an open and frank discussion about this. But this will have an impact on financial solvency standards reporting for the eighty-plus RBOs that are in the Medi-Cal market for 2024.

The way this is being rolled out by DHCS, it is requiring the groups to pay when they don't have any certainty of a capitation increase at a 20 to 25% higher rate. RBOs don't maintain the level of reserves to do that. That's impossible. So, we have a growing problem here in the Medi-Cal managed care market in California. I know that this is not the DMHC's responsibility, but it will have an impact on your ability to maintain oversight of the Medi-Cal managed care RBO market. Thank you.

CHAIR RIDEOUT: Thanks, Bill.

MR. ATHA: Excuse my voice. Sean Atha, Vivant Health, formerly River City Medical Group. I want to thank you all for, again, doing all you are

doing. I am standing here primarily in many cases in support of Bill. Everything he just mentioned in regards to the TRI rate and the relationship from a risk bearing organization in California. So, our population. We serve roughly let's just say around 270,000 Medi-Cal in the Greater Sacramento County area

And, you know, were there are requirements that we sort of pay out like immediately by the end of December? Totally. We know. And so at the end of the day we are doing what we can do most responsibly to communicate to our entire provider network that, quite frankly, expected higher rates as of January 1, you know, 2024, and we said, well, they are coming, it's happening, something is happening. Something is there but we just continue to communicate. And it's not just us, it's a statewide issue for all groups.

And so now the concern is, you know, when will we really see the money. In some cases where we have clearly had some good data we have started to roll out some payments to certain providers that the data was completely there and clean. But we don't have it across the board for all of our areas, particularly our capitated network. But when we look at it further, they said, well, we also are expecting further -- and aboard for Prop 35 is coming together, we will see what that looks like. But quite frankly, and this is just, you know, an immediate reaction to what we are looking at in the future, the whole Prop 35 program is completely dependent upon additional increase in additional funding coming from the federal government, which, quite frankly after last night I have huge doubts if it will, you know, come about, but we will see. We will all wish in our crystal ball.

But the reality is, we are looking to DMHC. We appreciate all of your work. But to be sort of assisting us in leveraging the pressure of a collective

state government to make sure that our solvency is maintained, because there's a lot of pressure on us just to pay out no matter what. And yet, when everyone looks at it, I don't think anyone can look at and say it makes 100% sense. And so we are really appreciative of your protection on our solvency to make sure that we are doing -- what we are doing is right. We want to be working within the letter of the regulations, the law, with our providers at all levels. But when it becomes -- we feel like we are really pinched and we want to do right by our providers, but we can't make payments with money we don't have. So, anyway, I will leave it there. Thank you very much for your time.

CHAIR RIDEOUT: Sarah or Mary, could I ask an educational point? Can either of you describe how the working relationship between DHCS and DMHC is on that type of issue? Is it their primary responsibility even though you are regulating those plans as well, or? It sounds like it is.

MEMBER WATANABE: I will take that. So, I mean, this is not a new issue. I think Pritika and her team have been engaged quite regularly with DHCS on this, I have had conversation with DHCS' leadership about this, so this is really squarely in DHCS' wheelhouse. But want to be clear, I think we are also sensitive to the downstream impact to the solvency and the uncertainty that I think has collectively been expressed here. So, I will just say, we will continue to take this back and continue those conversations again. I think this is, this is the number one item when we asked DHCS to come to this meeting that we asked them to talk about. I know there has been some guidance that has gone out, but we will continue to flag that. But appreciate the reminder too about the Prop 35 payments that are supposed to start which just kind of adds to this, but this is really DHCS' area.

CHAIR RIDEOUT: So, just a reminder that this committee is advisory, but I would make a strong suggestion that we invite DHCS and focus just on this issue, because it's so urgent, and then make sure the person that comes actually can speak to that issue. I think a lot of the presentations are relatively general overviews, and I think in this case we might want to take on the specific topic. That is just my suggestion.

Okay, any other questions or comments from the public in the room?

Any questions or comments from the public on virtually?

Any questions or comments from the public on the telephone?

Okay, well, we are going to go into the next topic, which is provider solvency, so would like to welcome Derek Jang. Derek, have we had you here before?

MR. JANG: No, it's my first time.

CHAIR RIDEOUT: Great. Well, welcome and, you know, have at it.

MR. JANG: Okay, thanks. I am Derek Jang. I am a Senior Examiner within the Office of Financial Review. I will be providing the provider solvency update, quarterly update for the risk bearing organizations. Next slide.

Okay. So, this first slide provides a status of compliance for the risk bearing organizations over the most recent four year period. As you can see in the rightmost column the current RBOs. We have 207 RBOs that are required to file. There are 2 new RBOs that began reporting for the period. For the 5 RBOs that were deactivated, all were compliant at the point of deactivation. They are smaller in size, they all have less than 10,000 lives, and 4 of them were Medicare

lives only.

Following up on the chart there are 191 RBOs, or 92% of the RBO population, that is in the Compliant category meeting all the solvency criteria. This includes 5 RBOs on our monitor closely list. And some context regarding the monitor closely list. These are RBOs that are compliant but there are some overarching trending concerns. These trending concerns can include low financial solvency reserves, downward financial trends and metrics, financial reporting issues, or consecutive periods of net loss.

