STATE OF CALIFORNIA

DEPARTMENT OF MANAGED HEALTH CARE

FINANCIAL SOLVENCY STANDARDS BOARD (FSSB) MEETING

DEPARTMENT OF MANAGED HEALTH CARE

980 9th STREET

ROOM OF EXCELLENCE, 5th FLOOR

SACRAMENTO, CALIFORNIA

WEDNESDAY, AUGUST 14, 2024

10:00 A.M.

Reported by: Ramona Cota

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APPEARANCES

BOARD MEMBERS

Jeff Rideout, MD, Chair

Abbi Coursolle (participated virtually)

Paul Durr

Mark Kogan, MD (participated virtually)

Jarrod McNaughton (participated virtually)

David Seidenwurm, MD

Jessica Sellner (participated virtually)

Mary Watanabe

DMHC STAFF

Pritika Dutt, Deputy Director, Office of Financial Review

Dan Southard, Chief Deputy Director

Jordan Stout, Staff Services Manager I

Michelle Yamanaka, Supervising Examiner, Office of Financial Review

ALSO PRESENTING/COMMENTING

Rafael Davtian, Deputy Director (participated virtually)
Department of Health Care Services, Health Care Financing

René Mollow, Deputy Director (participated virtually)
Department of Health Care Service, Health Care Benefits and Eligibility

Concerned Citizen (participated virtually)

William "Bill" Barcellona
America's Physician Groups

Janice Rocco (participated virtually)
California Medical Association

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PROCEEDINGS

10:00 a.m.

(Chair Rideout called the meeting to order, welcomed all participants, and Board Members introduced themselves.)

CHAIR RIDEOUT: This meeting is being conducted in a hybrid format, with the opportunity for public participation in person or virtually through video conference or teleconference.

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.

The restrooms on this floor are locked. 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.

For our Board Members here in person, please do not join the Zoom meeting with your computer audio.

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 “Raised hand” feature. All questions and comments from Board members will be taken in the order in which “Raised hands” appear.

Public comment will be taken from individuals attending in person first. For those making public comment at the podium here in 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 “Raised 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.

And for attendees participating online with microphone capabilities, you may use the Raise Hand feature on Zoom, and you will be unmuted to ask your question or leave a comment.

Only a few more. To raise your hand, click on the icon 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. I think most of us have used Zoom probably enough to know how to use that, but if you have any problems let one of us know.

As a reminder, the Financial Solvency and Standards Board committee meeting 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 the 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 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 then 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.

(Board Member Kogan joined the meeting.)

CHAIR RIDEOUT: So, that takes us through the housekeeping.

There are two other matters that we need to take care of. One is for Committee Members, any comments or corrections to the transcript of the last meeting? Hearing none, none on Zoom, can I have a motion to approve the transcript?

MEMBER MCNAUGHTON: So, moved.

CHAIR RIDEOUT: Thank you. Paul?

MEMBER DURR: Second.

CHAIR RIDEOUT: Thank you, Paul.

All those in favor say aye.

(Ayes.)

CHAIR RIDEOUT: Aye. Okay. Any opposition from committee members?

(No audible response.)

CHAIR RIDEOUT: Hearing none, we will consider the transcript

from the February 28 meeting approved.

And then the last bit of business is approving the meeting minutes from the last meeting. Were there any corrections or comments on the meeting minutes?

Okay, hearing none, is there a motion to approve those minutes?

MEMBER DURR: So, moved.

MEMBER SEIDENWURM: Second.

CHAIR RIDEOUT: Thank you, David.

All right, all those in favor say, aye.

(Ayes.)

CHAIR RIDEOUT: Any opposition?

(No audible response.)

CHAIR RIDEOUT: Okay, we are back on track and three minutes ahead, I think Mary. I will turn it over to Mary for the always interesting Director comments.

MEMBER WATANABE: And I have a lot today, thank you, Jeff. It is good to be back together. I think it has been six months since we had our last meeting since there was not a lot of updates in May.

So, I will start with an update on Covered California and our Individual and Small Group market rates for 2025. I can't believe we are talking about 2025 already, but here we are. On July 24 Covered California announced the Preliminary Health Plan Premium Rates for 2025, citing an average statewide rate change of 7.9%. Just for reference, last year was 9.6%. They are attributing the rate change to many factors including a continued rise in health care use, increase in pharmacy expenditures, the rising cost of care, labor shortages and

other issues affecting the health care industry.

Thankfully, because of the robust financial help available through Covered California, most enrollees will see a small impact to their monthly cost. And then, just as a reminder, Covered California has worked to reduce the impact of increased consumer costs in 2025 by providing more support or its state-enhanced cost-sharing reduction program, which will eliminate deductibles and lower the cost of care for over a million Californians.

And then as you are probably aware, these are preliminary rates, because the Department of Managed Health Care needs to also do our review. So, DMHC's actuaries are currently reviewing the individual market rate filings which take effect on January 1st as well, to ensure the health plans' proposed rate changes are reasonable and justified.

We received rate filings from 13 health plans, including 12 that offer products on-exchange and one that offers products off-exchange. The proposed rate change for those plans ranges from 1.8% to 15.4% and the weighted average rate change for those plans is 7.8%.

We are also reviewing the Small Group Market Premium Rate Filings that take effect in January, on January 1st. We received rate filings from 12 plans; and the proposed rate change ranges from 0% to 16.8%, with a weighted average rate change of 7.2%.

We have posted the rate filings on the DMHC's website. We are taking public comment. We will finalize rates usually by October 1, so we typically announce the final rates at the end of September. And then as we usually do, Pritika will do a full presentation in November on what we had in terms of our rate filings. I think typically we have invited Covered California to

come in the first part of the year after they have gotten through their open enrollment to do an update as well on what they are seeing in the Individual Market. I do want to just take a moment to thank Pritika and her amazing team of actuaries. This is their very busy season, and they are putting in a lot of long hours analyzing these rates, so great work to that team.

I will also provide a quick update on risk adjustment transfers. We will have a more detailed presentation in November on this. But just a reminder, the risk adjustment transfer program is intended to transfer funds from health plans or insurers with low actuarial risk to those with high risk. For 2023, 1.32 billion was transferred between the California health plans and insurers. Blue Shield received 1.3 billion in risk adjustment transfers. Health Net received 8.7 million, and United Healthcare Benefits Plan received 17.7 million. Thirteen health plans had to pay into the risk adjustment pool, with Kaiser paying 730 million. So, again, I think more information to come at our next meeting.

Just a reminder that we have a new dental rate review program. So, beginning January 1st of 2025, health plans that are offering dental services are required to submit rate filings to the DMHC. This was new, a new requirement pursuant to Assembly Bill 1048. Dental plans are required to file information regarding the methodology, factors and assumptions used to determine rates annually at least 120 days before implementing any change. We issued an All Plan Letter on July 8, and shared the dental rate review templates and guidance with the plans. The first set of rate findings will be due from the plans on March 1, 2025. And again, as we always do, we will have more information on our first dental rate review findings probably next year for you.

The next update I have is about California's efforts to set new

Essential Health Benefits or EHBs and a Benchmark Plan. And I am going to warn you, my update is somewhat technical so bear with me as I try to break this down into something understandable here. But as you are probably aware, we had a public meeting, so we have shared this pretty broadly. This is really a joint effort between the Department of Managed Health Care and the Administration, along with the Legislature. We are very fortunate the California Health Care Foundation and Covered California have provided financial support for us to contract with an actuary, our consultant Wakely, to assist with the actuarial analysis.

The Affordable Care Act requires all Individual and Small Group plans to cover Essential Health Benefits or EHBs. These benefits must include benefits from 10 broad categories or services which include, just to name a few, primary care and specialty visits, emergency and urgent care, behavioral health services, maternity and hospital and surgical services.

Within the broad category of these services, each state can decide what specific services are included and which are not required to be covered.

Federal law puts guardrails on the scope of the benefits a state can determine to be EHBs, including requiring the plan to use what is called a Benchmark Plan Process to define the state EHBs. The Benchmark Plan Process that we are engaging in now requires the state to look at the scope of benefits provided by the typical employer plan in the state. And this is really to make sure that the benefits are not too skimpy, so looking at the least generous plan; and not too rich, so we can't exceed the most generous plan.

It is important to note that up until recently, a state could not do what we call an a la carte selection of benefits to define EHBs. Instead, the

Federal Benchmark Plan Process required us to look at an existing product that was offered and then supplement with additional benefits to make sure that it met all of those federally required categories.

Using that Benchmark Plan Process, California selected as its Benchmark Plan the Kaiser Foundation Health Plan Small Group HMO 30 for our health plan. You are very familiar with this, I am sure. I think that has been our benchmark plan since 2017, if I remember correctly.

The Health and Human Services at the federal level recently finalized a rule that allows states to mandate new benefits without exceeding EHBs or triggering the requirement for states to cover the cost of these new benefits, but only if we adopt a new benchmark plan. So, this would allow California to do kind of this a la carte benefit selection, and for the legislature to adopt a new benchmark plan.

So, despite the long list of services that have been covered under our benchmark plan, there are a few that have not been covered and have been the subject of legislation over the years. This includes hearing aids, wheelchairs and fertility treatment, dental services for adults, and chiropractic care. It is also worth noting here that EHBs do not include who is providing the care, so we can't mandate the type of provider or cost-sharing or utilization management, like prior authorization.

So, we have a pretty fast timeline for this. We had a public meeting on June 27 to solicit public comments on the benefits we should consider for adding. You can find all of the materials on our website from that meeting including the transcript, the recording of the meeting. We also recently posted all of the public comments that we received. So, if you are interested in seeing I

think close to 150 public comments, those are now posted on our website.

So, the next step really is between now and May 7th of 2025, May 7th of 2025 we need to notify the Federal Health and Human Services Agency of our selection of a new benchmark plan, so that's kind of the critical date for that new EHBs and Benchmark Plan to take effect for the benefit year starting January 1st of 2027. So, between now and May we will be working very closely with Wakely to understand how much room we have to add benefits, as well as pricing out the cost of the benefits that have been -- what we are tracking, as well as what came in through public comment.

And then just a reminder, the legislature will also need to consider and adopt the new Benchmark Plan and there will likely be hearings and public comment associated with that. We also do need to have a formal public comment period associated with selecting the new Benchmark Plan. So, more to come in kind of that process.

Just moving on to another topic. Our Annual Report for 2023, we released this last month. It is worth noting we had the highest number of enrollees under the Department's jurisdiction. We are now up to 29.8 million consumers and 140 licensed health plans. If you get a chance to look through the report you will see it was a very, very busy year for us yet again. I am really proud of the team and a lot of our accomplishments and their continued commitment to our mission.

Okay, two more updates, bear with me here.

So, coming next month we are going to release a solicitation for a subcommittee of our Health Equity and Quality Committee. You may remember we have talked a little bit about the health equity and quality measures that we

have set along with a benchmark. We will be collecting those measures this year for the first time.

One of the things we struggled with a little bit on this committee is behavioral health measures. We only have one measure, and I believe it is depression screening. Maybe in follow-up, forgive me if I don't get the title of the measure correctly, but it is also a measure that we can't collect from our behavioral health plans. And so there is definitely an interest to add some measures specific to behavioral health. So, we will be convening a subcommittee. We are really looking for those with lived experience, those that are providers, and in particular anyone that is familiar with behavioral health quality measurement. We have adopted HEDIS measures, but I think we may need to look outside of HEDIS measures and the NCQA measures for behavioral health. So, we are really looking for those with expertise to participate on this subcommittee. Likely two to three meetings, at least, with the goal of making a recommendation to the larger Health Equity and Quality Committee that we would reconvene at some point next year. They would then adopt new behavioral health measures to add to our measurement set going forward. So, excited about that work continuing, but if you know someone who has expertise, particularly in behavioral health measurement or lived experience. We will make sure we share that. It will be posted on our website, but please pass that on.

And then again looking ahead to next year. AB 2767 was signed by the governor in July, and it will expand our FSSB board membership from 7 to 11 members. It also adds two eligible categories including consumer advocates and individuals with training and experience in large group health insurance purchasing. So, we will talk more at our next meeting about that process to add

some new members, so looking forward to a bigger group.

