STATE OF CALIFORNIA

DEPARTMENT OF MANAGED HEALTH CARE

HEALTH EQUITY AND QUALITY

COMMITTEE MEETING

VIRTUAL ONLINE/TELECONFERENCE MEETING

HOSTED BY THE

DEPARTMENT OF MANAGED HEALTH CARE

SACRAMENTO, CALIFORNIA

WEDNESDAY, AUGUST 17, 2022

12:00 P.M.

Reported by: Ramona Cota

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APPEARANCES

Voting Committee Members

Anna Lee Amarnath

Bill Barcellona

Dannie Ceseña

Alex Chen

Cheryl Damberg

Diana Douglas

Tiffany Huyenh-Cho

Edward Juhn

Jeffrey Reynoso

Richard Riggs

Bihu Sandhir

Kiran Savage-Sangwan

Rhonda Smith

Kristine Toppe

Doreena Wong

Silvia Yee

Ex Officio Committee Members

Palav Babaria

Alice Huan-mei Chen, represented by Taylor Priestly

Stesha Hodges

Julia Logan, represented by Crystal Esparza

Robyn Strong

APPEARANCES

DMHC Attendees

Mary Watanabe, Director

Nathan Nau, Deputy Director, Office of Plan Monitoring

Chris Jaeger, Chief Medical Officer

Sara Durston, Senior Attorney

Shaini Rodrigo, Staff Services Analyst

Sellers Dorsey Attendees

Sarah Brooks, Project Director - Facilitator

Alex Kanemaru, Project Manager

Andy Baskin, Quality SME, MD

Ignatius Bau, Health Equity SME

Mari Cantwell, California Health Care SME

Meredith Wurden, Health Plan SME

Janel Myers, Quality SME

Other Presenters/Speakers

None

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PROCEEDINGS

12:02 p.m.

MS. BROOKS: Good afternoon and welcome to the eighth Department of Managed Health Care Health Equity and Quality Committee. My name is Sarah Brooks. I am a Director with Sellers Dorsey, a consulting firm that has been brought on by the DMHC to help support this effort.

AB 133, the budget bill from last year, charges this Committee with making recommendations to the DMHC specifically on health equity and quality measures and benchmarks that should be utilized for oversight of managed care plans overseen by the DMHC.

As discussed in previous meetings, these recommendations will be made and put forth to the DMHC in the form of a report drafted by Sellers Dorsey that is representative of the Committee's positioning.

During last month's meeting we heard from Sara Durston regarding DMHC's regulation process and from Covered California, DHCS and CalPERS on their respective benchmarking processes. In addition, we finalized the recommended measure set and began discussions around benchmarking and measure stratification.

Our last meeting was very fruitful. There was active discussion by Committee Members allowing for consideration of the different benchmarking approaches. During today's meeting I encourage you all to continue to consider the major tenets from last month's meeting including the focus on equity and setting a floor for all plans regulated by the DMHC. We will finalize discussion specific to benchmarking stratification today and next month's meeting we will review the report, the draft report, and get feedback from you all then on that.

So as a refresher, the Committee will move forward with the following recommended measure set. You all are familiar with these measures, I thank you for letting me read them to you: colorectal cancer screening, breast cancer screening, hemoglobin A1c control for patients with diabetes, controlling high blood pressure, asthma medication ratio, depression screening and follow-up for adolescents and adults, prenatal and postpartum care, childhood immunization status, well-child visits in the first 30 months of life, child and adolescent well-care visits, plan all-cause readmissions, immunizations for adolescents, excuse me. And then for the CAHPS survey, we have getting needed care, which includes two different questions, easy for respondent to get necessary care, tests or treatment; and then the respondent got an appointment with specialists as soon as needed.

During previous meetings, there was discussion on DMHC's enforcement effort and approach rather than an improvement performance approach. This is an important distinction to make and will come up throughout today's conversation so wanted to highlight that again now. Ultimately, this is an equity initiative and the objective of this measure set and benchmark is not to create incentive around improving performance necessarily but rather to bring all health plans to the same level by setting the floor for performance and a standard of care across California.

So with that, as always, we have a very packed agenda. I am going to turn it over to my colleague, Janel Myers, who is going to go through housekeeping. Janel.

MS. MYERS: Thanks, Sarah. For our Committee Members, please remember to unmute yourselves when making a comment and mute

yourself when not speaking. For Committee Members and the public, as a reminder, you can join the Zoom meeting on your phone should you experience a connection issue.

Questions and comments will be taken after each agenda item. For those who wish to make a comment, please remember to state your name and the organization you are representing.

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

As a reminder, the Health Equity and Quality Committee is subject to the Bagley-Keene Open Meeting Act. Operating in compliance with the Bagley-Keene Act can sometimes feel inefficient and frustrating, but it is essential to preserving the public's right to governmental transparency and accountability. Among other things, the Bagley-Keene Act requires the Committee meetings to be open to the public. As such, it is important that Committee Members refrain from emailing, texting or otherwise communicating with each other off the record during Committee meetings because such communications would not be open to the public and would violate the Act.

Likewise, the Bagley-Keene Act prohibits what is sometimes

referred to as serial meetings. A serial meeting would occur if a majority of the Committee Members emailed, texted or spoke with each other outside of a public Health Equity and Quality meeting about matters within the Committee's purview. Such communications would be impermissible even if done asynchronously; for example, member one emails member two who emails member three. Accordingly, we ask that all members refrain from emailing or communicating with each other about the Committee matters outside the confines of a public Committee meeting.

MS. BROOKS: All right, thank you, Janel.

So as Janel mentioned, this meeting is subject to the Bagley-Keene Act. And just a friendly reminder not to utilize the Chat during the meeting as that is not allowed by Bagley-Keene.

All right, so we will move on to Slide 6, please. Slide 6 walks us through today's agenda which includes a presentation from DMHC Director Mary Watanabe to discuss the DMHC's regulation and enforcement process. We will have a vote on benchmarking methodologies and measure stratification as well.

Throughout today's meeting we will identify the Committee's recommendations and then conduct a vote at the end of the meeting on all of the identified recommendations. I want to pause there for a second and just say that as we go through the meeting and we have discussion on the different issues we will come to consensus and I will say, what I hear from you all is that you are saying this. We will come up with all of the recommendations for benchmarks and measure stratification. At the end of the meeting we will take a vote on all of that information together at one time. So at this time -- next slide, please.

At this time I would like to do a quick roll call of DMHC

representatives, Committee Members and introduce the Sellers Dorsey team. Mary Watanabe?

MS. WATANABE: Good afternoon, I am here.

MS. BROOKS: Hello. Nathan Nau?

MR. NAU: Good afternoon, Sarah.

MS. BROOKS: Chris Jaeger?

MR. JAEGER: Present.

MS. BROOKS: I was going to say I thought I saw Chris. Sara Durston?

MS. DURSTON: Good afternoon.

MS. BROOKS: Next slide, please. Anna Lee Amarnath?

MEMBER AMARNATH: Hello.

MS. BROOKS: Bill Barcellona?

MEMBER BARCELLONA: Present.

MS. BROOKS: Dannie Ceseña?

MEMBER CESEÑA: Present.

MS. BROOKS: Alex Chen/

MEMBER ALEX CHEN: Present.

MS. BROOKS: Cheryl Damberg?

MEMBER DAMBERG: Present.

MS. BROOKS: Diana Douglas?

MEMBER DOUGLAS: Present.

MS. BROOKS: Lishaun Francis?

(No audible response.)

MS. BROOKS: Next slide, please. Tiffany Huyenh-Cho?

MEMBER HUYENH-CHO: Present.

MS. BROOKS: Edward or Ed Juhn?

MEMBER JUHN: Good afternoon.

MS. BROOKS: Jeff Reynoso?

MEMBER REYNOSO: Good afternoon, present.

MS. BROOKS: Rick Riggs?

MEMBER RIGGS: Good afternoon.

MS. BROOKS: Bihu Sandhir?

MEMBER SANDHIR: Present.

MS. BROOKS: Kiran Savage-Sangwan?

(No audible response.)

MS. BROOKS: Rhonda Smith?

(No audible response.)

MS. BROOKS: Kristine Toppe?

MEMBER TOPPE: Present.

MS. BROOKS: Doreena Wong?

MEMBER WONG: Here.

MS. BROOKS: And Silvia Yee?

MEMBER YEE: Present. Thank you, Sarah.

MS. BROOKS: All right, Palav Babaria?

MEMBER BABARIA: Present.

MS. BROOKS: Hello.

Alice Chen. I believe, Taylor, you are on; is that right?

MEMBER PRIESTLY: Hi. Yes, Taylor Priestley.

MS. BROOKS: Welcome Taylor.

All right, Stesha Hodges?

MEMBER HODGES: Here.

MS. BROOKS: Julia Logan? I believe Crystal may be on?