There are 16 RBOs, or 8% of the reporting RBOs, that are on a corrective action plan due to non-compliance with one of the solvency criteria. There's a feature slide that delves into those.

And then there are no non-filers.

Following up on the annual survey reports. We have received 14 annual survey reports for the fiscal year end 2024. A majority of the RBOs file with a fiscal year end of 12/31, so those reports come in at the end of May, so that is when we are going to receive the bulk of the annual survey submissions.

And then lastly, we have monthly financial statements from 9 RBOs as a requirement of their CAP. These monthly financials, similar to the monitor closely, is a requirement of the CAP and allows us to monitor the groups on a more interim basis as opposed to the traditional quarterly report.

There is a supplemental handout that was provided. It is titled RBO Enrollment and Grading Criteria. It has some summary information regarding the RBOs financial positions over the past five quarters. Some categories in this slide include in enrollment ranges, relative TNE presented as a ratio of tangible net assets over total liabilities, relative working capital presented as a ratio of

current assets over current liabilities, again, measuring sort of the RBO's short-term ability to meet its short-term obligations, cash-to-claims ratio shown as met or not met with the requirement being 0.75 or higher, and then claims timeliness shown as a percentage and demonstrating the RBO's ability to process claims timely. Next slide.

Okay. So, this slide shows corrective action plans for the risk bearing organizations over the most recent four-year period. Again, in the rightmost column you can see we have 16 corrective action plans or 8% of the RBOs on a CAP. For the 16 CAPs we have 12 continuing from the previous reporting quarter, and 4 new CAPs as identified from the current filing. For the 12 CAPs that are continuing, 9 are improving from the prior reporting period or they are meeting their approved projections. Three are reporting worse or not meeting their projections, with 1 being referred to our Enforcement Division for further administrative action. For the 4 CAPs that are new in the period, 1 was due to an audit adjustment from an annual report and then 3 are due to emerging deficiencies within the quarterly survey. And then for the 4 new CAPs, two were due to not meeting claims timeliness and then two were due to not meeting some additional solvency metrics, specifically TNE and working capital.

Similar to the previous slide, there's another attachment. It lists the 16 CAPs. It is sorted by MSO. It has some additional summary information including RBO name, MSO name, contracted health plans, enrollment ranges, quarter the CAP was initiated, compliance status with the final approved CAP, and grading criteria deficiency. So, you can reference this if you want some additional information regarding those 16 CAPs.

And then subsequent to our third quarter review some action has

been taken with regards to those 16 CAPs. Six CAPs were completed, 5 with the groups fulfilling their CAP requirements and then 1 where the RBO was deactivated. And then we have 2 CAPs were approved subsequent to our Q3 review. So, this puts our current CAP count at around 10 CAPs. Okay, next slide.

Okay. So, we have touched on current status of RBOs. We have touched on CAPs. Now we would like to delve a bit into the individual solvency criteria. This slide provides a stratification or a grouping of where the RBOs sit with regards to their relative compliance with tangible net equity. So, the TNE shown is a ratio of TNE divided by required TNE. The required TNE is calculated as the greater of 1% annualized health care revenue or 4% non-capitated medical expenses. So, with regard to this slide, we have two RBOs that failed to meet this metric, are below this 100% range. And then some additional items. We had 156 RBOs that are sitting pretty -- 500% or above and then everybody else is kind of compliant through, so basically the middle of the chart right there. Next slide.

Okay, relative working capital. So, this is calculated as current assets less their current unsecured affiliate receivables divided by the current liabilities. Metric is shown as a measure to show the RBOs' resources, basically their ability to finance sort of their day to day operations. We have 3 RBOs that failed to meet this metric. Smaller in size. All I guess below 25,000 lives. And then everybody else kind of sits sort of in the middle compliance. So, we have 99% that are compliant through some means above that 1-to-1 ratio. Next slide.

Okay, cash-to-claims ratio. This ratio is computed as the cash and the capitation receivable collectible within 30 days, divided by total claims liability.

Similar to the working capital requirement but more of a measure of the RBOs ability to meet their short-term sort of claims liability, more claims liability centric. The minimum requirement is 0.75. So, through the slide we have two groups that fall below that 0.75 metric. We have 6 RBOs that are below 1-to-1 ratio but are compliant. And then the majority of everybody else sits above in some form of compliance, as shown in the 1-to-1 ratio or above. Next slide.

Okay. The last solvency criteria metric we have is the claims timeliness. So, this so this is the RBO's ability to pay, adjust or contest or deny claims within 45 working days. We have two groups, sorry, three groups that failed to meet this metric. Two being smaller in size, below 25,000 lives, and then one over 100,000 lives. And then everybody else sits above compliance, so 204 RBOs compliant with that claims timeliness metric. Next slide.

Okay. So, we talked about solvency criteria. The next couple of slides are delving into the enrollment for the risk bearing organizations. So, we have roughly 9 million lives assigned to the risk bearing organizations at -- within the quarter. The slide shows enrollment over the most recent four-year period. So, this 9 million RBO enrollment is a decrease of approximately 1.1 million from the prior reporting quarter. And then some additional context regarding the decrease. It was primarily Medi-Cal due to the termination of a special aid contract. So, these lives were previously assigned to a risk barrier organization and those lives now are assigned to a specialized health plan. Next slide.