And that, I think, wraps up my update. I probably took us off schedule a little bit, but I am happy to take questions from the Board and the public.

CHAIR RIDEOUT: Thank you, Mary. One housekeeping thing. I failed to ask for members of the public, any comments on either the meeting minutes or the transcript. I want to make sure I ask for that, kind of going back to Item 2. Hearing, none, okay.

And I would also like to acknowledge that Mark Kogan joined very early in the process. Mark, do you want to introduce yourself real quickly for the record. Mark, I think you are still on mute.

MEMBER KOGAN: Apologize again. Sorry for being late. I am a gastroenterologist in the Berkeley area, private practice, and happy to be here.

CHAIR RIDEOUT: Thank you, Mark.

So, turning to the Director's remarks. Are there questions or comments from committee members, starting with those in the room? Paul.

MEMBER DURR: Mary, I think a great overview, I always appreciate your perspective on things. You now, it comes to mind with the average rate increases being 7.2% and I think what we are all seeing is that that's a need from the provider community because of the -- whether it is the acuity or the benefits that the patients have, and then the essential benefits that are going to be there. How is that going to balance with OHCA and trying to get to that 3.2% or 3.5%?

MEMBER WATANABE: That seems to be the topic of the day lately and we are getting lots of questions about that, and there is a requirement

for us to consider that in our rate review process. There's more that encompasses that 3.5% spending target than just premiums, but I think it -- this actually may be a topic for us to discuss, you know, at a future meeting too. It is just how we consider that. I know there's a lot of work and future guidance coming out of OHCA, so we are looking forward to working closely with them on that too. But I think that it is an issue that has come up quite a bit as we talk about adding new benefits and what the cost will be. As you can imagine, there is a lot of desire to add benefits and we don't have unlimited room to add, but we also will need to consider the impact of premium, so that will be part of the, I think, the decision and the opportunity for public comment as well.

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

Okay, we will move to committee members on Zoom or the phone. Any questions for Mary or comments? Jared.

MEMBER MCNAUGHTON: Hi there, thanks so much. I really appreciate the update, Mary, that was great to hear, and just always appreciate just the information.

I have a question that is -- actually I don't know a lot about, so I just will put that out there first, so I might need a little help from my team later. But we, I know, have been noticing, at least in our market, on the benefit side for behavioral health, especially for BHT therapy programs, just a unique difference between what a covered benefit is on the Medi-Cal side of the house versus on the commercial side. And so when folks are moving between these spaces, I am just curious if the Department is looking at that at all or your thoughts on that. I just would love to learn a little bit more. We were just talking about it yesterday,

so that is why it is all so fresh. And I don't even know the right question to really ask, except we have just been noticing these, just these chasms of difference between those two worlds, if you will.

MEMBER WATANABE: Yes, no, I appreciate you raising that, Jared. It is actually, I think, something I have spent a tremendous amount of time over the last few years talking about. We actually have an initiative that was part of, I think, the governor's behavioral health reform, for us to actually do some analysis. We have actually been working with the Department of Health Care Services over the last year to do really a deep dive to fully understand what those differences are. I think many of you, like me, have heard about, you know, if you have a serious behavioral health condition, figure out how to get into Medi-Cal because you get something different and better. So, actually, Dan Southard, our Chief Deputy Director, has been leading the work here, where we are kind of getting to the kind of tail end of doing that analysis.

I will say, and Jared, you may appreciate this. Some of this is what we have, I think, historically, called wraparound services, intensive case management. There are services that are covered through Medi-Cal, primarily at the county, that are not typical health care services, so support for employment or housing. So, there are some things that I think, you know, we probably will never cover on the commercial side, but I think we are really digging and trying to understand what those differences are. And hopefully, you know, ultimately leading to potential recommendations on where there should be alignment.

But, Dan, can I put you on the spot? I don’t know if there is anything else you want to add about the work you have been doing.

MR. SOUTHARD: Yes. I think the only other thing that I would add

is who is providing the services. So, at the County Behavioral Health Plans, a lot of what are traditional non-providers in the commercial world, because they are not licensed or particularly certified. So, examples would be community health workers or case managers. Really provide a lot of services in the Medi-Cal side. So, we are looking at how do we align that on the commercial side too. Mary covered this pretty, her overview was pretty substantive, so I don't have anything further to add there. I think we will probably be discussing this in a public forum, probably in the next quarter.

CHAIR RIDEOUT: Thanks, Dan. Would it be helpful at all if our team shared any data on this or what we are seeing, or if you folks feel like you have got all that that you need already?

MR. SOUTHARD: Chair, more than happy to receive any information you would like to share. You can send that directly to me.

CHAIR RIDEOUT: Thanks so much, Dan.

Are there other questions or comments from committee members?

One that I would have to add to this is that with AB 2767 expanding the number, does it change the charter of this committee? Because even the two questions from Paul and Jared are technically outside the charter of this committee.

MEMBER WATANABE: Yes, I don't believe it did. And again, I think, you know, the purpose of the Board has always been to advise on financial matters, but we have also brought, I think, the kitchen sink here. There has been a lot of interest just in the other activities of the Department. I think I could probably make the case that all of it ultimately has some financial impact. So, I think the charter pretty much stays the same but adding some new

representatives. And again, we have had, thank you, Abbi as a consumer representative. We have historically tried to have a consumer representative. But this formalizes that category. And then, obviously, a large group purchaser will be an addition as well.

CHAIR RIDEOUT: All right. I would like to turn to the public, first those in the room for questions or comments. Seeing none. Actually, I can see the public.

Now turning to either Zoom or telephone. Do we have any questions or comments?

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

CONCERNED CITIZEN: Yes, hi. So, I would like to make a public comment. This meeting is about financial solvency. I don't know what my time frame is, however.

CHAIR RIDEOUT: Excuse me. Can you identify yourself by name and any organization you are affiliated with, if you are comfortable doing that.

CONCERNED CITIZEN: I did not identify because, obviously, I did not want to. So, I would, I would like for this Board to respect my, my wishes and continue respecting that.

CHAIR RIDEOUT: That’s fine. Just want to make sure we didn't miss it.

CONCERNED CITIZEN: Okay with that being said, so, I don't know what my time frame is. And then, this meeting is about financial solvency, correct? And how you, you know, allocate funds and pay off your debts and things of that nature. One way that you guys could actually come together is

ensuring that the Department of Managed Health Care actually goes after insurance companies each and every time that issue is brought to your attention. And there is a way for you to enforce those policies that you set forth, of which there has been multiple times where you failed to do that. Where you failed to go after an insurance company for lying in their grievance responses, not providing the grievance responses in a legal timeframe, manipulating the responses, omitting pertinent facts, and things of that nature.

I think that it is imperative that if an agency is overseeing these insurance companies, and an issue is brought to your attention and then you fail the constituent to do your part of the job, it becomes a systemic issue that -- to which the constituent is feeling like there is no hope. A constituent should never have to go to your location, downtown Sacramento, wearing a body camera and discussing these issues to the representatives with the Department of Managed Health Care after repeatedly discussing these issues, calling in on the phone.

Speaking of calling in on the phone, trying to discuss and talk about the issues on the phone, being met with nothing but -- being told that, oh, because you are recording the phone call we are going to disconnect the call. The problem with that is, is that when the constituent is calling your place to get help, to get some guidance on the issues that they have with the insurance company, you are already recording the phone call. And because you are already recording the call, although California is a two-party consent state, there is no expectation of privacy.

So, when a constituent calls you, when a constituent goes online and files a grievance or a complaint form, and they are contacting the very agency that it is set in place to assist that constituent in any issue that they have

with their insurance company, through whether it may be through HMOs, Medi-Cal, and you turn around and you do the things that you do by not aiding, by not helping, by turning that constituent away, how you can get your money? Because I know that you get your money, and correct me if I'm wrong, by each time that you fine and go after these insurance companies for the -- the -- the things that they do, or for the thing that they don't do. Lack of services, lack of support, lack of being able to handle grievances correctly.

CHAIR RIDEOUT: So, can I first of all acknowledge your comments and your concerns. I think we also cannot verify the accuracy of each of the statements you have made, but I would like to give the Director a chance to respond you.

CONCERNED CITIZEN: So, I just want to say one thing. I know that you can't confirm the accuracy because I am just now telling you and it is probably your first time hearing this. But Sarah Ream, your Director Mary Watanabe, and a lot, a plethora of individuals within your department will know what I am addressing. And again, let me not -- let this statement not be underheard. Each and every call --

CHAIR RIDEOUT: It is clearly not underheard. My comment was that you have made a lot of statements about the actions of the Department or the failures of the Department.

CONCERNED CITIZEN: Correct. Correct.

CHAIR RIDEOUT: We understood that that's your position. As committee chair I can't confirm or refute any of those, and that is not my role.

CONCERNED CITIZEN: Would you like for me to give you, would you like for me to give you --

CHAIR RIDEOUT: Hang on. Hang on.

CONCERNED CITIZEN: -- the calls?

CHAIR RIDEOUT: Hang on. Hang on. What I would like to do is give the director of the department, Mary Watanabe, who you just referenced, a chance to respond to that to understand whether this is the right forum for those concerns or not.

CONCERNED CITIZEN: Well, I mean, this is financial solvency, correct? So, how you can --

MEMBER WATANABE: Maybe if I can just jump in here. I think we are well familiar with you and your concerns. I will just add, so this Board oversees the financial solvency of the health plans. As you have noted, there are financial issues related to the department. So, the Department is actually funded on assess -- based on assessments of the health plans, not on enforcement actions. Dan is actually going to talk in a few minutes about our budget and our assessments. But I appreciate you calling in and for your feedback to the Board. With that I think, Jeff, we can move on.

CHAIR RIDEOUT: Okay, are there other individuals either on the phone or on Zoom that would like to make a comment or have a question?

MR. STOUT: There are none at this time.

CHAIR RIDEOUT: Hearing none I think we will close this section and move on to the next topic, which is an update from DHCS. So, René and Rafael, if you are, I think both on Zoom, take it from here. And I'm sorry we did cut into the time just a little bit.

MS. MOLLOW: Not a problem. I think Rafael is going to start for us.

MR. DAVTIAN: Yes, good morning. Thank you, René. Good morning. So, Rafael Davtian, Deputy Director for Health Care Financing. I will start off. I will start off today's presentation for us and then René and I will, we will pass back and forth once or once or twice on some topics.

So, we are looking today to share, share some updates regarding the Medi-Cal budget, talk a bit about some changes to the Medi-Cal program, and then at the end do a bit, a bit of a deep dive on the Managed Care Organization tax and the targeted provider rate increases that are funded using MCO tax revenues. Next slide, please.

So, if we dive, if we dive straight into budget updates. There were a lot of, a lot of items, a lot of changes within, within the budget. I will not attempt to, I will not attempt to try to cover, try to cover all of them, all of them today. I will focus on some select, select highlights. There is -- our Medi-Cal, the Medi-Cal budget is about a 1,000 page document overall every six months so I will focus on some of the, the key, some of the key changes, some of the largest changes, and some of the changes that are, may be of most interest to folks.

So, one of, one of the key, key areas within, within our budget, of course, is related to behavioral health transformation. Which supported by, supported by Prop 1 which passed in March, in March of this year, is intended to improve access to, access to behavioral health care, increase transparency across a variety of domains, and expand, expand treatment for behavioral health services. There are a lot of components to, to behavioral health, to the Behavioral Health Transformation or BHD initiative. I will focus just on a, I will focus on a few key items that are, that impact the DHCS budget.

Of course, there is the Behavioral Health Services Act, which

modernizes and reforms the preexisting Mental Health Services Act. It provides, BHSA updates funding for behavioral health to provide services to those with the most serious illnesses and also to, to cover treatment of substance use disorders.

It modernizes county allocations, requiring prioritization of county funding and encouraging innovation in a variety of focus areas including housing interventions, full-service partnerships, and a range of state-led investments in areas such as population-based programming, workforce investments, and improved statewide outcomes.

Part of BHT is also the Behavioral Health Infrastructure Bond Act, which, again includes a, includes a number of different components, but specific to, specific to DHCS. That includes approximately 4.4 billion in bonds for DHCS to support new behavioral health treatment beds as well as outpatient capacity that can help serve tens of thousands of people each year.