MEMBER ESPARZA: Present.

MS. BROOKS: Hi, Crystal.

Robyn Strong?

MEMBER STRONG: Present.

MS. BROOKS: All right. And then just the list of Sellers Dorsey team that are working on this effort here. Next slide, please.

All right. These materials that are presented here on Slide 13 will be utilized throughout the meeting today and can be used as reference documents as well. Specifically, the Final Recommended Measure Set Workbook, a Summary of 2021 National Quality Compass Data, and a Summary of the California Plan Performance are very informative and will provide the necessary details during the benchmarking discussion. So as we get to the benchmarking discussion we really recommend you look at this workbook.

The workbook received by Committee Members contains performance data for the 5th percentile, 10th percentile, 25th percentile, 33.3rd percentile, 50th percentile, 66.7th percentile and 75th percentile with respect to the Quality Compass, NCQA measures stratification status, and other relevant information as requested by Committee Members.

You also received a Summary of 2021 National Quality Compass Data. This includes the same information as is in your workbook. However, it presents it in a more simplified manner and includes a smaller subset of all of the data or percentiles that are included in the workbook itself.

Committee Members should have received several documents ahead of this meeting for your review. Those included the agenda, presentation, both the July 13 meeting summary and transcription, the Final Recommended Measure Set Workbook that we just talked about, the Summary of the 2021 National Quality Compass Data, a Summary of California Plan Performance and then a Public Comment Handout as well. Next slide, please.

All right. So Committee meetings have been scheduled through September. Today's meeting will be the last meeting prior to the review of the health equity or the draft health equity report during the September meeting. So we will get through finalizing benchmarking and measure stratification today and this is our final meeting to get through those items. All right, so next slide, please.

All right. So we will now take questions and comments from Committee Members. Just as a reminder, please state your name and organization before asking a question or comment. So I will just look to see if there are hands raised by Committee Members specifically.

Okay, not seeing any, Shaini, do we have any members from the public raising hands?

MS. RODRIGO: There are none at this time.

MS. BROOKS: Great, thank you. Shaini.

All right, we will move to Slide 16. All right. The July 13, 2022 meeting summary was included in your meeting packets. If there are no changes to the meeting summary then they will be considered final and will be posted online. So just checking with Committee Members to see if there are any comments or edits to the July 13 meeting summary?

Okay. And not seeing any hands raised, Shaini, again I will ask if there are any public comment hands?

MS. RODRIGO: There are no hands raised at this time.

MS. BROOKS: Thank you. Shaini.

All right, so we will move to Slide 18. So today we will continue the discussion around DMHC's regulation and enforcement process. As we know, the DMHC measures and monitors different health plan requirements in many ways. Today we have DMHC Director Mary Watanabe to provide additional information on the subject matter. At this time I will turn it over to you, Mary.

MS. WATANABE: Thank you, Sarah. I just want to take this opportunity as we are headed into our last two meetings to thank our Committee for your participation. I know this has been a very intense and long meeting, intense process, but I have just continued to be very impressed with your ongoing participation, but just the robust discussions that we have had over the last seven meetings. You have obviously taken this very seriously and you have done a really good job of representing your communities and the organizations that you are here on behalf of. So I just wanted to take a moment to say thank you. Hang on; we have got another intense meeting but one more to come.

Before we head into our final discussion on benchmarks I wanted to just kind of reiterate some of the things we have said early on in the meetings. Sara Durston did a really good job last week on regulations. So I want to make sure everybody that is here today, part of that benchmarking discussion hears about this again because there's really two elements of this initiative that are unique and groundbreaking in many ways and I know they have also caused some confusion.

The first is that we will take enforcement action against any plans that do not meet the benchmarks we set. In order to take enforcement action we really need to clearly articulate the benchmarks in regulation. These are required in AB 133, the budget trailer bill from last year, so they are not optional. This really was the intent of this initiative, to really signal that this administration takes very seriously that we are addressing health disparities.

So again just a couple of things that Sara mentioned last time about regulations: The DMHC differs from other state agencies that contract directly with plans. We don't contract with plans, we are their regulatory agency, and as the regulator our job is to make sure the plans meet the requirements that are in law. To implement any of the Committee's recommendations we will have to promulgate a regulation that identifies the measures the health plans will have to report and what standards they must meet. And a regulation, if you are not familiar, is a rule that implements, interprets or makes specific the law, and in this case it is specifying the requirements of AB 133.

In the regulatory process the DMHC must comply with California's Administrative Procedures Act. The formal rule rulemaking process takes about a year. And once we start that formal rulemaking process we can't have any informal conversations about the regulation. I am going to reiterate this because we have had a lot of questions about how can I comment on what the Committee is doing? And I will just say, there is an opportunity attending these meetings for the public to give comment. You can submit comment in writing up to a week after the meeting. But once we start the formal rulemaking to codify both the measures and the standards there is another opportunity for formal public comment. It has to be in writing. And I think the one thing I will say is once we

start that process please don't call me or email me because as much as I would love to talk to you, I can't. Everything has to be formal, on the record, in writing. So I just want to make sure that is clear. There's going to be future opportunity to comment as well.

The other thing I will just reiterate here is the regulation really needs to have detailed requirements that we can enforce and that can withstand a challenge from the health plans.

So let me talk a little bit more about enforcement. We talked about this early on in our meetings but I want to make sure this is very clear. Starting in measurement Year 2025 the Department will take enforcement action if plans don't meet the standards set forth in the regulation. Ideally, this would be a specific percentage. There have been conversations about a percentage of improvement, or the plan has made efforts to try to improve their performance. These are ideas that are typically used in a pay-for-performance approach but we could end up in an administrative hearing or even in superior court arguing and arguing about the definitions of what does improvement mean or how did you calculate that. And so having something very specific that we are holding plans to is going to be really important.

The other thing I will just say, just maybe an example of that is having, like I said, a specific percentage so that it is very clear any plans that fall below that percentage, those are the group, that is the group that we would take enforcement action against.

In case you are new to the DMHC and what enforcement action really means. Our job, again, is to hold the health plans accountable for the law. When they don't, enforcement action looks like fines and penalties or corrective

action plans. This is really important to think about when we talk about setting benchmarks because we are really talking about what performance level is so low that we believe enforcement action, including a financial penalty, is needed to address the low performance and hopefully to incentivize investments to improve performance. And again, this is not just overall performance improvement but really looking at poor performance by racial and ethnic groups and we will talk more about this later today.

You might be wondering, what does that mean? What is that financial penalty? You know, we -- I can't tell you what the numbers would be but there's a number of factors we consider when determining penalty amounts including the nature, scope, or gravity of the violation, the willfulness, the cooperation of the plan, the financial status of the plan, and the amount necessary to deter similar violations, which I think is probably most relevant here as well.

So I, you know, I just wanted to make sure we were really clear what enforcement means. But this is really what makes us unique and why we have to codify things in regulations. So I hope that was helpful, a little bit of a refresher. I know for some of you that have been through this at previous meetings but I would be happy to take questions. And I think, Cheryl, I see your hand up, go ahead.

MEMBER DAMBERG: Mary, I found that very helpful. One question that I had once you move to codify this is, you know, whatever benchmark, say the Committee recommends, and let's say you go with it. Is there the ability to modify that benchmark in the future and what is the process for that?

MS. WATANABE: Yes, no, we have actually been thinking a lot about that too just based on the conversations we have had. So as I mentioned, the regulation process takes about a year. That is the formal rulemaking process. The process of kind of, you know, what leads up to getting to that point can also take sometimes a year to really think, okay, what are we going to do, there's a lot of documentation that that we need to include. In AB 133, we will reconvene the Committee in five years, revisit kind of what we have done; and then it probably will take another year to recodify any changes in regulation.

Having said that, you know, this is, this is new, it is innovative, we are going to try some things. But if at some point probably, you know, we need probably two years' worth of data to say, okay, maybe that didn't work. We would have the opportunity to reopen the regulations so I don't want to completely rule that out. But they are also just by the nature of how you know, quality measurement works, there is a delay in getting the data and having at least probably two years to say, okay, how did that work? Does that help, Cheryl? Kind of?

MEMBER DAMBERG: Yes, no, sorry, I had you on mute. That does help. But, you know, kind of what it tells me is, when you say five years you are talking five years from 2022 or from 2025? Because I am just trying to figure out like how long that back tail is before you can make a change? So are we talking about, you know, 2030, 2032?

MS. WATANABE: Yes, no, you are -- so it is really five years from the convening of the Committee, so 2027, and then we are probably talking 2029 by the time we have that codified.

MEMBER DAMBERG: Okay, thank you.

MS. WATANABE: Yes. Okay, Kiran, I think I saw your hand up next.