Okay. So, similar to the public comments, everybody was kind of interested in Medi-Cal lives so we have a couple slides dedicated to Medi-Cal lives and sort of the overarching compliance of the risk barrier organizations with regards to that Medi-Cal population. So, we have approximately 4.8 million

Medi-Cal lives assigned to 77 RBOs and this represents 53% of the total lives assigned to all of our RBO population. And then the relative compliance of those 77 RBOs, 68 have no financial concerns, 3 are on our monitor closely list, and 6 are on a CAP. And then for the six on a CAP, one was on a CAP for claims timeliness and five on a CAP for some additional solvency criteria. Okay, next slide.

Okay. And then we like to take a look at some of the larger medical groups with Medi-Cal population lives assigned to them. So, we have this slide which shows the top 20 RBOs with more than 50% estimated Medi-Cal lives. This represents approximately 3.5 million enrollees, or roughly 39% of our total RBO enrollment. And then the relative solvency criteria compliance for these 20 RBOs, 18 had no financial concerns, 1 was on our monitor closely list and 1 was on a CAP. And then for the remaining 57 RBOs with Medi-Cal lives assigned to them, there were roughly 1.2 million lives assigned to these. Fifty had no financial concerns, 2 were on our monitor closely list, and 5 are on a CAP.

Yes. And I think that is the quarterly update for the risk bearing organizations. Any questions?

CHAIR RIDEOUT: Thank you, Derek, you get to come back.

So can I take questions or comments from committee members in the room.

MEMBER WALTERS-WHITE: (Indiscernible) RBOs?

MR. JANG: I want to say -- do you?

MS. DUTT: Go ahead.

MR. JANG: Okay. Yes. I mean, with regards to trends, like I said, our current CAP count is 10, so I think it is relatively smaller than it was in

previous reporting quarters. But like had been alluded to, you know, previously with the question for Medi-Cal lives and some of the concerns that the Medi-Cal RBOs may be facing in future quarters, you know, that trend may reverse. It just kind of depends sort of on how that, you know, the reimbursement rates hit the RBOs and some of the solvency criteria and how that shakes out going forward. Right now I would say we are sitting okay, but I would say monitor sort of those last three slides and kind of see whether more CAPs arise from the risk bearing organizations, specifically the Medi-Cal population.

CHAIR RIDEOUT: Other questions or comments?

I have got, Derek, a question. Given that both the committee members and the public have raised the issue of the funding of downstream providers from Medi-Cal plans. What should we be looking at in this information to be early in the process of identifying who to care about? And you know one way to do this is look at the compliant plans versus the non, another is to look at the big statistic like no financial concerns or CAPs. But we do see pretty regularly cash-to-claims and other maybe other early warnings. If we could be alerted to in future meetings so that we are ahead of that curve. Because a lot of these seem fairly, you know, big, big sticks or big metrics to really look at.

MR. JANG: Yes. I mean, I know there's slides that show sort of the stratification of the relative compliance of TNE working capital cash-to-claims. So, if you see sort of a distribution towards sort of the latter half or the lower end, then you know that could be sort of an early precursor warning. And then additionally we have that monitor closely section, so I think there was what, eight or nine-ish on the monitor closely list. So, if that number starts delving into like 15, 16 or higher then, hey, we have, you know, some more groups that may be

transitioning to CAPS.

MS. DUTT: So, one of the things we did was provide the enrollment and grading criteria handout. So, if you see the TNE, working capital, cash-to-claims on the declining side, then, like, we will start working with those RBOs and questioning them on, okay, what's going on? Is there any reason for the decline? Engaging with them early, like said previously. Engaging with the plans or RBOs early on to see what's going on. But it's a lot of numbers in here, but like those are things --

CHAIR RIDEOUT: I was going to say, if you could summarize, you know, who you are looking at closely, that would be good.

MS. DUTT: Yes. So, with RBOs, as we had previously discussed, things are very confidential. We get the data. We have a lot of data. There's only certain things we can present. So, you know, when we have somebody on the watch list that's not something we present, but you can see it when they fall on a CAP. That's why we provide ranges and it's more summarized reporting, but we cannot point out who we are looking at.

CHAIR RIDEOUT: Yes. Just because we do this for living, you know, there's ways you could blind this, there's ways you could make it, you know, just sort of a summary number. You could show changes without naming organizations. But you are naming them here so, you know, I guess I am a little bit confused about what we can see or not see.

MS. DUTT: Right. The relative TNE, relative working capital. It's a calculation, that's what the regulation allows us to publish. This data is available on our website. But just when you start getting in detail, how much profit somebody's making, their actual enrollment, those type of details are

confidential. So, like I said, we can go play with the slides and see how we can show more meaningful data without, like, identifying who we are watching closely.