And finally, the budget includes initial funding for both state and county implementation on the order -- you know, taken together, on the order of about, about $200 million starting in ’24-25. Next slide please.

The budget also includes changes related to the Children and Youth Behavioral Health Initiative, which is a key component of the Department strategy for addressing and improving behavioral health -- addressing behavioral health needs and improving behavioral health outcomes. In this instance, focused on our child and -- child and youth populations. As part of the initiative, or CYBHI as we call it, we are required to establish a statewide all-payer fee schedule to reimburse school-linked behavioral health providers who provide services at or near a school site. And related to, related to this, related to this

work there, the department is pursuing a third party, a third-party administrator to, to help manage and operationalize, operationalize this fee schedule.

We are -- as part of CYBHI the budget also includes a new wellness coach benefit that is effective July -- January of 2025, as of which wellness coaches will primarily serve children and youth operating as part of a care team in school, in school settings or school-linked settings, and providing core services such as wellness promotion and education screening, individual or group support, care coordination and crisis referral. Next slide, please.

And then finally, well, not finally for the budget but finally for the, for the slide deck, for the, for the slides. The budget includes new or increased directed payments to children's hospitals and to public hospitals. We are also pursuing increases to directed payments more broadly, for non-public hospitals as well. But really the budget included significant investments in, investments in hospital care and access for Medi-Cal members. Leveraging directed payments as a, as a mechanism, as a vehicle in our managed care delivery system to provide, provide these, this increased funding to hospitals that provide critical inpatient, emergency or outpatient services, to our members. And in the case of some of our public hospitals, even, even professional services that are provided as part of the larger health system.

And then lastly, I will note the budget includes funding $200 million over a three year period to support California's Reproductive Health Access Demonstration, which, which serves, which is pending, pending federal approval but serves a number of purposes. Primarily supporting access to family planning and related services for members, supporting California's reproductive health safety net, and then encouraging and really driving system, system and delivery

transformation among those safety net providers. Next slide, please.

I do want to acknowledge the, you know, the items I covered on the previous slide are things that we are very excited about, things we are very excited to to be implementing, to be pursuing, in some cases to be continuing to pursue even, even in spite, even despite, in spite of a challenging budget situation, as we all know. I do want to acknowledge there were a number of budget solutions and reductions or eliminations that were, that did impact the Department. I won't go into, I won't go into these in detail. But of course, the Department did, we did take steps to be part of the overall statewide, statewide budget solution looking to, looking to make changes. And in some cases, making or make reductions or delay, delay implementation of programs. Or just be more creative about some of our programs while, while maintaining the goal, while maintaining that goal and maintaining the focus on providing continued coverage and providing continued core, core services to, to our members.

And I believe that is the last slide so I will, René, I will hand it over to you.

MS. MOLLOW: So, thanks, Rafael. Hi everyone. So, again, I am René Mollow. I am the Deputy Director for Health Care Benefits and Eligibility here at the Department of Health Care Services, so my team oversees benefit policy development for all Medi-Cal benefits, with the exception of individuals with mental health, you know, severe mental health issues, substance use disorder services, and then children with special health care needs. But all the other Medicaid benefits fall within my portfolio here in the Department and then we do all things eligibility. So, I will focus and share a couple of the things that I think are of interest to the committee.

So, one, really wanted to highlight the work that we had been doing over this past year as it relates to the Medi-Cal redeterminations. So, we finally ended our continuous coverage unwinding policy as of May 31st of this year. We had over 13 million renewals that we had to do. This does exclude certain populations because our caseload is still hovering around 15 million or so individuals. But it is 13 million individuals that were subjected to the renewal policies that we had to implement at the end of the public health emergency unwinding.

So, as of June, again, this is a snapshot of our data. The 88% of all renewals have been completed. And then the remaining renewals are those that came in during the months of March through May of 2024 and we still have people that are in what we call the cure period. Meaning, if they were required to do a renewal because we could not do it with existing information that our county partners had and they had to reach out to the individual, and if the individual was nonresponsive and they were then discontinued from coverage, individuals would have a cure period, which is 90 days from the end date of their eligibility to then resubmit the information to the county partners. And within -- if they do submit that information within that 90 day cure period, it is still considered to be timely and then their coverage would be reinstated back to the month in which they had lost their eligibility. So, it doesn't matter which -- you know, like if they came in the third month, as long as it was within that 90 day cure period it will go back and retroactively reestablish eligibility for those individuals. Next slide, please.

So, in looking at our work over the course of the year, there was a lot of work that we did as a result of federal flexibilities that helped to minimize the burden for the renewals, for both our county partners as well as for our Medi-

Cal members.

So, one of the big things that we had observed because of federal flexibilities that we were able to implement, we saw our Ex Parte rates, which means the county partners have the ability to look at existing information in their files to then renew a Medi-Cal member. And to the extent that they don't have the information that they need, which is primarily income, then they have to reach out to the individual to get that information. But with some of the work we were doing initially, our Ex Parte rates were about 35% from the months of June to November, and then they increase up to approximately 66% from the last part of 2023 going up through May.

And it was because we had federal flexibilities in order to help us in terms of increasing our Ex Parte rates for our members. So, that meant we went from 35% of people being able to be automatically renewed by our county partners up to 66%, so then the delta are the people that the counties had to reach out to. This also helped us to have higher Ex Parte rates for our seniors and persons with disabilities, because typically those are the populations where we have to do an outreach to get additional information about their income. So, that really did help us in this space in terms of helping to maintain coverage for people who otherwise may have lost their coverage because we did not have the necessary information to make an eligibility determination on their behalf.

In terms of looking at disenrollment rates, because of the federal flexibilities that we were able to implement; and California had received 17 federal flexibilities. And of those flexibilities, the ones that really helped us had to do with individuals with either zero income that was reported, or individuals with incomes up to 100%. And we could use historical information on their income to

then renew their Medi-Cal eligibility. And this federal flexibility dealing with income based upon either 0% income where the person reports no income, or they have an income up to and including 100% of the federal poverty level, those policies became automated in the county eligibility and enrollment systems and that really helped to significantly reduce the numbers of individuals that were otherwise disenrolled for what we call procedural reasons. Meaning, we didn't have information on them, the counties reached out to them, did not hear back from them, and then they had to discontinue them from coverage. So, we went from about 18 to 22% individuals being disenrolled for procedural reasons, because they did not return that information to us, to approximately 8 to 10%. Again, during the latter part of the year up through May for the discontinuance, you know, for the unwinding policy.

So, approximately when you look at our caseload in total, we disenrolled approximately 1.9 million individuals through the continuous coverage unwinding. This information is also posted on our website. We do monthly reports of the unwinding and what we were seeing as we were going through that 12 month period. Even though the unwinding has now ended, we will continue to do those monthly report-outs in terms of looking at our populations and how the counties are progressing with the renewals of Medi-Cal members. So, next slide please.

In terms of policies that were new for this year for the Medi-Cal program. One that is really important I think to our plan partners is the Medi-Cal New Adult Expansion. And so again, on January 1 we implemented our new adult expansion, which included individuals between the ages of 26 to 49 years of age without satisfactory immigration status, who now would be enrolled into

full scope Medi-Cal coverage to the extent that they otherwise meet all other eligibility requirements for the Medi-Cal program.

So, on August 1 we did publish our data sets for this expansion, and this was our last of our coverage expansions. We first started back in 2016 for children, and then over the course of the past several years we have incrementally increased the coverage of populations without satisfactory immigration status into Medi-Cal. And we have reported it on the Open Data Portal, the numbers that were enrolled as a result of this New Adult Expansion. They are noted here on the slide, and we will continue to report-out on the enrollment numbers on a go-forward basis for all the expansions that we have undertaken. We do report-out on the numbers actually in the Open Data Portal, that's through the agency data. Next slide, please.

And, oh, the one thing I will say -- it was on the slide, on the prior slide. The populations that were covered through this new coverage expansion, they are mandatorily enrolled into managed care. And so they went into the managed care plans based upon their county of residence. There had been extensive outreach and education done for the populations prior to the actual expansion taking place. Next slide.

A couple of other notable policies that also went into effect for Medi-Cal is we also eliminated assets for all Medi-Cal members, effective January 1, 2024. We had done some incremental steps towards asset elimination. First, we had raised the asset limit; and now we have actually effectively eliminated the asset limit. So, again, it brings some parity to our seniors and persons with disabilities when you are looking at how we look at their income eligibility for the Medi-Cal program. So, we just look at income, we look

at residency for purposes of establishing Medi-Cal eligibility here in our state.

We also, unfortunately, and as Rafael had indicated, we did, sunset Health Enrollment Navigators. Again, that was part of the budget solution. We did recognize the effectiveness of the Enrollment Navigators in terms of helping people to apply for and maintain their coverage, but it was one of the difficult decisions that we had to make in terms of looking at things for solutions in terms of closing the budget gap.

We also implemented on July 1 two new portals for presumptive eligibility. One is a Children's Presumptive Eligibility Portal. This came about because of the elimination of the child health and disability -- Child Health, Disability and Prevention program, where we made some significant consolidations and restructuring of that program. Moved a lot of the CHDP program into our managed care plans in terms of their responsibility for the members that they cover. But one of the things that we developed and enhanced upon was a Presumptive Eligibility Portal, meaning for individuals coming into medical offices.

And we expanded the populations, the provider populations, for those that could do presumptive eligibility as a result of this. So, we have a new portal, there's expanded providers that can participate in the Presumptive Eligibility program. And this allows children who may present in medical offices, clinics, hospitals, whereby if they are within the income limits of the Medi-Cal program, they can be granted full scope temporary Medi-Cal coverage pending an application for the Medi-Cal program. We are working on getting data in terms of what we are seeing as a result of the implementation of this new portal.

We also have the Newborn Gateway Portal that became effective,

July 1. And the Newborn Gateway Portal is a way for us to help better capture newborns that are born of mothers who are involved in the Medi-Cal program. And so this is a Newborn Gateway for, you know, hospitals, birthing centers, providers that have knowledge of the birth of the child, and to report that so that the identification of the child can then be readily established. Versus it being delayed, which is what we have been seeing over the course of time.

There is also a proposal for continuous coverage for children ages zero up to five years of age. That will be contingent upon the ballot initiative that is going out in November in terms of if that policy is able to move forward or not.

And then also we are still continuing to leverage the federal flexibilities that we had received under the continuous coverage unwinding, and of importance are the zero income and the incomes up to 100% of the federal poverty level. Those are still being leveraged at this point in time. And the federal government did give states the options to maintain these federal flexibilities through the end of June of 2025 and at this point California is still continuing those policies. If there's any changes then, of course, we would do all appropriate public noticing regarding those changes. Next slide, please.

And I think now I get to turn it back over to Rafael. Rafael.

MR. DAVTIAN: Thank you, René. So, one of the, one of the key components of, one of the key items within the budget that I did not talk about earlier is the, is the MCO tax and the targeted provider rate increases and investments supported with, with the tax. So, we will spend the next few, next few minutes and the next few slides sharing information about changes to the MCO tax that was, that was approved last year, as well as, as well as changes to the plan for, for targeted provider rate increases supported by the tax.

So, as folks may be, may be tracking, AB 119 last year authorized a renewal of the managed care, of the MCO tax for an effective period of April 2023 through December 2026. We requested federal approval of the, of the tax last year and obtained, obtained that approval in December, and started, of course, to actually implement and collect the tax.

There were subsequent amendments to the MCO tax structure that were authorized through SB 136 and AB 160 both this, both in 2024. That increased the amount of the tax applicable to Medi-Cal lives and we have submitted an amendment request or modification request to our federal partners seeking approval of those, of those amended amounts. Next slide please.

In total, the tax represents a significant source of revenue for California over the next, over the next several years, with the majority of, with a portion of that revenue being used to support increased, increased managed care capitation payments that are necessary to account for the, for the Medi-Cal impact of the tax. But the bulk of the dollars, most of, most of the dollars being used either to, either to help support and sustain existing services and coverage in the Medi-Cal program. As you can see, about 18 or 19 billion dollars of state fund support in this fiscal year and the next two fiscal years, as well as to enable the Department to implement augmentations to various rates and rate methodologies, or to make other investments to the, to the tune of over, over $2 billion of new investments starting, starting In January of 2025. Plus, sustaining the investments that were implemented last, last fiscal year, which I will, which I will talk about in a moment.