MEMBER SAVAGE-SANGWAN: Yes, thanks, Mary, this is really helpful. And, you know, I am excited to see how this works and what we learn and what it accomplishes. Just a small process question which is that, so this Committee is delivering just recommendations to you to decide how to proceed and then however you decide to proceed will go into regulation. So I just -- is there an interim step in there where you would come back to the Committee to share how the Department has decided to move forward before promulgating your draft regs so there can just be one more round of feedback or does it have to go straight into regs?

MS. WATANABE: Yes, no, and I don't have a perfect answer. I think the tricky piece here is we have now -- we have added an additional meeting. The report was due to the Department by the end of September, we are probably going to bump that out just a little bit to make sure we have time to have a, you know, a thorough report. We need to issue guidance and templates to the plans in November in order for them to start collecting this information in 2023 measurement year. So likely what will happen is we will, based on the recommendation of the Committee, make decisions about what measures are to be collected. We will have some time as we start working on regulation processes to potentially share that for our informal stakeholder process. So more to come on that. We are now bumping up against a very aggressive timeline so bear with us but it is always our intent to be as transparent as possible. But I just want to make sure everybody is clear. Once we are in formal rulemaking we can't have informal conversations. As much as we would love to

we can't. Diana.

MEMBER DOUGLAS: Thank you, Diana Douglas with Health Access. One just quick note I want to make. Is there, if there is a capability to turn closed captioning or transcripts on for this meeting? I am not sure if that is something that is typically available or if that is something that could be enabled, that would be appreciated for accessibility for folks who are watching.

And then on to my question, which I think is maybe similar to what Kiran noted. I guess I am wondering if after the formal rulemaking process when we are able to come back and have those discussions, would there be a possibility for, I don't know if I want to say reconvening the Committee, but even in an informal manner gathering the folks that have participated in this process in the Committee, even on an annual basis or every so often between now and the next official reconvening in five or so years, to give an annual update on how, you know, how it's going, how plans are doing in meeting the benchmarks and so forth. It might be helpful since we know eventually this will be a process repeated, to not have the full five year span go without any kind of reconvening of the folks here to give an update and just, you know, stay attuned to how it's working.

MS. WATANABE: I would be happy to take that back and think about kind of what that would look like and the timing. You know, we will have an annual report with our findings. And maybe after we have the annual report released, everybody has time to digest it, that would make sense, but we will take that back, Diana.

On the closed captioning, thank you for that note. I am assuming my team is looking into that. And if there is something we can do or can do

quickly we will certainly try to, try to do that. Ed.

MEMBER JUHN: Thanks so much. So, Mary, just to make sure that we are tracking to what you had shared earlier, is it in this Committee's understood understanding that it is the preference to have some type of absolute benchmark for both Commercial and Medi-Cal plans and today we are thinking about how to think about those absolute benchmarks whether it is going to be annually adjusted or fixed. Is that the right sort of framing as we enter into our benchmarking discussions or is there still time to think through about absolute versus improvement? Just wanted to make sure we are tracking?

MS. WATANABE: Ed, appreciate that. I wish we had more time to maybe, you know, have further conversations. But the goal today is really to land on, at least for this initial round, what are those benchmarks? I think there are some nuances we will have to discuss of what that percentage might be. Is it fixed? Will it change from year over year? How will we handle line of business? If you have looked into the meeting materials there's a number of slides related to that. To Sarah's earlier comment, we have not provided slides that say, these are the things we are voting on specifically. We want to be able to respond to kind of what we are hearing from the Committee to inform what the vote will be. So we are going to be a little bit flexible and adaptable today based on the conversation that we have but I think there's a number of, a number of different factors we will have to discuss today. Diana.

MEMBER DOUGLAS: Thank you. I'm sorry, this might just be something I missed or I am not remembering from the last meeting. But did we already vote on relative versus absolute or was that based on the conversation from the last meeting that we are just going on with, with absolute measures?

MS. WATANABE: Sarah will correct me if I am wrong but we have had a lot of discussion about benchmarks but the only votes have been on the measures. And so the goal today is to try to reach some consensus on what the options would be for benchmarks and then hopefully vote and have something that can go into the report that will we will review at the next meeting. Sarah, is that correct?

MS. BROOKS: That is correct, Mary. I believe you are talking to me.

MS. WATANABE: Yes, sorry, Sarah Brooks. We have a number of Sarahs, yes.

MS. BROOKS: All right. So I am not seeing any other hands raised from Committee Members. I will just check with Shaini to see if we have any public comment questions.

MS. RODRIGO: There are no raised hands from the public at this time.

MS. BROOKS: Okay, thank you, Mary. All right.

So we will now continue the discussion around benchmarking. All right. So throughout this agenda item we will walk through a variety of different recommendations that will be applied to the recommended measure set that we voted on, we voted on during previous meetings. Each of the items that are voted on will build upon each other in a stepwise manner. So as Mary mentioned and as I mentioned earlier, we will come up with a set of recommendations that will be voted on at the end of the meeting. Next slide, please.

Slide 21 outlines the specific meeting materials that will be

essential for the discussion including the Final Recommended Measure Set Workbook that we talked about earlier, the Summary of the 2021 National Quality Compass Data and then the Summary of California plan Performance. Next slide.

As we have discussed, this initiative is specifically focused on equity and reducing health disparities. To that extent, this is an opportunity to create a standard of care across California driven by the DMHC.

As a refresher, during last month's meeting we heard from DHCS, Covered California and CalPERS regarding their respective organizations' benchmarking processes. Covered California and DHCS both provided examples of how their respective organizations hold plans accountable by having contracts that require enforcement and have mechanisms to incentivize quality improvement.

In contrast, DMHC as a state regulator is responsible for holding plans accountable to a standard of care or floor for all DMHC regulated plans. In addition, DMHC utilizes regulation to require corrective action and enforcement action if health plans do not meet the intended benchmark. So you can see that this slide demonstrates the purchaser versus the regulator in terms of information. Next slide, please.

So also as a refresher, during last month's meeting there was discussion and rationale for using a national benchmark rather than California-specific benchmark. This is the case because using California's performance data for enforcement would not be appropriate for the purpose of this measure set because a significant number of plans would subsequently be subject to enforcement. So I think to say that again in a different way, if we use California

benchmarks only then there will always be plans that are not able to meet the requirement, or the percent, the benchmark that is set, excuse me. Next slide, please.

So during our discussion on benchmarks the following terms will be used: percent or percentage and percentile. Percent will be discussed today in terms of plan performance. So we have a slide here in terms of definitions.

For example, for breast cancer screening if the plan screens -- let's go back to Slide 24, please. Yes, thank you. So for example, for breast cancer screening, if a plan screens 6,791 out of 10,000 persons, then they have screened 67.91% of persons. So that is the percent/percentage, all right. Next slide, please.

Percentile is a value on a scale of 1-100 that indicates the percent of this distribution that performed is at or below it. For example, for breast cancer screening, if the 25th percentile performance is 67.91%, then 25% of plans screened 67.91% or fewer persons. Conversely, excuse me, 75% of plans screened greater than 67.91% of persons. Next slide, please.

So during today's discussion we will review four distinct recommendations that will be applied to the recommended measure set. For each recommended item we will share an example of what is being referred to, discuss the strengths and challenges and determine Committee consensus around each recommendation. At the end of the meeting a single vote will occur, as we discussed.

The specific recommendations that we will discuss today if benchmarks will be set by include what is listed on the slide here. So Commercial, Medicaid, or by Line of Business percentile as a floor; common or

measure-specific percentile as a floor, fixed or annually adjusted percentile as a floor, and the Quality Compass percentile as a floor. And we will go through what each of those mean as we go through the different slides.

So I am going to go ahead and turn it over to my colleague Andy Baskin who is going to take it from here and talk a little bit about Commercial, Medicaid or by Line of Business benchmarking. Andy.

DR. BASKIN: Thank you, Sarah. Can you hear me okay?

MS. BROOKS: I can.

DR. BASKIN: Great. The next slide, please. I will actually talk about a brief part of it before I hand it over to Ignatius.

In your materials you do have some materials about the measures that were chosen and gives you the actual Quality Compass percentile performance results. For instance, as you are seeing on this page, this is just a subset of what you have been given in the workbook, the national 25th percentile for the child and adolescent well-care visits is a performance of 45.44%. So as we just stated, that means that 25% of the plans met that particular measure, 45.44 or less in terms of their performance. And by the same token, 75% or greater, we also give you the Medicaid number, as you can see there. And you can obviously see that they are always going to be different, obviously, because it is a different set of plans that are used to create the percentiles.

But I will caution you and you will be able to see this if you look at the entire workbook and look at the bigger set of numbers that the percentile for performance, let's say for example the 25th percentile, is not always higher in one line of business versus the other universally. As it turns out, if you were to actually look at the data for the 25th percentile, 3 out of 11 of the measures -- I

don't say 13 because there's 2 measures where there's not enough data so there actually is nothing to compare. But of the 11 measures where we have comparative numbers of performance for the 25th percentile, it turns out in 3 of those measures the Medicaid plans actually perform higher. Their 20th percentile result is actually higher than the Commercial plans. But of course, that means that 8 of them is the other way around where the Commercial is higher than the Medicaid plans.