MEMBER WATANABE: Yes, no, and I will just add, I mean, I think we were up close to 30 CAPs a year or so ago, longer maybe. Bill knows this. But so, I mean, I think 16 RBOs on a CAP, I mean, that that feels like we are doing better, but I think that's one of the things we will we will monitor closely over time. So, I think just generally, if you can compare, we have all these documents from the FSSB meetings posted on our website so you can go back and kind of compare over time. But I think we will take back if there are certain indicators that we are seeing a downward trend or something that we collectively should be keeping an eye on we can certainly try to highlight that for you. We just -- we have some very specific prohibitions on what we can share, and I think we have pushed the limit. We have really increased our reporting and really pushed the limit on what we can share, but, but we will certainly take back where we can highlight things for the Board.

CHAIR RIDEOUT: Okay, Committee Members virtually any questions or comments?

MEMBER DURR: Jeff, it's Paul. So, one comment that I have. Derek, very nice job. That was excellent, thank you. On the supplemental report that you provide to the Board on the CAP review summary that lists the different RBOs and kind of their status. I did notice that there are two of the three non-compliant final CAP provider or RBOs. The first one and the last one on the list were also noncompliant on June 30th so it gives me more concern. Certainly the first one only has zero to 5000 members, but the last one on the list is someone

that is, I know we talked about last time has a health plan as well. That gives me concern that if they are noncompliant with their CAP two quarters in a row, is that (indiscernible).

MS. DUTT: Paul, thank you for pointing that out. In January, towards the end of January the Office of Enforcement issued a Cease and Desist order, two separate ones, one for Meritage Health Plan, one for Meritage Medical Network, to freeze their enrollment, which means that they can no longer take additional enrollment effective February 27. So, that C&D was issued on January 27. They had 30 days to put that implementation -- to implement that. So, they can no longer take enrollment effective, like I said, February 27, and then until they demonstrate compliance. So, our Office of Plan Enforcement has been working closely with OFR. We are working with the contracted health plan. So, thanks for pointing that out.

MEMBER DURR: I appreciate the update. Thank you.

CHAIR RIDEOUT: Okay, taking questions from the public or comments in the room. Bill.

MR. BARCELLONA: Well, I was hoping Sean would come up first, but Bill Barcellona, APG. Thank you, Derek, for that report, much appreciated.

I just had a quick question on the enrollment numbers. I know we have a growing number of restricted licensees that are playing in the Medi-Cal market now. Did those -- How does that work in terms of enrollment at an RKK versus an RBO for Medi-Cal lives? Do you know what I am saying?

MS. DUTT: I kind of do, because the restricted Medi-Cal plan would take full risk, whereas the RBO can only take professional risk.

MR. BARCELLONA: So, where there is delegation from the RKK,

the Restricted Knox-Keene plan. So, where there's delegation to the RBO you will see that. But then if the restricted plan is retaining the risk then they will pay all the claims, et cetera.

MR. BARCELLONA: I think you know, because we are seeing a number of groups that are bumping up to the restricted level from RBO, and I didn't know if we were -- so when they make the transition up to an RKK do we lose the enrollment on the RBO quarterly report or does it stay?

MS. DUTT: So, it depends how they structure the arrangement. For example, the RBO could take -- or the RKK, the restricted plan could hold the main global risk contract with the full-service plan.

MR. BARCELLONA: Right.

MS. DUTT: And then -- then the restricted plan delegates those lives for professional service only to the RBO. So, it depends on how these arrangements are structured. Typically, they keep those RBOs in there because that's their model, right, because it's their affiliated entity. But it totally depends on how the RKK structures their delivery system.

MR. BARCELLONA: And one last question on reporting. A bill was introduced this week that would modify the OHCA statute to define an MSO as a health care entity. Is the department -- do we even have a handle on how many MSOs there are in California?

MS. DUTT: So, we -- we have -- so when an RBO uses an MSO they provide that information to the DMHC.

MR. BARCELLONA: Yes.

MS. DUTT: But when you are talking about the global count of all MSOs, I don't think we have that. But if one of our RBOs or one of our health

plans, if they are using an MSO, we are aware of that arrangement. Like restricted plans, will be required to file that contract with the Department for review. But for the RBO, that is who we interact with is the MSOs if the RBO is using one. But then like I said, a total count, I am not sure.

MR. BARCELLONA: So, yes, I think the only consistent list we had was with Cattaneo & Stroud, and that's fairly dated by over a decade now. Okay, thank you.

CHAIR RIDEOUT: Other questions or comments from the public?

Okay, we will move to online. We have a question online.

MR. STOUT: None at this time. Derek, when you are prompted, please state your name and organization.

CHAIR RIDEOUT: You are so prompted.

MR. SCHNEIDER: Hi, my name is Derek Schneider, I am the CFO for MedPoint Management. Actually, the questions you are raising here about the impact things you should be looking for as it relates to the solvency metrics actually ties in with what Bill was mentioning earlier. The focus, for the most part of what Bill was mentioning earlier was more on the cash side for the targeted rate increase. That's usually the easy part is, you know, the state pays the plans, plans pays the RBOs, RBOs pay the providers for the TRI increase. Yes, that's pretty straightforward.