In addition to these, these Medi-Cal rate-specific investments, the budget also includes a $40 million one-time allocation in state fiscal year ’26-27

to support, to support Medi-Cal workforce development and retention efforts. And that is, that is one of the out years, out year items that is also, also reflected within or also included within the total investments supported by the tax.

I do want to note that the MCO tax package, the new investments are conditioned, conditioned in the 2024 Budget Act or linked to, rather, the passage of Prop 35 on the November 2024 ballot, such that if Prop 35 passes, the '24 Budget Act package for the MCO tax would become inoperable as it is, as it is not feasible to fiscally sustain both. Next slide please.

So, the 2024 Budget Act, as I mentioned, maintains investments that were implemented, investments and rate increases that were implemented last fiscal year with, with the prior budget. That includes investments, investments in hospital services to the tune of about $200 million for the Distressed Hospital Loan Program and for Small and Rural Hospital Relief, and additional investments of about $300 million annualized, state funds only. But there is a corresponding federal share to those. But about $300 million state funds to increase rates for certain targeted services effective January 2024 to no less than 87.5% of the lowest Medicare, Medicare rate locality in California. And those increases apply to primary care services including both physician and non-physician professional services, to maternal health, including OB and doula services, and to non-specialty mental health care. Next slide please.

Effective January of 2025 the budget authorizes new, authorizes and funds, new rate increases in eight categories, including ED service, ED physician services. We are, we will be implementing or increasing the reimbursement for these services to be benchmarked to 90% of the Medicare rate.

There are -- we will be making investments in reproductive health and family planning to the tune of about $90 million a year on an annualized basis.

We will be increasing rates for community health worker services to benchmark those, benchmark reimbursement for those services to 100% of Medicare starting in 2025.

Making additional investments, or rather providing rate augmentations for both ground emergency medical transport services, or at least select GEMT services and for emergency air medical transport services. And these will, these increases will not only, not only be the rates that we operationalize in our fee-for-service delivery system, but also rates that we require our managed care plans to pay. They will, in effect, the increased reimbursement rates will become the new Rogers rate for reimbursement of non-contract emergency and post-stabilization services.

And then lastly, investments in the, in the space of community-based adult services, congregate living health facilities and pediatric day health centers.

The combination of all of these investments represents close to $270 million in state funds on an annualized basis, significantly more once we account for the federal match. And these increases will be, will be implemented both in our fee-for-service delivery system and in our managed care delivery system as, as applicable. Next slide please.

In the next fiscal year starting, well, starting January 2026 on a data service basis, we will be implementing another round of rate increases and investments in -- across four primary categories. The largest of these is, are

increases to or additional increases to physician and non-physician professional health services, particularly building upon the investments, the investments that we started in 2024 for primary care, OB and non-specialty mental health, but particularly also expanding, expanding the scope of rate increases to include specialty care.

Unlike the approach that we, we took for, we took this year at the start of 2024, these rate increases will no longer be benchmarked to the lowest Medicare rate locality, but will be benchmarked to the, to the appropriate or to the applicable Medicare rate locality. And so we will be introducing in 2026 a geographically varied rate structure for these, for these services, where rates will be, rates for these applicable services will be benchmarked to between 80 to 95% of the Medicare rate applicable in that, in that specific locality where the services are being provided. In addition, as part of 2026 we will be introducing that geographic variation for other categories, for certain other categories of rates that were covered on previous slides including, for example, for ED physician services and for community health worker services.

Of these investments, these investments for primary and specialty, that's primary and specialty care, physician and non-physician professional services, amount to close to about $2 billion annually in total fund, total fund increases across both our fee-for-service and managed care delivery systems. In addition to these we will be making augmenting, augmenting payments for services and supports provided by federally qualified health centers and rural health clinics starting in 2026 to the to the tune of about 50 million state funds annually. And further invest -- and investing further in rate augmentations for private duty nursing services and nonemergency medical transportation services,

again, both across our fee-for-service and managed care delivery systems.

And then finally, not a rate increase but still something, something very important funded, funded using these MCO tax, tax revenues. Starting in 2026 the budget, the budget allocates funding to enable continuous Medi-Cal coverage for children until the age of five. That is a change in coverage, of course, not a rate increase, but also something we are very, very excited about as a matter of, as a matter of policy and as a question of coverage for and access for our members. Next slide, please.

And that is it. So, happy --

CHAIR RIDEOUT: Thank you, Rafael and thank you, René for a very comprehensive overview.

I will start with committee members in the room with questions or comments. Paul.

MEMBER DURR: Yes. Rafael and René, very wonderful presentation, thanks for the nice overview. I have a couple of comments and a couple of questions.

So, first, I can't help but continue to think about increased mandates, which increases the overall cost. And it just came to me, is there a joint effort between the Department of Managed Health Care and DHCS to educate our legislators about what they are creating on the impact from a financial viability standpoint? So, we want to balance the overall cost increase, but we are continuing to increase benefits, which are good; but just wonder if the legislature and the people there truly understand the downstream impact of what that means from a cost perspective. So, just an idea about education sessions for the legislature generally.

I think the overall increase in the re-enrollment I think was fabulous. I think you pointed out, René, the overall trend, that where you started and where it wound up you learned, and you got better at it. And I just think publicly you should be complimented for that great effort to change probably what started, to evolve it to something that became much more effective. So, my compliment to you and the team for recognizing how we can do things differently. And I don't think you get compliments enough so my compliments to you on that great work.

MS. MOLLOW: Thank you.

MEMBER DURR: My other thought is, with the change with regards to the expansion for adults, that is a great thing, but has anyone looked at the overall cost impact to that? I think that might be more difficult, but it would be an interesting thing because these are undocumented people that probably were going to the ED but might be something to study at some point. Maybe get an academic association to do that, or something, that might be an idea.

And then last point, Rafael, is on the MCO tax dollars. That's great. My question is, are the dollars getting to the providers?

MR. DAVTIAN: I am happy to answer that, your last specific question. So, the -- as we, as we look at, as we look at how to operationalize those, those rate increases, we will be, we will be implementing them, the majority of them, in both the fee-for-service and the managed care delivery systems. In the fee-for-service delivery system the payment is, of course, directly to the provider so the payment, the payment increase is seen directly by the, by the provider. In our managed care delivery system, we do not pay the providers directly. We pay the managed care plans, and then managed care plans contract with and pay providers, or in some cases, pay providers on a non,

on a non-contract basis. And as part of, as part of implementing these, these rate increases, we do, we do plan to leverage directed payment mechanisms, in many cases, to specifically direct managed care plans to, with respect to the, to the payments for these increases or at least the payments related to these rate increases, so that we have, you know, we have assurance that the money, that money makes it to the providers rendering services.

MEMBER DURR: Yes, thank you for that, Rafael. I think it is important that your contracts with those plans mandate the payment downstream going to the providers. I think that is the only way that it won't stay at the plan, but we will get to the providers. So, I appreciate your thoughtfulness on thinking ahead on that.

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

MEMBER SEIDENWURM: Yes, I have a question. Going back, my understanding with the MCO, well, excuse me, with Prop 35, is that merely makes the MCO tax permanent. And my question was, in one of your slides you had the thing saying if that passes that would make some of your changes there inoperable, and I am not sure I understand that.

MR. DAVTIAN: So, the MCO tax package in the 2024 Budget Act is, is written to become, to become inoperable if Prop 35 passes. Prop 35 in addition to, in addition to extending or essentially continually renewing, renewing an MCO tax, also includes provisions related to, related to the allocation of MCO tax dollars that are, that are different from, different from the, that are different from the components, the components or the domains that are funded in the 2024 Budget Act. And so there is a -- Prop 35 would require, would require a

different use of those MCO tax revenues than what is, what has been included in the ‘24 budget, 2024 budget.

CHAIR RIDEOUT: Rafael, I am hesitant to ask for a follow-up, but it might be good for this committee to see a bit of a side by side on -- because you have given us a nice list of what DHCS is planning to do. It would be nice to know which ones stay and which ones go. Is that, is that reasonably doable?

MR. DAVTIAN: I am happy to take that back for us to look at.

CHAIR RIDEOUT: Thank you.

David? I’m sorry, Mark, did you have any other follow-up on that?

MEMBER KOGAN: No, I think that was actually, thank you, exactly what I would have requested is a side by side so we could see where the differences would be.

CHAIR RIDEOUT: David.

MEMBER SEIDENWURM: Yes, there we go. With respect to the individual Medi-Cal members, I am curious if there are any possible adverse consequences that might occur if they were auto-enrolled, for example, with a historical income that was a qualifying income, and then perhaps got a job or some other source of income. Would there be some sort of, any kind of penalty that that person might be subject to, or any other sort of difficulty they might find themselves in?

And similarly, with the elimination of the asset test, are there any sorts of fee recaptures that someone might be subject to without knowing what they were necessarily signing up for?

MS. MOLLOW: So, so David, thank you for that. You faded out on your second question.

MEMBER SEIDENWURM: The second question was regarding any similar recapture or other consequences that might occur with the elimination of the asset test for enrollment?

MS. MOLLOW: None that we are aware of. So, on both sides. So, the first question was about the use of the flexibilities, I believe, in just if people's income changes. Did I understand that first question correctly?

MEMBER SEIDENWURM: Yes.

MS. MOLLOW: Yes. So, the way Medi-Cal works today, we look at current income. I know Covered Cal looks at income from a year in arrears. And so we would, you know, as people are looking at say if there's any tax implications we would validate that, you know, they had credible coverage through the Medi-Cal program for the months in which they had eligibility. People can always, and we have had this happen to us, people will actively raise their hands to say that they want to come off of the Medi-Cal program. But even with your higher income, you can still be eligible for Medi-Cal, it is just that you then fall into what we call share-of-cost Medi-Cal and then you have to, you know, meet your share of cost before Medi-Cal starts to pay any of your medical bills. So, people can still do that. But we still do have a share-of-cost Medi-Cal program for individuals. But people, you know, as we have gone through the process of all the transitions, individuals always have had the ability to say, I want to come off of your program; and then we would oblige and pull them out of the program.

And then the assets, you know, as we looked at asset tests and all. Again, it, you know, over time and for all the changes that we have made in the eligibility space, we have found that it was more of a burden for our members,

because if they were over assets they would have to spend them down before they could come into the Medi-Cal program. And we just found that over time we have been looking at ways in which we can create efficiencies and lessen the burden for people. Because if they are eligible, they are truly eligible. But some of these policies that we have had in place, which again date back to when the program was first implemented, which was back in 1966. So, we have just tried to course correct some of the antiquated policies that we have used in terms of administering our program. And trying to help people be more aligned as we are looking at the actual income limits as a way to help people determine if that is the that would be more of the defining line for eligibility versus not, versus looking at the use of assets.

CHAIR RIDEOUT: Are there other questions from committee members? I don't see any raised hands.

I had just two quick ones. Rafael on the notion of the lowest Medicare rate in the state. Can you give us a range of what the lowest/the highest looks like right now? Because I know you are going to adjust that geographically, but I am curious. Putting everybody in the lowest category is not 87.5%, necessarily.

MR. DAVTIAN: It depends, or it varies, rather, from each, from procedure code to procedure code. There, there is, there is a different range that we see. But it is, it is not uncommon for us in some cases to see, you know, a difference of anywhere from, you know, 5 to 10% to sometimes 20 to 30% for a particular procedure code between the lowest, lowest Medicare locality in California and the highest Medicare locality. Currently, currently and for 2025 these, you know, with these codes, we will be looking, looking to benchmark at

the, at the lowest Medicare rate. I guess technically it is, you know, the lowest Medicare rate with a hold harmless. Meaning, if our, if our rate is higher than the lowest Medicare rate, we will still maintain our rate. But as of 2026, yes, we will be looking at the locality-specific rate for each of these affected procedure codes.