And just for your interest once again, those 3 particular measures are the pre and postnatal care, which I count as one measure although there's two results to it, the adolescent immunization measure and the controlling high blood pressure. And I don't know that there's anything particular about those measures that I could point out except to say that Medicaid plans obviously are paying attention for some reason or not to these particular measures. So we shouldn't make any judgments about one set of percentiles being universally because it is just not the case.

The other thing I want to point out is that as you make your decision-making that the difference between Medicaid and Commercial can be smaller differences, sometimes only a percentage point or two percentage points in terms of the performance at the 20th percentile. But on other occasions there can be very, very significant gaps or differences, a delta between those numbers, such that to close that gap between -- to move Medicare to Commercial or the other way around, move Commercial up to Medicare, can be a daunting process. In fact, hard to believe it can happen unless over several years' time. So I will stop there and go to the next slide and turn it over to Ignatius.

MR. BAU: I think Andy meant to say Medicaid, not Medicare, so just to make sure.

DR. BASKIN: Ah, yes, you are correct. I work in the Medicare world too often, I apologize.

MR. BAU: So again, we are toggling between the percentages and the percentiles and so that is why we started with those definitions. But if there were a common benchmark across all plans, across all Commercial plans and Medicaid plans regardless of line of business, then clearly it is easier for everybody to understand, people know what the target is. But then we have these differences that are naturally occurring right now between what those Medicaid performance levels are versus the Commercial performance levels.

And in one case, if you looked at the well-child visits, the gap, as Andy said, between Medicaid and Commercial is pretty significant for that well-child visit measure for the first 30 months. Only 45% of Medicaid plans are reaching that 25th percentile if we use that as the benchmark, versus 74% of the -- Commercial plans are at 74% screening for well-child visits, Medicaid is only at 45%. So that is a pretty steep difference for those Medicaid plans to catch up from screening 45% of those patients who needed well-child visits to get up to the 74%. So that is an instance where the gap is pretty significant.

There are other measures that we are looking at in the 13 measures where the gap as Andy said is only a couple of percentage points so the difference would be easier to make up. And this is all trying to make sense of all this in terms of the numbers. Next slide.

So similarly, if we switched it and used Medicaid as the benchmark rather than the Commercial benchmark then it would mean that it would be

easier for many of the Commercial plans to meet that benchmark because the Medicaid benchmark is lower for 8 of those measures and you would still have the benefit of having some consistency in terms of a floor for everybody. There are going to be those 3 measures, as Andy noted, in which the Commercial plans are generally doing worse than the Medicaid plans so they would have to catch up on those 3 measures, whereas conversely the Medicaid plans would have to catch up on 8 of the measures. Next.

And so again, here, you know, we can we can speculate and have good conversations about why the rates are different by line of business. Clearly the Medicaid population is generally low-income, may have more barriers, especially when it relates to access and screening kinds of measures, the consistency of care that they have with their primary care providers. And so again that may be the reason; but we also want for equity purposes eventually to move to a place where we are holding everybody to the same standard. Next slide. And so -- keep going, next slide.

So one way that we could address that is to set the standards by line of business. To hold the Medicaid plans to the Medicaid 25th percentile and hold the Commercial plans to their 25th percentile. That is something that the plans would be used to. The downside of that, the challenge of that approach would be that it would imply that difference in performance again, sometimes Medicaid doing better than Commercial, sometimes Commercial doing better than Medicaid, is something that we would want to continue for the short term. And we eventually want to get to a place from an equity perspective, where we don't have a different standard of care for a line of business. But again, in this interim first phase of implementation that may be a better way that the

Committee will want us to make that recommendation. So I am going to stop there and start responding to the hands. Sarah, do you want to call on folks?

MS. BROOKS: Thanks, Ignatius and Andy. Kiran, your hand is up.

MEMBER SAVAGE-SANGWAN: Yes, thank you for going over all that, super interesting. I just had a, I need a reminder. Does this -- are these benchmarks or the whole program, is it going to apply to the non-Knox-Keene licensed Medicaid plans, the COHS, or is it only to a pretty small subset of Medi-Cal managed care plans? Just so we know what universe we are talking about here.

MS. BROOKS: Mary and Nathan, my recollection is that there is some language that has you working with DHCS on non-Knox-Keene licensed plans; is that correct? Am I remembering correctly?

MS. WATANABE: You are correct. The DMHC will enforce the measures and the benchmarks for all plans that we regulate. For the Medi-Cal managed care plans, the COHS that we don't regulate, DHCS will be doing that.

MEMBER SAVAGE-SANGWAN: So DHCS will enforce the same benchmarks in addition to all of the things that DHCS is doing specifically through a contract; is that right?

MS. WATANABE: Yes.

MEMBER SAVAGE-SANGWAN: Okay, thank you. Thanks.

MS. WATANABE: Yes. Unless, Nathan, tell me if I am wrong, but I believe that is true.

MR. NAU: I am I am not sure on that one, Mary, we may want to follow-up on that last part. I think, I think the -- well, I see Palav with her hand up, maybe she can clarify, but I thought they would continue with what their

benchmarks are.

MS. BROOKS: Palav, did you have a comment on that?

MEMBER BABARIA: Yes, and I had another comment which I can hold or add right now. But yes, we have set the minimum performance level for all contracted plans, which includes the non-Knox-Keene licensed plans, at the Medicaid 50th percentile benchmark. So I don't know if on that slide we looked at sort of how does the Medicare 25th percentile compare to the Medicaid 50th, but we are going to be holding all plans that we contract with to the 50th percentile independent of this process.

MS. BROOKS: So it sounds like maybe Kiran and Mary and Nathan can add here, but we can certainly circle back with some follow-up on that after some additional discussion is held. Does that make sense?

MS. WATANABE: We will go back and read AB 133 and we will follow-up. We will go free, we'll research.

MS. BROOKS: Thank you for your question. Silvia.

MEMBER YEE: Hi, this is Silvia from Disability Rights Education and Defense Fund. I just wanted to get an update on the closed captioning situation. I take very seriously the request, an explicit request for the closed captioning. My own experience with Zoom is that the closed captioning has to be turned on before a meeting starts; and if that doesn't happen there is no, there is no way to actually turn it on during a meeting. And while it may be very inconvenient I would certainly think that taking a few minutes to sign off and then sign back in is worth it to ensure accessibility, full accessibility of this meeting, or as much as captioning will provide. Thank you.

MS. WATANABE: Yes, maybe let me -- I will respond to what I

know and others can jump in if there is something more current. Our understanding is that we may have had to arrange for someone to be able to type and transmit the captions and we did not get a request. We have requests that you can request accommodation in advance and we didn't get any requests to do that so we haven't set that up. We are looking right now if there's another option to turn that on automatically or have some other service to do that quickly. But we are not seeing, I am going to just pause and see if Daniel, Shaini, anybody else has found any other option to do it immediately. Because I am happy to pause the meeting if there is a way that we can do it. Any updates from anybody on the phone?

MS. RODRIGO: Right now we do not have any updates in terms of being able to get this on right now immediately. We are still trying to look for options but at this time we have yet to find something.

MEMBER CESEÑA: Hi, this Dannie from the California LGBTQ Health and Human Services Network. Zoom does have a closed caption option. And Silvia is correct, everyone would need to log off. Whoever is in charge of the Zoom room would have to go into the Zoom website under this calendar event within the Zoom website and turn on closed captioning and then we can all log back in again. But you have to do it from the Zoom website while we are all logged off.

MS. WATANABE: Daniel and Shaini, do you have the ability to do that if we log off?

MR. RUBINSTEIN: Um. Sorry.

MS. WATANABE: And does that change the -- yes, go ahead.

MR. RUBINSTEIN: I am double-checking the Zoom webinar

settings right now. I have gone through several of the tabs. I don't actually see that option but Shaini could verify. Some of my screen is blocked off because I am the one sharing the PowerPoint. Unfortunately it might -- I am not sure if it is an option for webinars because this is a meeting, not -- this is a webinar, not a meeting, and unfortunately Zoom does have different settings for meetings versus webinars. I just went through the tabs again and I don't see a closed caption option but maybe, Shaini, maybe if you could double check.

MS. WATANABE: Dannie's is saying it is an option for webinars. So let's do this because I want to try to do what we can to turn this on. Maybe if we can just pause for a minute and see if we can figure this out. We may have to resend out panel links to log back in as well; it may change our Zoom link. So let us -- can we just maybe everybody take a break for a couple minutes while we see what we can do, is that okay?

SPEAKER: Sounds good.

MR. RUBINSTEIN: I am going to go ahead and stop sharing for a moment if that’s okay?