The problem is, what you have is the impact on the RBO is more of a balance sheet impact that you -- that is not really covered by the cash that is really a passthrough through the RBO to the providers. Because what happens is, when you intake or you raise, retrospectively raise the payments that RBOs are having to make on a fee-for-service basis back to 1/1/24, you are effectively

raising the spend rate on the IBNR lag. So, therefore in your experience period is going to have a higher amount. It's going to then, therefore necessitate a higher reserve for future periods, even if those were one-time payments that we got at the end of December for TRI. But it is going to impact the IBNR or IBNP on a go-forward basis. That is going to have an impact on your cash-to-claims ratio and your working capital ratio.

What is also going to happen is as you get those payments in from the plans, and you are going to see this in Q4 because most of the payments for TRI happen in Q4, most of them in the last week of December. But you are going to see that on the Q4 statements where the amounts came in, you book a -- because you know those are going to be passed through you book a liability for what is going to be paid out on a fee-for-service basis, so your medical claims expense is going to go up and your capitation is going to go up, or some liability is going to be set up in medical expense. That is going to have an impact on your TNE requirement because that is based on 1% of annualized revenue or 4% of annualized medical expense. So, therefore your equity requirements going forward for an RBO are going to be inflated by the TRI payments. And again, that's an ongoing calculation.

The problem is, you know, the first part, making the payments is easy because that's, that's a cash transaction. You get cash in, you pay cash out. But these, these items that are impacting the solvency metrics are effectively funded by equity, increases in equity or profits. So, that's really how -- and therefore they are unfunded because there is no cash payment that is going to fall to the bottom, you know, that is going to the owners to fund into the RBO, and there is no leftover on the TRI because it is a pass-through to fall to profit to

subsidize these increased reserve requirements that are going to hit for a TNE working capital and cash-to-claims. So, those are really unfunded. So, those are really going to be some of the unsung impact of TRI that is going to impact what you see here from a solvency perspective and, you know, it is going to be kind of the fallout of trying to make this happen, to make TRI happen. It really has not been taken into account but you are going to see it starting in Q4 with those statements because that's, again, that's when the payments happened. So, therefore the liabilities and everything changed in Q4.

MS. DUTT: Thank you, Derek. So, we just got the fourth quarter of financials not too long ago.

MR. SCHNEIDER: Right.

MS. DUTT: So, Derek, I know that MedPoint has a lot of the RBOs under, you know, where MedPoint helps them with reporting to the DMHC.

MR. SCHNEIDER: Mm-hmm.

MS. DUTT: So, Michelle can coordinate with you if we are seeing a decline in the grading criteria. Because when you are describing it, that's what I am thinking. Okay, there's increase claims so a reduction in the cash-to-claims ratio hitting the balance sheet impacts your TNE and working capital. So, we are, we are still looking at, the preliminary review is still going on, on those 12/31 financials that just came in, but we will be reaching out with questions.

MR. SCHNEIDER: Great. Yes, we started getting some questions. And that's, effectively the answers along some of them. Why was there a decline or why was there, you know, a change. And that's, that's a big part of it is the equity requirements and everything had a significant impact. And again, it was, you know, you look fine until, you know, you start getting payments the last week

of December. And obviously you don't have time to make those payments out, but I appreciate that. And Michelle and Derek and the team are definitely in contact with us. But it is something the really the Board should be aware of too, because even once this is done, you are going to continue to see that impacting the balance sheet metrics. But thank you.

CHAIR RIDEOUT: Thank you, Derek.

Are there other questions or comments virtually?

Other questions or comments on the phone?

Okay, we will move on to the health plan quarterly update. Pritika, you are back on.

MS. DUTT: Okay. The purpose of this presentation is to provide you an update of the financial status of health plans at quarter ended September 30, 2024. All licensed health plans are required to submit quarterly and annual financial statements with the DMHC. Additionally, we get monthly financial statements from plans who are newly licensed, and also from plans whose TNE falls below 150% of required TNE. Or if we have financial concerns with a plan's financial solvency we may place them on frequent monitoring, which is monthly reporting.

We also included a handout that shows the enrollment at September 30, 2024 by line of business, and then TNE for five consecutive quarters, which goes from September 30, 2023 to September 30, 2024 for all licensed health plans. The information is broken into three categories, full-service plans, restricted full service and then specialized health plans.

As of January 6, 2025 we had 142 licensed health plans. We are currently reviewing 11 applications for Knox-Keene licensure, 6 full service and 5

specialized. Of the 6 full service, 5 are looking to get licensed for Restricted Medicare Advantage, 1 is looking to get licensed for Direct Medicare Advantage to get a direct contract with CMS. And for the 5 specialized plans, 3 are looking to get licensed for EAP and 2 for dental.

Additionally, we have been meeting with several entities that are still interested in obtaining a Knox-Keene license. We continue to get those requests and have pre-filing meetings.

And then so to highlight some of the newly licensed health plans. Universal Health Plan, Inc. was licensed on September 16, 2024 as a restricted Medicare Advantage plan. Their first financials will be due to the DMHC for the fourth quarter, which is due on March 3, 2025.

And then Spring Care of California, Inc was licensed on November 7. It is an Employee Assistance Program or EAP plan. Their first financials will be due on March 3 for the fourth quarter.

And then Gold Coast was newly licensed on February 7, 2025 for a Medicare Advantage DSNP plan. We will start including their financial results in with the first quarter financials that's due in May 15.