CHAIR RIDEOUT: Thank you. René, on the 1.9 million. Also compliment the process improvement that is obvious in this. On the 1.9 million that were disenrolled. Any surprises on that by category? I am assuming that is no longer eligible because of income or moved out of state or death or something like that.

MS. MOLLOW: No. What we see and what we had seen prior to the public health emergency, and even with, you know, before some of those flexibilities were fully operational, meaning being automated. Because of the 17 flexibilities, we got the biggest bang for our buck, so to speak, with the income flexibilities. But the highest number of disenrollments are due to procedural reasons. So, most people do not -- they lose their coverage because we never heard back from them. And again, we have that cure period that even within that cure period of the 90 days, we see about 3 to 4% that may come back, but that tracks to historical experience in the Medi-Cal program. And historically, that is also seen in other -- across state Medicaid programs. It is not -- we do have the numbers that are lost for income purposes because they are over income, and in those instances those individuals, we have processes in place because of SB 260 where people were then transitioned over to Covered California to be assessed for their various plans for individuals based upon what their incomes are. But it is not, it wasn't surprising to us. It just, you can now really see it in the data, and it is something we are reporting out on. But historically, in California

and nationally, procedural discontinuance's rate amongst the bulk of why you see people being disenrolled from Medicaid programs.

CHAIR RIDEOUT: Thank you. Jared, I think you have a question. I'm sorry if I missed you.

MEMBER MCNAUGHTON: No, no, no, I just rose my hand, thanks so much. I just wanted to just give a shout-out to René and Rafael both for just their incredible support of the program. From the public plan perspective on the Medi-Cal side, they have just been phenomenal supporters, sharing best practices from René's team on the whole eligibility process, the partnership with the counties, how to do it the best possible way. It has just really been a refreshing time where -- one of those times where kind of a crisis brings everybody together in a great way and it has really worked incredibly well.

Also just appreciate Rafael and his team's approach to this entire mechanism for provider increases. Behind the scenes of all of this is -- and he didn't get into this at all and I give him props for that. Probably I shouldn't get into it either. But it is so complex. All of the provider contracting that has to take place, the reach-outs that have to take place, the education to make sure providers understand how this entire targeted rate increase works. And the Department has really done, I think, a great job listening to all of us with boots on the ground to share with our providers what some of the real-world applications are of this. I just really appreciate their partnership on it, because both of these items are huge and they both have massive implications for the front line and just appreciate their willingness to be partners on that.

MS. MOLLOW: Thank you.

MR. DAVTIAN: Thank you, Jared.

CHAIR RIDEOUT: Thanks, Jared.

All right, I think that is all the questions from committee members unless I missed anybody. Okay.

So, we will take questions from the public starting with those in the room first, and I see Bill coming up. Please introduce yourself and your organization.

MR. BARCELLONA: Can you hear me now? Look at that echo. All right. Bill Barcellona, APG. Thanks again for your report. Rafael, I had a very quick question for you about the release date of the MLR reporting template for providers. I think you had indicated we'd see it in the beginning of Q2 and I don't think we have seen it yet. Is there a release date on schedule at this point?

MR. DAVTIAN: I will have to confirm, confirm the release date. We are, we are behind schedule in terms of it not, of course, not having gone out at the beginning of Q2. It is, it is something that we are, we are actively working to, working to try to get out within, within the next, the next few, next couple of weeks, to few weeks. I believe there may already be some, I believe there are already maybe some technical assistance sessions that are, are being scheduled or have been, have been scheduled with folks. So, some of the information, some of the information has flown, flown out. I believe there, I believe there are actually some TA sessions as early as next week. Additional information is coming out on a flow basis. But I can follow-up, follow-up, I am happy to follow-up offline with you, Bill, and confirm those particular dates of when specific pieces of information or, you know, templates versus instructions versus guidance documents are coming out.

MR. BARCELLONA: Thanks very much.

CHAIR RIDEOUT: Are there other questions or comments from people in the room, public?

Not seeing any, I will move to any questions or comments from attendees virtually.

MR. STOUT: There is one. When prompted please state your name and organization.

MS. ROCCO: Hi, this is Janice Rocco from the California Medical Association. Given the statements by both of the DHCS speakers as well as some of the questions about the MCO tax and the funding priorities and the impact of Prop 35, I did want to make a general comment to frame the issue for folks who needed more information.

The 2023 MCO tax deal, which set the tax at three times the amount that it had been in previous incarnations of that tax, and then invested at least $2 billion a year into the General Fund, with the remaining funds going into a targeted set of rate increases to improve access to care. That was a deal made between the governor and the legislature in 2023; then in 2024 the governor proposed to sweep away all of that investment. Ultimately, some of it stayed in.

And then in late June the governor proposed adding a few things in that would only be funded if Prop 35 failed. That was a decision made by the administration, not something anyone asked for, and it is a decision that could be undone in January if Prop 35 passes. So, I don't want anyone to end up with the belief that there was anything other than a decision made by the administration to attempt to defund some of these things if Prop 35 passes.

CHAIR RIDEOUT: Thank you, Janice. Is there anything that CMA

is producing to look at what might change if Prop 35 passes?

MS. ROCCO: Yes, we absolutely have information about what will happen if Prop 35 passes. And we are among those supporting continuous coverage for children and would urge DHCS and the administration to actually seek the federal waiver so that it could happen.

CHAIR RIDEOUT: Thank you.

Are there other questions, virtually or by telephone?

Okay. Well again, thank you, René and Rafael, it was great report.

We will move on to Item number 5. Pritika, you are up.

MS. MOLLOW: Thanks.

MR. DAVTIAN: Thank you.

MS. DUTT: Thank you, Jeff. So, I will provide you a quick update on the financial summary of the Medi-Cal managed care report for quarter ended March 31, 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 and highlights enrollment and financial information for local plans and non-governmental Medi-Cal plans, which are the commercial Medi-Cal plans.

We updated this report to account for some of the changes in Medi-Cal contracting and Managed Care Models that went into effect January 1, 2024. So, if you look at the previous versions of the report and compare it to the current version, there are some changes that were made to reflect the changes in contracting and the Medi-Cal Managed Care Model.

You will also notice that throughout the report we are now referring to the Local Initiatives and the COHS plans as Local Plans. The NGM plans are

plans that report greater than 50% Medi-Cal enrollment but are not a local plan.

The report is broken into two sections, first focusing on, focusing on the Local Plans and then the Non-Governmental Medi-Cal Plans. Next slide, please.

So, the next three slides were presented by René at the November FSSB meeting, so they are borrowed from her, and these highlight some of the changes effective January 1, 2024, that impact the Medi-Cal managed care plans enrollment and financial, so these impact the plans that we oversee.

Also, there have been some changes to the counties these plans are serving. So, the DHCS entered into contracts with five commercial managed care plans to serve Medi-Cal members in 21 counties, starting in January 2024.

And then 17 counties in California changed the Managed Care Model, which includes a new Single Plan Model and then some plans are expanded. Some plans have expanded their model as COHS.

The third change was the direct contract with Kaiser. Next slide.

Based on the commercial plan and the county model changes, DHCS anticipated over 1 million members transitioned to the new Managed Care Model in January in 21 counties and that are listed on this slide here.

And then this slide shows the Medi-Cal Managed Care Model changes. Fourteen plan models prior to 1/1/2024 are on the left side; and then on the right side is what the mix of plan model types looks like now in 2024. As René had highlighted, the northern region of the state has transitioned to a COHS or a Single Plan Model, and then there is no longer the Imperial and San Benito model. So, these are very small slides here, but you have the handouts so you can look at that closely.

And now focusing on the report on hand here. So, there are 15 Local Plans that serve over 9 million Medi-Cal beneficiaries in 49 counties. Total enrollment increased by 2.2% compared to prior quarters. A majority of the local plans reported an increase in enrollment. Overall, the Local Plans' Medi-Cal enrollment increased by 155,000 lives when you compare from December 2023 to March 2024.

And for March 2024 the Local Plans reported net income of $389 million, and that's the total for all the 15 Local Plans. And all local plans were compliant with the DMHC's financial reserve requirement, or the tangible net equity or TNE requirement, which ranged from 386% of required TNE to 1533% of required TNE.

There are five NGM plans that serve 3.6 million Medi-Cal beneficiaries in 21 counties. Total Medi-Cal enrollment for NGM plans decreased by 3.7% in March 2024 and this is due to the changes in contracting that we discussed earlier. And effective January 2024, Aetna Better Health and California Health and Wellness exited Medi-Cal managed care business.

For the first quarter of 2024 NGM plans reported a total net income of $261 million.

And their TNE to required TNE ranged from 289% to 1613%.

So, the majority of the Medi-Cal managed care plans experienced an increase in enrollment for the first quarter of 2024 and these are largely attributed to initiatives such as Medi-Cal expansion to all income-eligible adults. And most Medi-Cal managed care plans saw growth in revenue, medical expenses, net income; and this is directly driven by the increase in enrollment and then adjustments in fee schedules resulting from the MCO tax and the target

rate increase that Rafael covered earlier.

The Medi-Cal managed care plans reported positive income for end of 2023 as well as the first quarter of 2024, which contributed to strengthening their tangible net equity position. So, all Medi-Cal managed care plans are doing financially well. They have good reserves and they continue to meet our financial requirements. Additionally, the three NGM plans distributed dividends to their parent companies.

And then, let's see what else do we have here. So, NGM plans typically reported higher net income, but lower TNE compared to Local Plans. Again, Local Plans hold on to their reserve while NGM plans have, you know, they have publicly traded parents where they make distributions, so thereby their reserve levels are lower compared to the Medi-Cal plans.

So, with that, it ends my presentation here. Any questions?

CHAIR RIDEOUT: Let's start with questions or comments from committee members in the room. Paul.

MEMBER DURR: Thank you, Pritika, very nice summary. I am always amazed at some of the high levels of TNE requirements, and I noticed on some of the -- some of them they continue to increase, and it just always reflects on how much of that money could be going to provider reimbursement rather than just their tangible net equity. And then also reflecting on the last comment you made which is, some of those are distributing those dollars back to their parent company, who are publicly traded companies. Which doesn't seem like the intent for those dollars should be going more towards provider reimbursement. More a comment than anything, so, thank you.

MS. DUTT: Thank you, Paul.

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

Seeing none. We have some committee members, Jared, I will start with you and then we will go to Abbi.

MEMBER MCNAUGHTON: Thanks so much. Pritika, always appreciate your sharing and presentation, thank you for that. I am curious to just hear, and maybe anecdotally even, if you are seeing any change this year overall in the state when it comes to the budgets and margins across the board for the plans? I know in our organization we are seeing a pretty massive jump on utilization of health services, so much so that we have alerted our board this week about the trend that we are seeing, that it is just out of the norm for us, significantly out of the norm. And I am just curious if you are seeing any of that utilization change or that trend? I know that our CFO is actually at the small rates workgroup today for DHCS, and a couple of the other CFOs have also mentioned that that's --they are starting to see that trend right now. And I know it is our -- it is our first time in, gosh, since I have been here, that we are actually missing our budget substantially because of that. And so I just was curious if you are seeing that across the state, if it is a regional issue, maybe there's just a couple of us that are experiencing it, but just that health services side, on the UM side really pushing up pretty, pretty substantially.

MS. DUTT: Thank you, Jared, for that question. As we compared the information with what was reported last year we saw a big decline in profits. If you look at page 7 of the report that was included with the packet, if you look at the March 2023 profits across the 15 Local Plans it was at 684 billion and then now it is at $389 million and that's with the increased enrollment, right? So, that

kind of shows that medical expenses have increased for these plans. I mean, we have -- we are also covering the medical expenses in here as well, so we have seen a decline in profit with the increase in enrollment.

MEMBER MCNAUGHTON: Thank you for sharing.

CHAIR RIDEOUT: Comment from Mary.