MS. WATANABE: That’s fine.

MS. DURSTON: So will we all leave the meeting? Should we all sign off and come back at a set time?

MS. WATANABE: Let's hold on maybe for just a minute. I am a little concerned that our Zoom link and our Panelist links may change. I don't know if anybody else has experience logging off and logging back in and whether that changes the Zoom link and we need to -- I want to make sure we resend that to the public as well. I don't know, Dannie or Silvia, if you have any experience when you log off and come back if it changes that?

MEMBER CESEÑA: Hi. Go ahead, Silvia.

MEMBER YEE: I was just going to say that I -- this is Silvia from DREDF. I have experienced that though I have to say I cannot remember whether it was a meeting or a webinar in which I logged off and logged back in. I didn't think a change was necessary. Dannie, you may have additional information.

MEMBER CESEÑA: Yes, I have logged off of webinars that I have hosted before to turn on closed captioning and have been able to log right back in using the same link. It's just like mentioned earlier, folks just need to log off so that way the entire system can re-update with the closed captioning.

MS. WATANABE: Thank you.

MR. NAU: Dannie, do you recall which tab you went into or where that function was in the system?

MEMBER CESEÑA: I will log into my Zoom right now and maybe I can take some screenshots to send to you.

MR. NAU: Thank you.

MR. RUBINSTEIN: I just found the automated captions button, it is in somewhat of a hidden menu. Let's see. I just, I just enabled it but I think we would have to leave the meeting and come back in.

MEMBER CESEÑA: Right.

MR. RUBINSTEIN: I am not sure if that will change the meeting link, I would assume not. And there's no, there’s no pop up when I enabled it saying that something else has changed.

MS. WATANABE: All right, so let's do this. We are all going to log off. For members of the public, this includes you. And then we are going to give

it 30 seconds or so and then come back in using all of the same links. If for any reason that does not work and you have any problems, you can either email the email that is at the bottom of the agenda or stakeholders, with an s, @dmhc.ca.gov. So if you have any problems I think the email that is at the bottom of our agenda or our stakeholder mailbox, and we will we will send you something to get you back on. And for the Committee, if somehow that Panelist link doesn't work we will get something out to you. All right, we will see you all hopefully in about 30 seconds. Thank you.

(Off the record at 12:50 p.m.)

(On the record at 12:52 p.m.)

MR. RUBINSTEIN: Enable auto-transcription.

MEMBER SANDHIR: Yes, it says it is enabled.

MS. WATANABE: Success. Well now we know for next time. All right, thank you. Thank you, Silvia and Dannie, for pushing us and helping us figure this out. All right.

MS. BROOKS: Perfect.

MS. WATANABE: All right, Sarah, back to you.

MS. BROOKS: Okay, there we go. There were a couple of hands up before the break. I think, Diana, you had your hand up. I just wrote down the order of people so I am not sure if you still had a comment, or if she is back.

MEMBER DOUGLAS: Hi, I am back, thank you.

MS. BROOKS: Okay.

MEMBER DOUGLAS: Let's see, switching gears back. I think my comment was just going to be that I would strongly advocate for at least, you know, having a time set to switch to benchmarks by a single or across all lines of

business rather than being separated out by line of business. I think, you know, understanding that plans in the Medi-Cal versus Commercial markets are starting out at very different places, understand if we may need to start out separating out by line of business. But I would urge us to have, you know, maybe not just the intention but have a specific timeframe in mind or voted on for combining those, say, whether that be after the initial five year period or something to that effect.

MS. BROOKS: Thank you, Diana.

Can I ask Sara Durston, is she on? I know she was on before. Just in terms of kind of the approach that Diana just described, which I think sounds a little bit like a phased-in approach of sorts. How does that work with the regulations?

MS. DURSTON: I'm sorry, it cut up just for a second. Diana, will you just restate what you had suggested?

MEMBER DOUGLAS: So would it be, would it be feasible to have a set point in time at which we would switch from separate benchmarks for each, for Medi-Cal versus Commercial to instead at some point in time move to benchmarks across both lines of business? And seeing, I guess, whether that would need to be at the five year mark or, you know, feasible to do it sooner or we want to set that at the five year mark once the Committee reconvenes for kind of the second round?

MS. DURSTON: Thank you. I think from a feasibility standpoint, with the regulation that would be feasible. The Office of Administrative Law, which reviews our proposed regulations to make sure it meets the requirements of the Administrative Procedures Act, is primarily concerned with clarity and

consistency. So making sure that when stakeholders such as everyone on this call reviews the proposed regulation do you get a good sense of what we would be holding plans accountable to? So I think if it is clearly laid out that for Year X to Year Y you are held to this standard and then it will change to this standard I think that is fine because people would know what the standards are. Whether or not that would make sense given the ramp up to reporting and how quickly we would get the data and the fact that we will be reconvening the Committee in five years, that is kind of a separate question. But I think that probably would be feasible just from getting it approved by OAL.

MS. BROOKS: Thank you, Sara, that that was helpful. I knew I had that question so I thought others might as well. Let me just see. There are a number of hands up. I think Diana has kind of put something on the table there for just -- we will make sure to come back to this, Diana, for discussion if we go on a different track, I just want to take a couple of hands. Palav, it looks like your hand is up.

MEMBER BABARIA: Yes, I think just a comment is that, you know, from a moral and ethical perspective I think this Committee and our state has really an opportunity to say it is unacceptable to set different quality and health outcomes based off of what your income level is, which is essentially what setting different targets for Commercial and Medicaid does. So I would really -- you know, we are doing a lot around equity inside of, you know, DHCS and Medi-Cal but I think this is a huge opportunity to close a lot of those disparities and inherent discrimination that we have between members who have Medi-Cal versus other types of insurance. So I would really highly encourage this group to set a single standard from day one and not phase it in. I do think there are ways

to not make that overly burdensome for our plans so whether that is slightly, you know, lowering the threshold or using a Medicaid threshold instead of Medicare as was presented. There's ways to mitigate that impact. But I think it sends a very strong message to say we are setting a single standard for our state and not accepting these inherent disparities anymore.

I will also point out because Medi-Cal has already set the 50th percentile as our floor that we are taking enforcement actions on. Anything up until the Medicaid 50th percentile benchmark as the floor is completely consistent with expectations that have already been outlined for our plans.

MS. BROOKS: Thank you, Palav. Let me just ask, Taylor, is your comment in alignment with this discussion here just given you are on the --

MEMBER PRIESTLY: (Nodded.)

MS. BROOKS: Yes. Go ahead, Taylor.

MEMBER PRIESTLY: Yes, absolutely, yes, yes. Just wanted to agree completely with the DHCS perspective, thanks.

MS. BROOKS: Thanks, Taylor. All right. Ed, it looks like your hand is up.

MEMBER JUHN: So maybe a follow-up question to what Palav had just mentioned; Ed Juhn, Inland Empire Health Plan.

There are measures currently that have been memorialized for the DMHC Health Equity Quality Committee here that are also included in our Managed Care Accountability Set, our MCAS measure. And recognizing that DHCS is holding Medi-Cal managed health care plans at a minimal performance level of 50%, you know, based on NCQA national benchmarks, would we -- would the DMHC benchmarks have to be consistent with that? And I guess the

question is what happens if we as a Committee recommend that the DMHC Health Equity Quality measure benchmark be at the 25th percentile, yet the DHCS minimal performance level for that same measure is at the 50th percentile? Or is that part of the discussion today and I apologize if it is.

MS. BROOKS: So others may have comments here and DMHC may want to weigh in but I think these are separate. There is connection between the issues, Ed, from my perspective. But we are having a conversation today about what DMHC would be requiring and it is separate and stands alone from what DHCS requires, if that makes sense.

MEMBER JUHN: It does, but I guess wouldn't that create a little bit of complexity, recognizing that the same measure that we are held accountable to is at a different threshold for both DMHC and DHCS for that same measure?

MR. NAU: Sarah, this is Nathan.

MS. BROOKS: Yes.

MR. NAU: Good questions and good points that are being made but just it goes beyond DHCS. So unless we had full alignment between DHCS, Covered California and CalPERS we would have the same challenge. So like Sarah said before, we are talking about the DMHC process. We would like to align as much as possible but I don't know how close we are going to get to full alignment to eliminate these good points that you are making.

MS. BROOKS: Thank you, Nathan and Ed. Anna Lee.