And one thing I do want to mention is that in January the DMHC released new financial statement templates. So, for the fourth quarter financials we did give health plans a two-week extension. So, they were initially due February 15, so we gave the health plans a two week extension to submit the fourth quarter financials. We will be capturing additional data points for financials to align with all the changes in the financial reporting requirements gap, et cetera. And then we also will be capturing, or are capturing now starting with the fourth quarter, county level, county level enrollment data for health plans. So, that will

be new for the fourth quarter and we will see how we can present that information for FSSB going forward.

At September 30, 2024 there were 30.13 million enrollees in full service plans licensed with the DMHC. Total commercial enrollment includes HMO, PPO, EPO and Medicare supplement.

So, another change in the new template you will see for the next quarter, we split PPO and EPO, so there will be two separate lines. Currently, the September 30, those numbers were combined, so those splits you will be seeing in future quarters.

As you can see on the table, compared to the previous quarter, total full service enrollment decreased slightly but, you know, stayed consistent from last quarter.

This slide shows the makeup of HMO enrollment by market type. So, HMO enrollment in all markets remained stable compared to previous quarters. Large Group HMO and Small Group HMO products experienced slight decrease in enrollment.

And this slide shows the makeup of PPO and EPO enrollment. So, PPO/EPO enrollment in all markets remained comparable to previous quarters, so there's not that much change happening there.

And then on the government enrollment side, which is Medi-Cal and Medicare. So, enrollment for both Medi-Cal and MA plans have experienced consistent growth until June 30, 2023. And then at 9/30 Medi-Cal enrollment decreased by about 44,000 lives and the Medicare enrollment increased by 40,000 lives compared to June 30, 2024. So the slight drop in Medi-Cal enrollment, as previously discussed during the previous presentation, was due to

redetermination and then unwinding of, you know, the continuous coverage, so that ended as well. So, DHCS has a nice dashboard on their website so that kind of shows what's happening with the Medi-Cal enrollment.

We have 30 plans that we are monitoring closely, which includes 25 full service plans and 5 specialized plans. So, there are various reasons why we monitor health plans closely, which may include but are not limited to the plan being newly licensed, so there's like volatility there, low enrollment, financial solvency concerns. We also keep track of if there's a parent entity involved we look at those parent entity financials. If there's concerns there then we will monitor the plan closely. If we see/hear about any claims processing issues. So, we get claims reporting, like the quarterly and annual claims reporting from health plans. So, if there's any concerns there we will place them on our watch list. Or if there's any issues we are seeing on examinations with providers not getting paid timely we place our health plans on monitor -- we will watch them closely. And then any enforcement action, staff turnover at the plans. If we see there's a lot of changes happening at the plans then we will put them on our monitor closely list.

So, the majority of the plans that are monitored closely are not very large in terms of enrollment, so they are smaller plans.

One Health Plan did not meet the Department's minimum financial reserve or TNE requirement, it's Meritage Health Plan. So, Meritage reported TNE deficiencies for month ending August 31, 2024, September 30, 2024, and October 31, and November 30. And then for quarter ended September 30 the plan reported noncompliance with the TNE requirement. On January 27, 2025, as I had previously mentioned, the DMHC's Office of Enforcement issued a

Cease and Desist Order to the plan that prohibits the plan from taking on any new enrollment effective February 27, which is tomorrow. So, the plan has filed a change in control filing with the DMHC, which is currently in review. So, we had previously mentioned that the plan's parent Babylon Health had filed bankruptcy, so Meritage Health Plan and Meritage Medical Network has been trying to find a buyer, so that's why we have a change in control filing which needs the Department's review and approval before that can move forward.

This chart here shows the TNE of health plans by line of business. A majority of the health plans with over 500% of required TNE are specialized health plans. The specialized health plans have a lower TNE requirement compared to full service plans. Again, that is because the medical expenses or risk is higher for full service plans because they do cover more. So, here the higher the plan's medical expenses the higher the reserve requirement for these plans are. So, if the Medical expenses are higher then the required team would be higher, resulting in lower percentages there.

This chart shows -- this chart shows the TNE of full service plans by enrollment category. So, 63 health plans, over half of the total licensed full service plans reported TNE of over 250% of required TNE. And as previously mentioned, if a plan's TNE falls below 150% of required TNE, those plans are placed on monthly reporting.

And this chart shows a breakdown of the 28 full service plans in the 150 to 250% range. If a health plan's TNE, as I previously said, falls below 150 those are placed on monthly reporting. We are also -- we also monitor the health plans closely if we observe a declining trend in their financial performance, which is TNE, net income, enrollment, cash-to-claims, working capital, to name a few.

And this chart shows the tangible net equity of full service plans by quarter. So, this chart here summarizes the handout that was provided with the meeting materials. So, if you wanted to look at details on which plan is reporting what percentage you can refer to that handout.

And this slide shows the working capital for full service health plans by enrollment as of September 30, 2024. So, working capital measures the health plan's ability to pay its bills that are due within the year. We want the ratio to be over 1 for health plans, or 100%. So, this is in ratios so it would be 1.0, but then when you equate to percentages it is 100%. Which indicates that the plan has enough short-term assets to cover its liabilities that will be due within the year. So, as you can see, 17 health plans reported working capital of less than 1.