MEMBER WATANABE: Yes, Jared, maybe I will just make a comment. I think I am having some conversations with the leadership at the plans, both the local plans and commercial plans, and that's one of the questions I have been asking is, what are you seeing with utilization? I think there was some expectation with the end of the public health emergency, getting back to some normal. That we would, you know, see some spikes and pent-up demand, and that that would start to level off. But I think what I am hearing is continued high utilization and even some increases. So, I mean, it is something I think we are tracking and I am having conversations about. We don't, we don't collect utilization data necessarily. We get the medical trend data on both the Commercial and on the Medi-Cal managed care side, but it is definitely something that is interesting. It is good to hear your perspective.

MEMBER MCNAUGHTON: Yes, and any, if you -- we are, of course, a public entity, so if you would like to see any data on that, we are happy to share with you any utilization trend data that we are seeing; more than happy to share that.

CHAIR RIDEOUT: Okay, moving to Abbi.

MEMBER COURSOLLE: Yes, thank you. I just wanted to follow up on some of the earlier comments. I understand, of course, that for TNE there is sort of a minimum requirement and there is not really a ceiling. But I sort of

share the concern that Paul raised, that when we see such high percentages for some of these plans, that that does seem like a flag that there might be something going on in terms of either low payment rates or under-utilization. And so I am just wondering if the Department is doing anything to sort of look at the plans that are reporting those extremely high numbers to ensure that there is nothing that we should be concerned about there.

MS. DUTT: So, thank you, Abbi, for your question here. So, in addition to TNE we look at other financial ratios. So, the high TNE does not indicate that the plan is sitting on a lot of cash, because what TNE includes is also their other assets like for example, long-term investments, any buildings they own. You cannot pay, you know, the cost with the building expenses. So, we look at other ratios. We look at the cash-to-claims, we look at the working capital. So, these other financial criteria we look at in addition to TNE. Why we bring up TNE? It is the minimum financial reserve in the Knox-Keene Act. But when we try to holistically assess a plan's financial viability, there's other financial criteria, there's other financial ratios we look at. There is a thorough detailed review that goes into the analysis.

Also, higher TNE does not mean like we don't have concerns on the plan. They could have other issues going on like operational or they could have claims payment issues. So, there's like a lot of analysis that goes into assessing the financial viability of these plans. So, like when you look at 1600%, that doesn't like -- so it doesn't automatically indicate that the plan has a lot of cash on hand, so that's why we started looking at other measures. And we provided that with the other presentation handout, with the health plan financial update. We have the working capital in there as well as cash-to-claims to show

you a little bit more than just the TNE.

CHAIR RIDEOUT: I know we have asked for cash-to-claims and we have gotten it. I know we can't identify individual health plans, either Commercial or Medi-Cal on that. Can you provide maybe averaging as well, or weighted averaging? Because I think it is hard to look at a range and not know, you know, kind of where the majority of folks are landing.

MS. DUTT: Sure. So, I think you are probably thinking about the RBOs, because that's where the confidentiality requirements are. With the health plans, the information we get is not confidential. So, if you look at one of the handouts with the last presentation, you can see those numbers there with the working capital and cash-to-claims. So, with the health plans, their financial information is publicly available. The financial statements, they get posted on the public website. So, there is more information. I can probably show it to you.

CHAIR RIDEOUT: We will see it in the session.

All right, any other questions, comments from committee members?

All right, we will move to questions or comments from the public here in the room.

Seeing none should I pick on somebody and say, go ask a question or something? Any questions or comments on Zoom?

Hearing none.

All right, thank you, Pritika.

We will move on and our next topic is the budget update. And just to clarify, that is a DMHC budget, not the governor's budget. I think we have heard enough about the governor's budget. So, Dan.

MR. SOUTHARD: Thanks, Jeff. Today I will provide you a brief

overview of the DMHC's fiscal year ’24-25 budget.

In our previous fiscal year, 2023-24, the DMHC’s budget consisted of $163 million in spending authority and 707.5 authorized positions.

For the current fiscal year, the DMHC’s budget has grown to $178 million in spending authority and 773 authorized positions. This represents an approximate 9% increase in spending authority and authorized positions over the previous fiscal year. Thank you.

This slide shows the DMHC’s spending authority in authorized positions over the past five fiscal years. As you can see on this slide, the DMHC has experienced moderate growth over the past five fiscal years, and since fiscal year 2020-2021, the DMHC has experienced an increase, an 85% increase in its spending authority and a 53% increase in authorized positions. Next slide please.

We will talk a little bit about our budget change proposals. And I think the last time I was here there was a question on what is a BCP, so I will just quickly do a quick description of that. So, as the legislature moves through with their bill revisions and introducing bills, any bills that impact the DMHC, we review those to determine what fiscal impact, what resources we may need if that bill is signed by the governor. So, that's an iterative process over a number of months that comes to a conclusion generally in the fall. And then if the governor signs a particular bill, we have 10 days to then produce our BCP and get it over to the Department of Finance. So a very short turnaround time after a bill is signed. And for fiscal year ’24-25 the DMHC had four legislative BCPs.

The first was biomarker testing related to SB 496. SB 496 requires health plans to cover medically necessary biomarker testing for the purposes of

diagnostic treatment and appropriate management or ongoing monitoring of an enrollee's disease or condition to guide treatment decisions. And for that BCP, the DMHC received five positions and funding to contract with vendors to implement the requirements of SB 496.

The next one was for SB 858, and this was a technical adjustment. It went to reappropriate a one-time funding authority in the amount of $2,778,000 received in the '23-24 Budget Act to fiscal year '24-25 for consultant services to enhance the DMHC's corrective action plan system.

The next BCP, and Mary talked about this in her Director Remarks, is related to AB 1048. And again, AB 1048 prohibits health plans and health insurers that cover dental services from imposing dental waiting periods for dental coverage in the Large Group Market, and also prohibits health plan contracts or policies covering dental services in all market segments from containing exclusions for preexisting conditions. Additionally, AB 1048 added new sections to specify the information required to be filed with the DMHC and the California Department of Insurance for the dental rate review process. And the DMHC received three positions and consultant funding in the amount of $650,000 annually for actuarial consultants to assist in the review of the dental rate filings.

The final legislative BCP for the DMHC was related to AB 904. And AB 904 requires a health plan or a health insurer to develop a maternal and infant health equity program by January 1, 2025, that would address racial health disparities in maternal and infant health outcomes by using doulas. Although this program would require health plans to develop a maternal and infant health equity program that addresses racial disparities and outcomes, it does not

mandate coverage of doulas. AB 904 also requires the DMHC to collect data and submit a report to the legislature by January 1, 2027 describing the doula coverage and programs established pursuant to this bill. And the DMHC received limited-term expenditure authority equivalent to two full-time staff to implement the requirements of AB 904.

The DMHC also had three workload BCPs, and that is -- we are doing our best to estimate legislative BCPs and that workload. But if we underestimate workload, we can present workload BCPs to the legislature to be included in the budget. And this year we had three of those. The first one was related to executive and management ratios to rank and file staff. This BCP is really to right-size our executive and supervisory staff to that of the rank-and-file staff and we received seven positions through this workload BCP.

The second workload BCP was related to our Help Center. We have seen a moderate increase in complaints and IMRs and calls to the Help Center, needing those staff to address that increased workload. And through this workload BCP we received 35 positions.

Then the final one was related to information technology security. And so we received funding in a previous, in a previous fiscal year for to purchase additional systems to enhance our security posture. And this BCP was adding positions to oversee those systems that we had purchased. And so we received nine positions that were BCP. Excuse me.

Then finally, how does this impact the assessment? So, the DMHC is funded by assessments on health plans, and that split is 65% of our budget authority is paid for by the full-service health plans, 35% is paid by specialized plans. And so for our previous fiscal year, fiscal year ’23-24, the full-service

health plans paid $2.74 per enrollee, per year to fund the DMHC's budget. That increased to $3.25 for the current fiscal year. And for specialized plans, in fiscal year ’23-24 the amount they paid per enrollee, per year was $1.21. And that increased 23 cents for our current fiscal year to $1.44.

So, that concludes my budget overview, but more than happy to answer any questions.

CHAIR RIDEOUT: Thank you, Dan.

Any questions from committee members in the room?

MEMBER SEIDENWURM: Question.

CHAIR RIDEOUT: David.

MEMBER SEIDENWURM: Regarding the issue of biomarker testing. As I understand that, that is pretty much an open-ended requirement. And the standards for biomarker testing, particularly the genetic type biomarkers for cancer, are poorly regulated, many of them are lab-developed tests. The FDA was starting to work on that, but with the new Chevron decision in the Supreme Court that might take longer than it might otherwise have taken to finalize. Is there anything that we can do, or you can do, to help ensure that those tests actually measure the thing that they say they measure? Because there is really very little standardization and very little standard at all. Is that within our purview?

MR. SOUTHARD: That may be a little bit out of scope of the DMHC.

MEMBER WATANABE: I am going to say, no. I’m going to say, no.

MEMBER SEIDENWURM: (Overlapping), right?

MR. SOUTHARD: And I will say there may be some check and balance at the health plan level on medical necessity. So, they have to cover it if it is medically necessary. So, I would assume if there is a request coming in for a physician for specific testing, the plan, to your point, doesn't believe it is medically necessary, doesn't meet the requirements of the FDA, that they may deny that. That would still allow a consumer to grieve that through the health plan's grievance process, and then come to the DMHC's Help Center for a potential independent medical review for to qualify.

MEMBER WATANABE: And maybe I will just flag, Sarah Ream, our Chief Counsel who normally does an update is on vacation, a much-deserved vacation. But there has been, I know, some activity with some decisions. The Chevron decision keeps coming up in almost every conversation I am having. So, again, I think at our next meeting we can have Sarah do some updates on some of those recent decisions, but thanks for flagging it.

CHAIR RIDEOUT: Okay, any other questions from committee members in the room? Seeing none.

Committee members virtually, any questions? I don't see any.

Okay, we will move to members of the public in the room. Any questions or comments?

Seeing none, we will move to members of the public virtually and on the telephone. No comment. So, I think we were done with that section. Thank you, Dan.

All right, we are moving through the agenda. Next we have the provider solvency quarterly update with Michelle Yamanaka. Michelle.

MS. YAMANAKA: Thanks, Jeff. Michelle Yamanaka, Supervising

Examiner in the Office of Financial Review. Today I am going to give you an update on risk bearing organization or RBO reporting for the quarter ended March 31, 2024.

We have 212 RBOs that reported this quarter. There were 3 new RBOs that began reporting and we also had 3 RBOs that were deactivated. For those deactivated RBOs, they all had less than 10,000 lives assigned to them. They were all compliant with the grading criteria.

We have 189 RBOs, or 89% of them that were in our compliant category. This includes 9 RBOs on our Monitor Closely list.

Twenty-two RBOs were non-compliant and were on a corrective action plan.

And we had one non-filer. We made a referral to our Enforcement Division, the enrolment was frozen, and recently we received the quarterly report that is under review.

We also received 199 annual survey reports for the fiscal year end 2023. A majority of the RBOs have filed. We also made a referral to our Enforcement division as they are currently -- as we currently have 10 of those RBOs that have not filed their reports that were due at the end of May.

We received monthly financial statements from RBOs on corrective action plans; 13 of them that we receive on a monthly basis. Review their progress with their corrective action plan.

To provide some additional information on the RBOs' grading criteria, there is a handout titled RBO Enrollment and Grading Criteria. We compiled all of the solvency metrics for the past five quarters for each RBO. It also includes enrollment as of March 31, 2024.

Moving on to corrective action plans.

There are 22 RBOs on corrective action plans. Again, 10% of the RBOs.

Of those 22,16 CAPs are continuing from the previous quarter, 6 are new.

Of the 16, 14 of those RBOs are meeting their approved corrective action plan and 2 are not. And we are currently in -- currently on an ongoing basis working with those 2 RBOs to obtain a viable CAP.

For the 6 new CAPs, one RBO was non-compliant with claims timeliness, and 5 of the RBOs were non-compliant with one or more of the solvency metrics, TNE, working capital or cash-to-claims.

Of the 22 CAPs, 17 are approved and 5 are in review.

There is also another handout regarding the corrective action plans and the RBOs are sorted by Management Services Organization or MSO. And it includes information regarding these CAPs such as the quarter the CAP was initiated, the compliance status of the RBO with its approved corrective action plan, and the grading criteria deficiencies.