MEMBER AMARNATH: Hi, Anna Lee Amarnath, Integrated Healthcare Association. I really appreciate everyone thinking through the difficulty and the challenges in establishing benchmarks when we potentially have different starting places and what else is happening kind of at all the

different state regulators. And I think I more wanted to foreshadow maybe a comment that could be related to a topic we will talk about later today, which also has to do with how we are planning on approaching benchmarking when it comes to disparity reduction. I mean, just reflecting on Andy sharing that while we typically, and you maybe more commonly see that Medicaid national benchmarks are lower than Commercial, that is not universally the case. And I think depending on what we decide as a Committee here for our recommendations, I guess I just want to foreshadow there is also opportunity to think about whether we want to also make any recommendations around disparity closure gaps that may involve differences in performance based on line of business. And so I just wanted to highlight that as an opportunity and it may just how we feel about that may depend on where we land on this conversation. But just recognizing ,you know, that that is a disparity that exists. And while it may typically be that we see Medicaid performance being lower nationally, it is not exclusive, as Andy pointed out, so just an opportunity.

MS. BROOKS: Thank you, Anna Lee. Bihu.

MEMBER SANDHIR: Bihu Sandhir from AltaMed. I really actually appreciate all these comments and it is complex. Especially with all the data that you presented today it just shows us that, you know, that there are differences within -- I mean, I think actually I was assuming that it was an assumption that we would have thought Medi-Cal would be lower but it is actually not always lower, which is good to see. I actually agree. I want to just make a couple of points. One is I do agree that I think having one standard would be definitely more helpful for us for to be able to actually, so that we could actually meet it. It is easier to, I think, you know, administer in the long run.

The question I have, is there something to consider, and I am not trying to make this more complex, but I think looking at the data that was presented today is, is it, do you think we have an opportunity. We are picking 25th percentile but maybe some of these measures where there's so much of a divide between, so much of a distance between the Commercial and the Medi-Cal is do we think we could pick another measure, another percentile for those particular measures so that they are at least closer? Having a 30 point difference in a measure is not, it is not, to me it doesn't seem it is going to be very hard to achieve it. You are setting up, I think setting us up to fail and that is not the intent of this Committee. I think it is we want this to be achievable. We don't, we don't want disparities.

But we also want, we don't want to necessarily bring down the bar, we want to make sure that we keep the bar at a level which is achievable for everybody. So could we be a little more creative and maybe in certain measures where there is such a difference to look at those a little differently and look at where the meeting point is with the percentiles. So that was just a thought. Thank you.

MS. BROOKS: Thank you Bihu. Let's see. Kristine.

MEMBER TOPPE: Thank you. I actually have a follow-up question for Palav because I have been, I was looking at the data and looking at the three measures in the workbook toward the bottom, the one where both the Commercial and the Medi-Cal plans fall below the national benchmarks pretty much across the board. And my question was around if the DHCS benchmark is 50th it looks like the, the 25th percentile for the Commercial plans is still outperforming that 50th percentile. So in the data it is like I am on row 17. It is,

you know, for the Commercial plans nationally it is like 74.4 and that is -- anyway, I am just trying to get my head around what the recommendation would be if we were to go with one, one benchmark, say it's Commercial or say it's Commercial 25th percentile versus like a Commercial benchmark for Commercial plans and a Medi-Cal benchmark for Medi-Cal plans. Because of the one you don't want to, you know, lower the bar for half of the plans that are, you know, the group of plans that are already meeting the mark. So I just wanted to get clarity around that recommendation.

MEMBER BABARIA: Great question. Yes, I think, you know, either you could just use the Medicaid benchmark instead of Commercial but then that results in what you are saying where you are lowering the goal for a certain subset of plans. Or I wonder if there's a phased-in approach where, you know, the first year is 20th percentile Commercial and then the second year goes to 25th. There's sort of, you know, a ramp-up period where it is still a single standard but there's a little bit of a runway, you know. And I will say like the infant well-child visit measure is one where there's a huge disparity. That is also where we at DHCS have a number of enormous efforts invested right now. And so while it is hard to move the needle rapidly that is what we are intending to do from a policy perspective, sort of irrespective of this conversation anyway. So there is alignment for some of these issues to have a faster timeline I think.

MEMBER TOPPE: Okay, thank you. And I actually had a follow-up question for Mary and Sara Durston. In terms of an ideal scenario for the Department and from an enforcement standpoint can you in regulation, say we are picking the, you know, the Medicaid or the Commercial benchmark at the 25th percentile, and then tie that to whatever the external rate is for that in a

given year? So that is obviously tying -- in the scenario I have in my mind it is the, you know, Quality Compass benchmarks which Commercial benchmarks are released at the end of July; Medicaid benchmarks are released at the end of September. So does the regulation allow for that? Is that common enough for the enforcement work?

MS. DURSTON: This is Sara Durston. I think the regulation could allow for that. So meaning that we would say it is 25% of Medicare. But then you are saying the Medicare changes every year so will it change along with that?

MEMBER TOPPE: Right. So the percentile is the 25th percentile, whatever, whether it's Commercial or Medicaid nationally. And then the rate associated with that benchmark would be the rate that the Department would use for enforcement?

MS. DURSTON: Yes, I think the regulation could state that. We would just have to make it clear what year you were being held to.

MEMBER TOPPE: Sure.

MS. DURSTON: We would just have to state that. And usually we tie it to the previous year. That way they know what they are being held to so it is not real time, there is some lag.

MEMBER TOPPE: Right. Right. So the measurement year versus the year that it is reported in.

MS. DURSTON: Yes.

MEMBER TOPPE: Okay, thank you.

MS. BROOKS: Kristine, this is a great question --

MS. WATANABE: And I will just --

MS. BROOKS: -- because it is something -- oh, sorry, Mary, I cut you off, go ahead.

MS. WATANABE: No, I was just going to say I think there is some value in tying it to something that is, you know, nationally recognized it is publicly available. There is not, there is not a percentage, in theory that would be disputable, right? Because we could clearly define that in regulation that it is the 25th percentile in the Quality Compass. But then really as Sara said, tying it to what year would that be applied to. But I think that is feasible regulation.

MS. BROOKS: Kristine, I think, great question and comments. We will be talking about this issue actually in just a little bit so perfect to kind of key it up for us to talk about.

And I think also just mentioning, because this came up before, that we will be talking a little bit about whether or not there should be a common percentile or a measure-specific percentile, so that is coming up in the discussion as well.

Cheryl, it looks like your hand is raised.

MEMBER DAMBERG: Thanks. I just have some additional clarification questions, one of which I think follows on Kristine's. So as I am thinking about this lag and, you know, let's say it was set to the 10th percentile national. You know, one of the advantages is that percentile, the actual performance is going to change year over year so it will allow for improvement, you know, in performance nationally and so that bar will shift over time. So I just kind of want to be clear that we are all in agreement that that is what would happen under that scenario.

But I think to Kristine's point, so if measurement year 2023 is when

the first quality measurement would happen is that 10th percentile national benchmark set off of the 10th percentile of performance in 2022? I think I am just trying to get the years straight; if that makes sense.

MS. BROOKS: It does make sense. I know, Andy and Ignatius, we had some conversation about this earlier. I don't know if you have specific comments that you wanted to make in follow-up to Cheryl's questions and comment?

DR. BASKIN: Yes, if I could, Sarah. We had a long discussion about this actually a few hours ago before the meeting, Cheryl and there are several ways that can be done. And as a detail, however, I would ask that we, if we have time it is the last thing we discuss because there is -- obviously you can set a target based on a Quality Compass result that is prior to the year you are measuring. Or you can do it afterwards and then take into account, you know, changes that occurred during that year. They both have pros and cons. I think that gets a bit complex. I think the basic questions we should answer is, as we have outlined, let's determine whether it is going to be same for each line of business first, then let's say whether we are going to have the same for each measure versus specific ones for each measure. And then when we get to it can talk about, gee whiz, how about this nuance that you are talking about is that, you know, what is the best way for the plans to succeed by having a benchmark that they won't know until after they have performed the service or before they have performed the service, which is essentially what you are, what you are asking. And I think that is something hopefully we can wait because it is much more complex than this discussion is.

MEMBER DAMBERG: I agree there is a lot of complexity here.

And then I guess the other thing, and this is a question back to Mary. Because at the start of the call you mentioned, you know, fines, penalties or corrective action plans. Is there some sort of start with the corrective action plan and, you know, give them some amount of time to improve and if after, say, one year they haven't, then you levy fines or penalties? Because I am trying to think about like for plans that fall below this benchmark, are they going to have some time to try to fix it before they face a penalty?

MS. WATANABE: No, I mean, this was really intentional. The first two years of reporting, so for measurement year 2023 and '24 we will, we will be taking enforcement action related to what we call procedural violations. So did you collect the data? Did you report it? Did you report it on time? Did you measure the right thing? And so there really is, that is kind of the phase-in period. You get two years to kind of make sure you are submitting the right information to us. And as part of that we can also say, okay, you have now fallen below the benchmark for, you know, these five measures for these racial and ethnic groups; submit a corrective action plan to us of how you are going to work to improve that.