This slide shows the cash-to-claims ratio for full service health plans by enrollment. Cash-to-claims ratio measures a health plan's ability to pay its unpaid claims using cash, marketable securities and receivables. It is calculated by dividing the cash and marketable securities and receivables by its unpaid claims liabilities. Similar to working capital, we want the health plans to maintain a cash-to-claims ratio above 1 or 100%.

And then here we tried to shed some light on the plans that are reporting a cash-to-claims ratio of less than one. So just to highlight, the requirement for RBOs are they have to maintain a cash-to-claims ratio of 0.75 or 75%. But on the health plan side the risk is higher, they are taking institutional risk, so we want them to maintain a cash-to-claims ratio above 1. So, some of these plans may be on our -- we are monitoring these plans closely.

So, that wraps up my presentation. I can take any questions.

CHAIR RIDEOUT: Questions or comments from Board Members in the room?

Pritika, I have one question. If you go to Slide 7, it looks like the number of closely monitored Medi-Cal plans is small in number but large in enrollment as a percentage of the total. Can you give us any color on who those plans are and where they show up on these other ratios? Not looking for names, although I know we have a little bit more liberty on the plan side. Of course.

MS. DUTT (OFF MIC): So a couple of these plans, I think probably hit on (inaudible).

CHAIR RIDEOUT: And internally, do you connect the dots between those plans and the providers that they use in terms of whether downstream payments are going appropriately or not, or?

MS. DUTT: Well, it depends, right? So, we try to see which health plans are -- so we capture data on which health plans are contracted with which RBOs. And then I think once the RBOs go on corrective action plan we engage the -- we engage with the health plan and the RBOs closely on that process. But we do coordinate with so -- our health plan team coordinates with Michelle's team on that RBO oversight. So, there's a lot of coordination going on between the two teams.

CHAIR RIDEOUT: Thank you.

David.

MEMBER SEIDENWURM: Are any of these plans serving geographically or culturally isolated groups such that their demise would be felt, you know, by our patient populations?

MS. DUTT: So, I mean, like, three of the plans are Medi-Cal plans

then we have seven Medicare Advantage plans. So, I am not sure about the demographics. I mean, but I mean. For Medicare plans they are over 65 years old and then we have the elderly population and then for the Medi-Cal plans they are serving the underserved, so there are concerns. But like said, we will start capturing that county level enrollment so that might be helpful for that discussion. Like to kind of see, like, what -- where these plans are, where their enrollees are. So, I think that would be helpful in the discussion.

MR. SOUTHARD: Not to put you on the spot but for example, would any of these plans be the sole provider in a county? You know, talking about Medicare Advantage, for example. That might be something to look at.

MS. DUTT: We will have to take a look at that.

CHAIR RIDEOUT: All right, questions or comments from committee members virtually. Paul, your hand is raised.

MEMBER DURR: Yes, thank you, Jeff.

Pritika, I always love your reports, so thank you. My question is sort of building on some of the conversation that has already taken place, but some of the concern with the cash-to-claims ratio report gives me some grave concern that there's I think five plans that have the smallest, small cash-to-claim, especially one plan that has over 300 -- I have to look at the report again -- over 300,000 members. And then, you know, their cash-to-claim ratio is less than .19. And then another plan that is between .2 and .39.

And I missed the earlier conversation, you might have answered Jeff. Some of the concern about monitoring those plans in particular with very low cash-to-claim, let alone the other metrics. Are you concerned about their longevity?

MS. DUTT: To answer a question, it depends. So, when you look at the financial statements, we look at like how the composition of those assets are. For example, the cash-to-claims ratio doesn't take into consideration any long-term investments; so, it's looking at your cash, marketable securities, receivables. So, we look at whether they have any access to other assets that can be converted, right. So, you cannot count long-term investments, but if needed they can tap into that. So, these things we look at, like their access to cash. If they have a parent involved we look at the parent's liquidity too, whether the parent company is able to provide any assistance to the health plan if needed. So, there are several factors we look at when we see these low matrix.

MEMBER DURR: Thank you for that and a good point. One thing that you made me think of is any provider complaints to the health plan. I know that's not financial data that's captured, but that might be an interesting add, to understand the level of provider or patient complaints to a health plan, that might add another metric to look at to give concern if a plan is performing well or not.

MS. DUTT: So, we do work closely with our Provider Solvency team that's under Help Center. If they see any trends, they share that with us. We work with our Office of Plan Enforcement on any issues with what we are seeing with health plans with respect to claims payment. We get complaints through our Director's Office; I work closely with the providers and plans on those. So, these like -- so we see the provider complaints. But typically those are for, like, bigger plans so I don't know whether they always correlate to a financial issue. It's more like we see, like, problems with the larger health plans.

CHAIR RIDEOUT: Any other questions from committee members virtually or on the phone?

Not seeing any we will move to the public. Any questions or comments from the public in the room?

No rush to the podium.

Any questions or comments virtually from the public? And none on the phone.

Okay, that concludes, number 7.