After our review of the March 31st financial filings, 6 of the 22 CAPs were completed. One RBO ceased operations, and that RBO had less than 10,000 lives. And 2 CAPs were approved, leaving 2 CAPs in progress.

Moving on to the grading criteria. First is tangible net equity. We compiled the information for Quarter 1 using the TNE and required TNE to calculate this ratio. RBOs reporting less than 100% TNE to required TNE were non-compliant with the grading criteria requirement. As of March 31, there's 146 RBOs, or 69% of them, that had TNE greater than 500%. Four of these RBOs

reported a non-compliance with TNE, and all of them had less than 10,000 lives assigned to them.

Moving on to working capital, relative working capital. This is also known as the current ratio. And we took the comparison of current assets to current liabilities, which measures if the RBO can meet its short-term obligations that are due within a year. At March 31, over 97% of the RBOs had a calculation of over 1%. There were 5 RBOs that reported non-compliance with working capital. Four of those had less than 10,000 lives. One RBO had between 25 and 50,000 lives.

Moving on to cash-to-claims ratio. This ratio is calculated by the cash short-term investments in capitation -- health plan capitation receivables collectible within 30 days and divided by the total claims liability. The data shows that there were a majority of the RBO had a cash-to-claim ratio of one or over, and there were 8 RBOs that reported non-compliance with these criteria. Five of those had less than 10,000 lives, and there was one RBO in three of the other range categories, 10,000 to 25,000, 25-50,000, and 50-100,000.

Moving on to enrollment. This slide -- sorry, one more.

Claims timeliness. We had 3 RBOs reporting non-compliance with claims timeliness. One RBO that had less than 10,000 lives, one RBO 25-50,000 lives, and one RBO that had more than 100,000 lives. These three RBOs reporting non-compliance were not -- were compliant with all other grading criteria. Moving on to the next slide.

Enrollment. As of March 31, 2024, there are approximately 10.3 million lives assigned to the RBOs. This is an increase from the previous year, with a majority of the increase in Medi-Cal enrollment.

Looking at the RBOs that are assigned Medi-Cal lives. Next slide please. There's approximately 6.1 million lives assigned to -- 6.1 million lives assigned to 79 RBOs. This represents 60% of the total lives assigned to all RBOs. Of those 79 RBOs, 67 had no financial concerns, 4 were on our monitor closely list, and 8 were on corrective action plans.

We also took the top 20 RBOs that had a majority of the Medi-Cal lives assigned to them. This represents 4.8 million lives assigned to those 20 RBOs, which is about 47% of total enrollment. Fifteen of those RBOs had no financial concerns, 2 were on our monitor closely list, and 3 were on corrective action plans.

And that concludes my presentation. Happy to answer any questions.

CHAIR RIDEOUT: Thank you, Michelle.

Any questions from committee members in the room first? Paul.

MEMBER DURR: Yes, Michelle, thank you, nice overview. My question is, when you froze the enrollment for the one to get the report, when do you unfreeze it? Because I would imagine you have to review the data to make sure it is compliant, but do you have a standard process?

MS. YAMANAKA: Yes, we do. Once we receive the report the examiner reviews the report. If they have questions they need to be answered. We need to complete our review on that financial report before we would recommend lifting the freeze.

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

Committee members on the phone or virtual? I think Mark you

have your hand up.

MEMBER KOGAN: Yes. Also just a general question. For the RBOs that get put on these corrective action plans, what kind of data do we have over years? Ultimately, how many of those actually succeed and how many of those eventually go broke or out of existence?

MS. YAMANAKA: We have data over the years since we started collecting the information. I would say a majority of the RBOs obtain compliance with their corrective action plans. We had to freeze enrollment on very few, which is a step that we don't take lightly, but if we needed to we would. But I would say the data would reflect a majority of these RBOs obtain compliance with their, with their deficiencies.

MEMBER KOGAN: And then, long-term they are successful?

MS. YAMANAKA: Yes, overall these RBOs -- the RBOs that become deactivated, a majority of them are small. They try out and, you know. They anticipate growing their business; however, some find it just doesn't work for them. And so we find that any of these RBOs that will deactivate, in most cases they are small, under 10,000 lives.

CHAIR RIDEOUT: All right. Abbi, I think you have a question as well, a comment.

MEMBER COURSOLLE: Yes. Thanks, Pritika for the presentation. I just wanted to go back to slide three where you talked about the two RBOs that are currently not meeting projections for their current CAPs, and I think you said you are working with those RBOs to come up with a viable CAP. And I was wondering if you would just give a little bit more information on sort of what that looks like to work with those RBOs. I assume that means some

revisions to the existing CAP that's in place, but if you could provide a little more detail that would be helpful.

MS. YAMANAKA: Sure. So, in this case, one of the, one of the CAPs are approved and one is in progress. So, with the CAP -- let me take the CAPs that are approved, first. So, what we do for the corrective action plans, once we approve a CAP, an RBO needs to file their monthly financial statements. So, we review on a monthly -- instead of waiting for quarterly to find out how they -- if they are if they are meeting their metrics, their approved metrics, we look at them on a monthly, on a monthly basis.

When we see them not going in the positive direction, we will contact the RBO to get additional information and find out from them, you know, you are not going the right way, what is your plan to go forward? In that case, we may need a revised corrective action plan. But that's the kind of steps we take to try to figure out how the RBO, if they can, to transition back to their metrics or to get into compliance on the date that they anticipated. Sometimes they may need additional time. We also work with the health plans to ensure they are along, and if they have any concerns, we need to get those addressed as well. But that's kind of the process for an approved corrective action plan.

In order to get to the approved corrective action plan, the whole time through this it is a collaborative process between the RBO, its contracting health plans and the Department. So, when an RBO submits a corrective action plan, it goes to -- immediately, goes to its contracting health plans as well as the Department. We are all reviewing it. In the event that the Department sees that it is not completed correctly, they are missing information, things don't tie, we will automatically reject it because it is something that cannot be approved. And that

is the process to get an approved corrective action plan. And that's where one -- and for one of the RBOs they are in this situation. We are trying to get an approved corrective action plan where all of us, RBO, health plans and the Department can agree upon the terms in order to obtain compliance.

So, I hope that answers your question. I am not sure if it does.

MEMBER COURSOLLE: Yes, that was really helpful, thank you.

CHAIR RIDEOUT: Other questions from committee members that haven't been recognized yet?

Okay, let's move to the public. First in the room, any comments or questions from the public? Bill.

MR. BARCELLONA: Bill Barcellona, APG. Michelle, I continue to be a big fan of your work. Just a few questions about the closures. So, 3 RBOs ceased operations. Were any of them due to financial insolvency?

MS. YAMANAKA: No, all of them were compliant with all grading criteria when they deactivated. They just felt that -- they terminated their health plan contracts, feeling that it wasn't, it wasn't what they wanted to continue.

MR. BARCELLONA: Okay. And they were all less than 10,000 life RBOs?

MS. YAMANAKA: That's correct.

MR. BARCELLONA: Were they predominantly Medi-Cal or did they have a balance of enrollment from other business lines?

MS. YAMANAKA: I would say they were majority Medicare.

MR. BARCELLONA: Majority Medicare. Okay, thank you.

CHAIR RIDEOUT: Other questions from the public in the room?

Turning to the Zoom or virtual. Any questions or comments?

Anybody on the telephone? No? All right.

CHAIR RIDEOUT: Thank you, Michelle.

We will move on to the Health Plan Quarterly Update. Back to you, Pritika.

MS. DUTT: All right. So, the purpose of this presentation is to provide you an update of the financial status of health plans at quarter ended March 31, 2024. As a reminder, all licensed health plans are required to submit quarterly and annual financial state statements to the DMHC, and those financial statements are publicly available on the DMHC website. 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 concerns with the health plan's financial solvency.

We also included a handout that shows the enrollment at March 31, 2024, and TNE for five consecutive quarters, which goes from March 31, 2023 all the way through March 31 2024, for all licensed health plans. We also added the working capital, which is the current ratio and cash-to-claims ratio information in that handout. And for the handout the information is broken into three categories, full-service, restricted full-service and specialized.

As of August 1, 2024, we had 139 licensed health plans. We are currently reviewing 11 applications for licensure. So, still, like a lot of demand from entities looking to get licensed. So, 6 of those 11 are full-service and 5 are specialized applicants. Of the 6 full-service, 1 is looking to get licensed to operate as a Medicare Advantage health plan, 4 are seeking for restricted Medicare Advantage, and 1 for Medi-Cal managed care. For the 5 specialized plans, 3 are looking to get licensed for EAP, 2 for dental. And then we continue

to meet with several entities that are interested in obtaining a Knox-Keene license and operate as a health plan.

At March 31, 2024 there were 30.2 million enrollees in full-service health plans licensed with the DMHC. Total commercial enrollment includes HMO, PPO/EPO and Medicare supplement enrollment. As you can see on the table, compared to previous quarter, total full-service enrollment increased. And you will see in the future slides that the change was due to -- driven by increase in Medi-Cal enrollment.

This slide shows the makeup of the HMO enrollment by market type. HMO enrollment in all markets remained consistent compared to previous quarters, although we did see Large Group HMO and Small Group HMO products experience slight decreases in enrollment in the first quarter.

This slide shows the makeup of PPO/EPO enrollment. And similar to HMO enrollment, PPO/EPO Large Group and Small Group experienced slight decreases in enrollment.

And this slide shows the government enrollment, which is Medi-Cal and Medicare Advantage. Enrollment for both Medi-Cal and MA plans have experienced consistent growth until June 30, 2023. At March 31, Medi-Cal enrollment increased by almost 450,000 lives, while Medicare Advantage enrollment decreased by 37,000 enrollees compared to the previous quarter.

This slide shows the 26 health plans that are monitored closely, which includes 21 full-service plans and 5 specialized plans. There are various reasons why we monitor health plans closely, which may include but not limited to newly licensed plans, low enrollment, financial solvency concerns, concerns with parent entity, claims processing issues, enforcement action, staff turnover,

to name a few. And a majority of the plans that are monitored closely are not very large in terms of enrollment. And similar to the RBOs issue here, a majority of the plans that are closely monitored in the full-service category are either Medicare Advantage or restricted Medicare Advantage plans.

So, we had four health plans that did not meet the DMHC's financial reserve requirement or tangible net equity requirement.

The first one was Central Health Plan of California. So, the health plan reported TNE deficiency with the March 31 year-end financial statements, so that's for December 31, 2023. The plan was purchased by Molina towards the end of 2023, so Molina infused capital into the plan and hence fixing the TNE deficiency. At the end of the quarter of March 31, 2024, the plan met the TNE requirement.

And then Holman Professional Counseling Centers, the plan was TNE deficient from December 31, 2023, all the way through March 31, 2023. So again, the plan was able to cure their TNE deficiency with month ended February 29, 2024.

And then TELUS Health is an EAP plan. They reported TNE deficiency for the year ended December 31, 2023, and our team is working with the plan to address the TNE deficiency.

And then the last plan on the list here is Universal Care. Similar to Central Health Plan. This plan was purchased by Molina towards the end of last year. Molina infused additional capital, and they were able to get their TNE deficiency cured also.

This chart shows the TNE of health plans by line of business. A majority of the health plans over 500% of TNE are specialized health plans. And

as we had previously highlighted in past meetings, the requirement for specialized health plans in terms of TNE is significantly lower. So, the full-service health plans, because they cover more Essential Health Benefits and the expenses are higher, so the TNE requirements are higher for full-service plans.

This chart shows the TNE of full-service plans by enrollment category.

So, 66 health plans, or over half of the total licensed full-service health plans reported TNE of over 250% of required TNE.

And this chart here shows the 20 full-service plans in that 150 to 250% category. So, if a plan's TNE falls below 150% the plan is placed on monthly reporting. We also monitor the health plans closely if we observe a declining trend in their financial performance, which is the tangible net equity, net income enrollment, to name a few. So, if we see a declining trend in TNE or other financial measures, we place those plans on monthly reporting as well.

This chart shows the TNE of full-service plans by quarter. So, this chart pretty much summarizes the handout that was provided. So, for the detailed information on health plan TNE levels and enrollment, please refer to the handout. It will show you the TNE levels for each health plan that is licensed with the DMHC, including some other measures.