So by the time we get to 2025 we have the regulation in place, there is been a little bit of a phase-in and hopefully some investments to make improvements there. So that, that is kind of the phase-in. I will just say that as the Director I have fairly broad authority when it comes to corrective action plans. But I will tell you that there is definitely the intent that we are going to take some aggressive action to address health disparities, which is why this enforcement approach. I don't know, Nathan or Sara, if you want to add anything to that?

MR. NAU: Nothing else from me, Mary.

MEMBER DAMBERG: Okay, thank you.

MS. BROOKS: Thank you, Mary. Thank you, Cheryl. Rick, your hand is raised.

MEMBER RIGGS: Hi. Thank you. Yes, Rick Riggs from Cedar Sinai in Los Angeles. And I want to, I want to commend us for wanting to set standards that are for Commercial health plans as well as any public health plans. I think my concern about starting there is I do not want to have individual areas, communities or other folks, disadvantaged by potential enrollment pieces that might put them in a way that they can't be served by the plan. Meaning that, you know, I am not sure exactly how all the sorting happens with regard to assignment for, you know, Medi-Cal managed care and the pieces around that. But I wouldn't want to disadvantage a plan that is the only one in a community, for instance, that is really helping to try to elevate the health care standards in a particular area. And so I think for us to make a statement about our goals of achieving equity with health care delivery is sort of where we should go and we should definitely do that. But ignoring the social determinants of health and the real-life factors and language pieces that sometimes are engaged in these delivery and enrollment pieces I think, I think we just have to be careful about the unintended consequences of that.

MS. BROOKS: Thank you, Rick. Bihu.

MEMBER SANDHIR; Bihu Sandhir from AltaMed. I actually wanted to comment on some of the things Cheryl had brought up. One thing is that, you know, I do think from us also, as I always say, the grassroots level. It is important for us to have, to know beforehand what the benchmark is because you are working towards it. We are usually goal-oriented. And so I do think it is

going to be very important. I know we are going to have this discussion earlier but we do need to define what are we going to be doing every year. So that way we know what we are working towards and which year are we going to be focusing on.

The other part is actually I like this percentile methodology because think of what has happened in the last couple of years. We had COVID, we had a pandemic. It affected all of our benchmarks. They did not necessarily go up. We haven't seen the full result of it yet but actually, there has been a huge impact. You know, I read a report for GI, for gastroenterology there was a 40% decrease for colorectal cancer screening in the country, which we haven't really even completely seen that yet. So the fact is these benchmarks don't necessarily always go up every year, it depends -- this will give us that ability, I think, to be a nimble with what the situation is, which is what we have all struggled with in the last two years because the benchmarks are set and we are like, well, we can't meet them this year because of all the things that are happening. And I think that is something that I, that is why I think this methodology is a good one going forward. Just some comments, thank you.

MS. BROOKS: Thank you, Bihu. Jeff.

MR. REYNOSO: Jeff with Latino Coalition for a Healthy California. More of a couple of clarifying questions with the data presented in the workbook. First of all, kudos to the team and everyone that put that work in from our last Committee meeting. When we see green, those are the measures where California within Commercial and Medicaid are performing better than the national benchmarks and when you see red it is the opposite, right? So poor performance. So the way that I read the measure set, there are five measures

for which there is better performance in California in the Medicaid and Commercial space compared to the national benchmarks. Am I interpreting that correctly? And if not, more background information would be really helpful.

MS. BROOKS: I see Andy has his hand up and I think he has got a response for you.

DR. BASKIN: Yes, so, Jeff, you've got it. But remember, those are only the percentile. So the 25th percentile for California is better than the national 20th percentile within the measures that are green. That doesn't mean that every plan has done better than the national, you know, 25th percentile. There are still some of those that were below California's 25th percentile which may also be below the national 25th percentile. But it is, as you said, if California as a whole, all the plans together, their percentile performance is better for the green ones than the national in the same percentile. Does that make sense to you?

Yes, that makes a lot of sense. Yes, thanks for clarifying. And, you know, I think just to reiterate comments earlier. You know, I think we would propose a percentile that is the same for both Medi-Cal and Commercial. You know, I think the focus of this Committee is equity; and equity, regardless of income is one of those drivers of health disparities so just wanted to make sure that that was on the record.

MS. BROOKS: Thank you, Jeff. So I am starting to hear some thoughts, consensus from you all. Palav, it looks like you have a comment so we are going to go to you and then maybe I will talk a little bit about what I am hearing from you all. Palav.

MEMBER BABARIA: Yes, just a quick clarifying comment to the

earlier concern about sort of, you know, is there a counter-downsides to doing it this way. And so even though we are talking about a single standard for the quality floor, Medi-Cal and just plan enrollment will still continue to be separated by line of business. So Medi-Cal has separate contracts with the Medi-Cal plans, Commercial payers have separate contracts with the plans. And certainly in counties where there is just one Medi-Cal plan, whether that is a COHS or a single-plan County, they will always get all of the Medi-Cal enrollment, independent of what sort of the quality scores are. There isn't sort of a dumping methodology to say, oh, someone else is going to go take care of them, because they are the single option in their community. So just wanted to provide that information.

MS. BROOKS: Thank you, Palav. Okay.

So I have been kind of taking some notes here. You know, what I feel like I am hearing from you all and just wanted to kind of read the room a little bit is that it sounds as if there is some consensus around eventually having a common benchmark but perhaps not having it at the beginning. And so I guess the question I would have for you all is, how long would that be? Would that be five years? Would it be less than five years? What does that look like? And then, you know, obviously, what would that benchmark be? Would it be Commercial or would it be Medi-Cal or Medicaid? And so just wanted to explore those questions with you all next if that sounds okay. And Silvia, you have your hand up right away.

MEMBER YEE: No, hi, this is Silvia with DREDF and I have just been thinking through much of what was said. Like many of you I also would prefer a common benchmark for all the reasons that have been said. I am

wondering about the possibility of having corridors on either side of a higher benchmark for the Medicaid plans that -- where there is a big difference between the percentiles that they are achieving and what Commercial plans are achieving, and a corridor that would narrow over time. It's just another way of approaching it. I was thinking actually of some of the DHCS contracts with MCOs and the kind of corridors they have for improvement, or not, and that kind of an approach. I mean, it could be as certain in terms; and I understand DMHC needs certainty for enforcement purposes. But something that recognizes that there is more variance and more social determinants of health that Medicaid plans may be dealing with. So I am just throwing that out, thank you.

MS. BROOKS: Thanks, Silvia.

Sara, I hate to put you on the spot but just don't, I wondered if you had any thoughts with respect to that in terms of codifying that or putting that into regulation? Just ideas.

MS. DURSTON: Thanks, Sarah. Again, I am kind of just really reiterating the same thing. As long as there is enough clarity. So if it is a set amount. It is hard to have things vary over time saying, you know, as things change so too will this regulation change, that doesn't give enough clarity. But if in the regulation we state, you know, the percentage shall be for this type of organization it will be this or it will be this set amount I think that would be okay. So I think that is possible, Silvia’s suggestion. But again I just want to reiterate that it is not always up to us. We like the idea of these innovative solutions but it is just making sure that it would pass muster of the review organization, the Office of Administrative Law.

MS. BROOKS: Thank you, Sara. All right, Alex.

MEMBER ALEX CHEN: Hi, Sarah. I just want to make two comments based on your summary just now. Just remind us from the last meeting, right. As Mary has said, the goal of this effort is to make sure that nobody gets left behind. That there is no disparity on inequity that predisposes one population or one characteristic of population that suffers, you know, worse consequence, you know, than the rest of the population, right. Our goal isn't to push the seeding in terms of trying to push improvement efforts universally, our goal is to make sure that nobody gets left behind. So I do want to just to make sure that with that in mind, you know, there's a few logical conclusions, right. One, having a single benchmark kind of makes sense, right, so nobody gets left behind. And, Sarah, your comment, your question, should it be, you know, a Medicaid or Commercial benchmark?

I think the one thing I would like to call out here is that there are populational differences by economic status, right, and employment status, and maybe even educational status based on the Medicaid population versus the Commercial population, right. And those are intrinsically disposing social and/or genetic and other factors that health plans and others may not be able to modify in the short-term, right, it is a societal issue. So there is a logical reason here to say that Medicaid benchmark makes more sense because we want to make sure that those people that are disadvantaged don't get left behind. Rather than pushing for a Commercial benchmark, which even if they underperform in certain areas for Medicaid, compared to Medicaid, there is a populational difference there, right. So I wanted to first of all call that out.

And then I just want to make a comment. This is just my own personal observation and comment for the last, you know, couple of years,

particularly during COVID, right. The DHCS MCAS measurement set the 50th percentile for Medicaid national benchmark for all California Medicaid health plans, I think is ambitious and we all acknowledge that, but we all know that is the right direction to go. But there's unintended consequences there that I think we have not talked about in this Committee, right. The way DHCS reinforces that is by county, right. So each county is going to be sanctioned differently based on the same benchmark for all counties, that is compared to the nationwide benchmark, right. There are counties in California that are severely disadvantaged. And I think maybe Richard had mentioned it before or someone has said that you don't want to penalize health plans that are serving in a disadvantaged community with a benchmark that they have no way of, excuse me, with a benchmark that they have no way of achieving, right, because there are some community and predisposing issues.