The last three agenda items to finish the meeting. Number 8, we take public comment on matters not on the agenda. Does anybody from the public in the room have comments on what to include?

Any comments from the public virtually? Oh, Bill, come on up.

MR. BARCELLONA: Thank you. Bill Barcellona, America's Physician Groups. Just had a quick comment on the implementation of AB 133 with respect to restricted license compliance with NCQA accreditation. So, this continues to be a kind of a confusing situation for some of the restricted licenses who were licensed and enabled to operate with significant delegation downstream to their MSOs or RBOs. And it's creating a situation where NCQA doesn't have a methodology in place to accredit an RKK when they have had a significant level of delegation like this; and yet the Department has licensed these RKKs case to operate in this fashion and yet the Department is obligated to require them to comply with the provisions of AB 133. So, we have a call set up with NCQA again tomorrow, but this is an ongoing issue and we need to get some clarity as we move forward on whether or not the AB 133 provisions will somehow impact the ability of these RKKs to continue in operation. So, just a comment. Don't need a response at this time.

MEMBER WATANABE: I will just say we are continuing to work

with NCQA too on the various requirements. So, happy to work with you offline on that, but thanks for flagging it again.

MR. BARCELLONA: Thank you. Appreciate it. Okay.

CHAIR RIDEOUT: Thank you. Any other public comments on other matters, virtually or on the phone?

None.

Okay, agenda items for future meetings. Any items from committee members?

I did have the one about trying to tie the earlier conversation to the DHCS presentation, if we can make that happen.

MEMBER WATANABE: So, maybe I will just add. I think obviously we'd love to have DHCS come to the next meeting and we will put a specific request to have someone talk specifically about the TRI payments and impacts to downstream providers as well.

I think we were hoping to maybe have Covered California come and talk about their historic open enrollment. I think -- I don't know if they quite exceeded 2 million, but they got really close. So, lots, lots of excitement with the latest open enrollment there. So, I think those are two we had planned.

We will have -- May revise should be out by our next meeting, which is, I think, May 28, so we will plan on having a budget update as well.

But open to anything else you all want to hear about, in addition to just taking feedback on all the reports that we present regularly.

CHAIR RIDEOUT: Any other agenda items to consider?

MEMBER DURR: Jeff.

CHAIR RIDEOUT: Paul.

MEMBER DURR: Yes, just one thing. Mary, as you think about expanding the Board as we are required to, what I was thinking is either a board orientation about the requirements--I'm sorry, I'm losing my voice--the requirements for the work of the FSSB. Meaning, what are we actually looking at, the financial solvency of risk organizations, and just being clear as to what that fiduciary duty that we have. And orienting the Board on the that type of work we are asked to do might be helpful, either in a general session that could be done over a couple of meetings, or in your purview, the right way to do that. So, thank you.

MEMBER WATANABE: Yes, that is actually great feedback. I think we had a prep call with Katrina to just say there are no dumb questions. Ask us. She can engage with us offline to ask. This is, I don't know. I told her it took me, I think, a year just trying to absorb. It is very technical. I still don't fully understand everything, but I have got a great team that does. So, I think we will maybe take back kind of the purpose and the role of, and maybe a little history lesson too. Bill can help us with the history and the purpose of this Board. But also just maybe some of the -- maybe doing a little bit of an orientation and background on some of the things that we talk about and present, so appreciate that suggestion. I am sure Katrina and others will welcome that.

MEMBER WALTERS-WHITE: Absolutely.

CHAIR RIDEOUT: Okay, I think that concludes our meeting today. Any final comments from committee members?

MEMBER WATANABE: Can I just make one?

CHAIR RIDEOUT: Of course.

MEMBER WATANABE: Sorry, Jeff. One final comment. I think,

Professor Currie, I think we followed up with the email address with you directly. But just for anybody else that has questions, comments or wants to engage with the Department on anything that you heard today or otherwise, send an email to public comments, that's with an s, at dmhc.ca.gov. So that's public comments with an s at dmhc.ca.gov, and we will follow up with you. Thank you.

CHAIR RIDEOUT: And our next meeting is May 28.

Yes, Jordan.

MR. STOUT: Professor Currie, please unmute your mic when prompted.

DR. CURRIE: Hello, yes, thank you. I was hoping for the future agenda items somehow we could, and I will email you, I did get that, some of the behavioral health issues that we do have with the plans. I know under DMHC as providers the providers can make a complaint, and as a consumer they can make a complaint. However, working with our regional centers, we find that there is a gap in the behavioral health side of being able to have the families receive the behavioral health services, in particular autism and intellectual disabilities receive those services. But I will definitely email you and thank you for hearing me out.

CHAIR RIDEOUT: Thank you.

All right, can I have a motion to adjourn?

Thank you, David. Second?

MEMBER DURR: Second.

CHAIR RIDEOUT: All right, that concludes our meeting for today. Thank you, everyone.

(The meeting was adjourned at 11:49 a.m.)

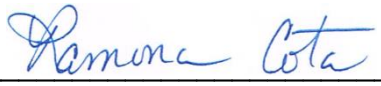
CERTIFICATE OF REPORTER

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 17th day of March, 2025.



RAMONA COTA, CERT*478

.