This slide here shows the working capital for full-service plans by enrollment as of March 31, 2024. Also, just to kind of provide a little bit on what the working capital measures. So, the working capital, or current ratio, measures the plan’s ability to cover its debts, expenses that are due within the year. So, this is something else we look at in addition to TNE. A plan with working capital with less than one is concerning, because that means that they are not able to

cover their debt that is due within the year. They have the money, but they may not have the resources to cover everything that is due within the year.

And this slide here shows the cash-to-claims ratio for full-service health plans by enrollment. And again, the cash-to-claims ratio measures the plan's ability to cover their claims expenses, which is claims payable and IBNR, so incurred but not reported claims. So, how much cash the plan has available on hand to cover their claims expenses. So, this is something also that we look at in addition to TNE. Like I said, there's a lot of other financial measures we look at to assess the plan's financial viability. So, that brings me to the end of my presentation. I can take any questions.

CHAIR RIDEOUT: Thank you, Pritika.

Any questions from committee members in the room?

MEMBER DURR: Yes, Pritika, thank you. Do you have concern about the 8 plans that have over 300,000 enrollees that have low working capital and cash-to-claim?

MS. DUTT: So, short answer, yes, but we continue to work with these health plans. When we get financial statements these are high priority, where our team would focus on reviewing these plans first and then working their way through all the other ones. But we -- if we have concerns, we look at everything, right, as a whole. So, we will look at their cash-to-claims, we will look at working capital. We will also look at their -- how their assets are built up, right. We will look at their long-term investments, what they have available, their cash flow from operations as well. So, there's a lot of things we look at. So, like I said, once we get financials, these are the priority plans we look at to make sure that they are working towards the right direction. If not, then we would contact those

plans, work with them closely, ask for projections and other detailed responses on what these plans are doing to get to a positive side of things.

CHAIR RIDEOUT: David, I think you have a question.

MEMBER SEIDENWURM: Yes. Just for clarity of presentation, I was wondering if perhaps we can highlight the thresholds for compliance and non-compliance in some way on these charts. You know, maybe through thickness of a line, or color of the heading or color of the type or the font or something.

MS. DUTT: The plans have to have higher than 100% of TNE, but you want them to maintain more than that. We try to make sure that the plans have over 200%. Because when you get like around 150 you are getting too close to non-compliance level, right, you are going down. We want to make sure plans have enough financial reserve. So, we will put something there, like maybe a note, that 100% is the minimum requirement for health plans. But again, I think that's the low requirement. Our examiners are looking for higher levels because we want to make sure that a big claims expense does not drive the plan out of business.

MEMBER SEIDENWURM: Or maybe some kind of stoplight.

MS. DUTT: I am visualizing (laughter).

MEMBER SEIDENWURM: You know, green, yellow, red.

CHAIR RIDEOUT: Okay, any questions from committee members on virtually? I don't think I see any. Okay, let's move to the public in the room. Any questions or comments from -- oh, I'm sorry, we have got one from Mark.

MEMBER KOGAN: Yes, just a quick question. When some of these organizations have missed for several different times. I mean, when is the

decision to put them on a CAP? I think like Empire is one that is not on a CAP but has missed several different times. And I am just curious how you decide when to do that.

MS. DUTT: Mark, are you looking at the RBOs or are you looking at the health plans handout? I think Empire is an RBO.

MEMBER KOGAN: I think it is, I think it is the health plan.

MS. DUTT: Okay. For health plans we -- like I said, we do get financial statements from them quarterly and annually. If we see a declining trend, we will place the plan on monthly reporting, and then we will start like reviewing those plans on a shorter time frame, a monthly basis. Also, we ask for financial projections at that point to see what the plans are doing to turn into a positive direction, with detailed assumptions as well. If we need to we do an IBNR analysis looking at their claims payment history in detail. Try to get to what is causing the decline in their financial performance. We also see if they have availability of additional resources, right. So, we try to see whether they have a parent entity, shareholders that are willing to put in more cash into the plan to give them a buffer on their reserves. So, we look at various different avenues a plan has available to them. But as far as just like addressing, the quick thing we do is put them on monthly reporting and ask for financial projections from the health plan. And then at some point if they keep declining, they go in a TNE deficiency situation, then we will get enforcement involved and start work with our Office of Enforcement involved and start working, you know, to get the plan in the right direction.

CHAIR RIDEOUT: So, Pritika, is it fair to say it starts very quantitative, but then you start applying more and more judgment about sort of

whether the plan in this case is responding; is that correct?

MS. DUTT: Correct, correct. So, we review the information. We want to make sure that they are addressing things timely, and then we keep Mary apprised on what is happening. And then at some point we do make an enforcement referral when they get into a non-compliance situation. Sometimes, if we don't get responses from the plans timely, we will try, myself trying to make sure they get the right chain of command involved, they will raise it with me. And then if we still have a hard time getting responses from them then we will get our Office of Enforcement involved and then go through that route. But we try to work with these plans to make sure that they address any issues quickly and timely.

CHAIR RIDEOUT: Anything else on that, Mark?

MEMBER KOGAN: No, I'm fine.

CHAIR RIDEOUT: Okay, thank you.

All right, moving to the public. Any comments or questions public in the room? Bill.

MR. BARCELLONA: Okay. Thanks for the report, Pritika. A few questions about restricted licensees. I think you said 10 restricteds are on the closely watch list right now. Of those 10, how many of them are in their mandatory close watch period? Are they new restricteds or are they on close watch because of issues?

MS. DUTT: So, there could be issues with like lower reserves, and then some of them are new and then some of them have very small enrollment. Where, you know, if they don't have that much reserves, or, like I said, small enrollment, right, again, the revenues are small. If big expenses come in they

could go into a non-compliance situation. So, as you can see the enrollment total for those 10, they are pretty small.

MR. BARCELLONA: Are the 10 all in the Medicare Advantage market?

MS. DUTT: Not all of them are, most of them are. Not all, but most.

MR. BARCELLONA: Any Commercial or Medi-Cal on close watch for the RBO and RKKs?

MS. DUTT: Let me get back to you on that one.

MR. BARCELLONA: Sure. That would be great to know.

The MA enrollment seems to be relatively stagnant year to year now as a total percentage of the whole enrollment under jurisdiction of DMHC, but yet we continue to see new entities filing for licenses in the RBO market and in the RKK market. So, there's a lot of competition there, but there are a lot of examples of low enrollment, right?

MS. DUTT: Yes.

MR. BARCELLONA: Okay. But no one -- have any restricted licensees filed to surrender their license this year?

MS. DUTT: I don't think so. I don't -- yes, we haven't had any restricted licensees that surrendered their license this year.

MR. BARCELLONA: Okay, all right, thank you.

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

Seeing none turning to the virtual audience. Anybody? Okay. I think that concludes that item.

The next item Mary is going to share are the ever-important 2025 meeting dates.

MEMBER WATANABE: Yes. So, we, Jeff and I compete to see who comes with our dates first for the next year, in the summer. But I think we have put together a list of proposed dates here for 2025. So, please let us know if any of these are major conflicts with your schedule or any other known events. But this is, I think, what we are hoping to move forward with. I will just note our next meeting is November 6, the day after the election. Which may be the best or the worst date of the meeting, I don't know, we will have to see, maybe we will have some things to comment on. But anyways, this is what we are proposing for 2025 so let us know any concerns. You can email Jordan. But otherwise, what we will move forward with next year.

CHAIR RIDEOUT: Any comments from anybody on that? We don't compete, we try to coordinate.

All right. So, the next item is any public comment on matters not on the agenda. So, it is another chance to raise topics of concern. Yes, Bill.

MR. BARCELLONA: Bill Barcellona, APG. I did have a few questions. I know Sarah is on vacation. I just wondered when the Department is planning on releasing the draft for the general licensure regulation, if we will see that in calendar 2024? And also the SB 137 one.

MEMBER WATANABE: I was going to say those are the two that I know when she has been doing updates there were fingers crossed you will see them this year. But we'll see. I feel like I have been saying that on SB 137 for five years.

MR. BARCELLONA: Okay.

MEMBER WATANABE: But it is for real this time, we are hoping to get that out this year. We will have Sarah do an update in November. And if you want me to follow-up, I am happy to do that offline too.

MR. BARCELLONA: Okay.

MEMBER WATANABE: Yes.

MR. BARCELLONA: All right. I am happy to bring a blender for the November 6 meeting if it doesn't violate provisions of the Knox-Keene Act (laughter).

MEMBER WATANABE: Thank you, Bill.

CHAIR RIDEOUT: Okay, any other public comments that were not on this agenda?

Okay, next we take a few minutes to look for agenda items for the future meetings. We have talked about a few things that will come up in November, but, committee members, in general any items you would like to see appear. I think we have OHCA coming at some point again, right?

MEMBER WATANABE: Yes. I was going to say, I was quickly looking through our last couple of agendas and I don't think we have had OHCA come since they set the spending target. Does anybody have -- Okay, okay. Because I think we canceled May. So, anyway, I think we could certainly see if Elizabeth and/or Vishaal can come and talk about that. It might be timely for us to kind of just engage with the Board on how we think about that for rates.

Obviously, an update on, I think, the work we are doing on EHBs if there is anything else to share.

And then Pritika has her normal standing items related to rates, risk adjustment transfers. MLR?

MS. DUTT: MLR.

MEMBER WATANABE: MLR. So, we have kind of got that whole package of our standing updates for November. But we will put down trying to get OHCA to come and give an update on the work they are doing.

CHAIR RIDEOUT: One thing, you know, Thursday is going to be a big, big day this week to see what gets out of appropriations so would you guys have, like, a scorecard or something that impacts DMHC?

MEMBER WATANABE: Yes. So, usually in November we will have a legislative update where Amanda will get to update you on all the bills that were signed and the implementation activity. So, we will also have that too, yes. By November we will know what has been signed and what new work is coming our way.

CHAIR RIDEOUT: Any other requests from committee members?

Okay, how about from the public? Any items they would like to see appear? The blender boy, there he is.

MR. BARCELLONA: Bill Barcellona, APG. Depending on what happens with AB 3129, which is the bill for attorney general review of private equity and hedge fund transactions. If that bill does progress out of the legislature and signed by the governor it would be interesting to maybe in Q1 or Q2 of 2025 look at how transactions are going to be reviewed across DMHC, OHCA and the Attorney General's Office. Because it would be very easy for a lot of current market structures to fall under a trifecta of reviews by all three departments and agencies. We all, you know, out here in in the real world, we are still trying to figure out how this is all going to work, especially when you are filing for restricted licenses. We still don't understand how the Department’s

review dovetails with OHCA's for those new entities. Because new entity filings that constitute 25 million or more in projected revenues fall under the criteria for an OHCA CMIR review as well. Thank you.

MS. DUTT: And Bill, circling back on your question on how many of those plans on the watch list, our monitor closely list, are commercial restricted. There are two that are restricted for commercial.

CHAIR RIDEOUT: Any other topics? And I think along the lines of Bill's comments, I think if we know that someone like OHCA is coming in the next meeting, it would be helpful to get specific questions that we would like to put in front of them. Whether they choose to answer them or not is another thing, but I think that helps committee members hone their presentations a little bit for them.

Okay, any other items? Anybody on virtual?

All right. Well, that concludes today's meeting. Can I have a motion for an adjournment.

MEMBER SEIDENWURM: So moved.

CHAIR RIDEOUT: Thanks, Dave. Second?

MEMBER DURR: Second.

CHAIR RIDEOUT: All right, so we are adjourned. Thank you, especially those that made the trip. We encourage all of you to come in person if you can. Take care.

(The meeting was adjourned at 12:31 p.m.)

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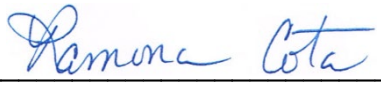
CERTIFICATE OF REPORTER

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

That I am a disinterested person herein; that the foregoing Department of Managed Health Care, Financial Solvency Standards Board meeting was electronically reported by me, and I thereafter transcribed it.

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

IN WITNESS WHEREOF, I have hereunto set my hand this 4th day of September, 2024.



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