So I think it is important to call out if we set a benchmark and that is going to be reinforced or enforced by county, right, that we don't set too high a benchmark just because there are just going to be some counties and some plans that would have a very difficult if not impossible time of achieving those benchmark if it is set at 50th percentile. So those are just my comments and observations.

MS. BROOKS: Thank you, Alex; and just a quick follow-up question. You talked a little bit about the advantages/disadvantages of Medicaid versus Commercial. Do you have a recommendation or a position with respect to what the Committee might consider in terms of choice?

MEMBER ALEX CHEN: Yes, I would go with Medicaid. I think that is the logical choice because of the populational characteristics. And I think I

also last time I called out something that we haven't discussed again and I think it is complicated so we may not need to discuss it for this purpose. But based on the data that we have at Health Net, and we have looked back five years, that for Medicaid members who are auto-enrolled or assigned to a health plan, versus Medicaid members who choose a particular health plan, there is actually a 12 to 15 point, percentage point difference in their MCAS measures. And I think that speaks to activation and engagement of members, right. So that is another reason why picking Medicaid as a benchmark kind of makes sense because Commercial members are usually choosing a health plan or provider by choice, whereas Medicaid members may be auto-assigned or had no choice in place. And those members, whether they have choice or don't have choice, their engagement behaves very differently, based on our experience.

MS. BROOKS: Thank you, Alex. That is very helpful, all of your comments are very helpful, thank you.

So I think just -- and I see a few hands up and just kind of reiterating some of the questions that I asked were just in terms of hearing from the Committee. It sounds like perhaps, you know, there is an idea here of moving towards Medicaid as a, as the benchmark that might be utilized, would like to hear feedback on that. Also, just, you know, if we do utilize a phased-in approach of sorts would we be looking at five years for a phase-in, less than five years? Just kind of curious about thoughts there.

And Taylor, I see your hand is up.

MEMBER PRIESTLY: Hi, thank you, Taylor Priestley with Covered California, here for Dr. Chen. I just wanted to offer a maybe a note of caution about an approach where a first number of years is with maybe separate

benchmarks and then a change over time. I know one of our most important learnings over the last few years, not as a regulator but as a purchaser, has been around the impact of complexity. I think Dr. Chen has spoken in this Committee before about kind of applying our learnings to our updated approach in our contract and really the emphasis on focus on the emphasis on simplicity so that plans can do the hard work of achieving. And again, recognizing the difference that we are talking about a regulatory approach. But I do just would share some caution with an approach that has a lot of movement maybe upfront.

I thought Silvia's idea around corridors was appealing, again, not as the person who would have to put that into regulation. But if there is a concept around sort of runway or if from the enforcement side there can be structures put in place, maybe that look at relative improvement in the early period of a five year, the early years of a five year period, that seems to me to be more promising in terms of where we are trying to get to. Which it sounds like there is, you know, general agreement around eventually we are looking at a single, a single benchmark.

Those are just my thoughts around what I think ultimately we want is plans across lines of business knowing where that, knowing where that mark is and having time to do the hard work, in some cases, of getting there, particularly given the number of measures. So just a note for simplicity where it is feasible and certainly considering the DMHC team that will have to draft those regulations around potential flexibility.

MS. BROOKS: Thanks, Taylor. Doreena.

MEMBER WONG: Thank you, yes. I have just been trying to absorb all of the different comments, which have been really, really helpful to try

to, try to figure out what would be the best standard or approach. And I guess I agree that it would be easier for one benchmark, for simplicity's sake. But I guess the question of whether it should be Medi-Cal or Commercial, I think to me it is tied to looking at, looking at wanting to make it easy for -- you know, make it doable and achievable for plans but also to really make a difference to the populations that, you know, that we are trying to improve access to care for. So I don't want the benchmark or the standard to be too low.

So if it was to be, let's say, a -- if we did decide to use Medi-Cal as a standard I think there are advantages to align it with what DHCS is doing. But it would be helpful, though, to see what that 50th percentile that DHCS is using, how that compares to what the Commercial plans are doing. And so it may mean, you know, a percentage or percentile in Medi-Cal or maybe a lower percentage or percentile in the Commercial plan. I guess to me it relates to a standard that would achieve the highest, I guess, improvement or could achieve the highest improvement. So I guess that is the next discussion we will be coming to when we are coming to actual percentages or percentiles. But I would like to get more specifics around when people are talking about a phase-in or a corridor. What that means so that we could take that into account as well.

MS. BROOKS: Sure. Great questions and comments, Doreena. A little bit more about the phase-in and maybe some of my colleagues can jump in here and talk about it as well. But I think just thinking about the concept of the fact that perhaps you would start out by having a different benchmark for Medicaid or Medi-Cal versus Commercial and then eventually phase-in or move towards having the same benchmark, which could be Medicaid or Commercial depending on what this Committee talks about. I don't know if there are, Andy,

Ignatius, Alex, Janel and others or others from the Committee that would make comments with respect to that. Not hearing any I think I hopefully answered that question then.

I guess, you know, the question I have for the group just here, I am just picking up different things that I am hearing from you all is, you know, would there want -- would there be a want to perhaps identify just a standard benchmark from the beginning? For example, Medicaid such as Alex was perhaps talking about and using that for the five years for the beginning of the program. And then, you know, obviously, when the Committee reconvenes having further discussion. What are your thoughts on that? Curious about your thoughts, thinking there? Kiran, I see your hand is up.

MEMBER SAVAGE SANGWAN: Great. And I had some of the same comments as Doreena so I will keep it short but I do have concerns with starting with two different benchmarks for Commercial and Medi-Cal plans. I think, you know, Palav expressed that very eloquently a little while ago but I share those concerns. And I would rather that we start with a benchmark that is based on Medicaid plan performance then that we have a, if you want to call it phase-in, phase-in. I would call it like, you know, a separate but equal approach, you know, that I think is really problematic.

And I guess I would struggle to understand why we couldn't at least say, every plan in California has to meet that Medicaid 50th percentile benchmark since that is already what DHCS is requiring. And just glancing through the list of measures here it is almost exactly the same as the DHCS list, there’s like two additional measures. So it's really, you know, something other than that for the Medi-Cal plans wouldn't make sense to me.

But I do have Doreena's question because in the workbook all the plans are sort of lumped together. So do we know, looking at that Medicaid 50th percentile benchmark, do we know where Commercial plans land around that? Like, is it true that they all already exceed that and therefore it would be irrelevant to them? Like I don't know that that is true and I am wondering if we have that data available to us.

MS. BROOKS: So Janel, are you on? I believe you are. Maybe not? There she is. I wonder if you could talk a little bit about some of the data that has been provided to the Committee Members. I think you are on mute if you are speaking. There you go. Maybe she is not -- it is not working, okay. Yes, I think her connection is not working. Janel, it doesn't look like you are connecting. We have provided data to you all in the workgroups, excuse me, in the workbooks throughout the different meetings that have included kind of some of the different distinctions that you have been mentioning and talking about. We framed up the data for this meeting based on recommendations and requests during last meeting. Andy, it looks like you have got your hand up so I will let you kind of jump in as well.

DR. BASKIN: Yes, I mean, I could partially answer the question or at least provide maybe a little bit more information. It's not quite in your workbook but we had done some look at how many plans would meet, for each measure would meet certain benchmarks on the Commercial side or the Medicaid site. Now, I don't have any information about what the Commercial plans would do with a Medicaid benchmark. But just looking at the Medicaid plans themselves; I only have it for four of the measures. But meeting the 50th percent -- you can hear me right? Can I be heard?

MS. BROOKS: Yes, we can hear you.

DR. BASKIN: Meeting the 50th percentile for at least four of the measures. We would have for example the, I think the breast cancer measure. Of the plans that are public reporting on Quality Compass, only 15 out of 24 would currently meet the 50th percentile, 20 out of 24 would meet the 33rd percentile, and 22 out of 24 would meet the 25fth. And there is some similar work with some of the other measures. I think the next measure 12 out of 16 would meet the 50th percentile, the next measure was 13 out of 16, the next measure was 14 out of 24. I think what I am trying to point out is if you started looking at this 50th percentile benchmark you are going to have a large portion of your plans who are currently not meeting that 50th percentile. You are going to have almost every plan get a corrective action on at least one measure if not multiple measures and I don't know that that is really a reflection of standard of care. I know it is aspirational but I just think people need to recognize how onerous that is going to be on most -- on a large portion of the plans. I wish I had better data for you but we only looked at a portion of that because we didn't think we were going in this direction.

MEMBER SAVAGE-SANGWAN: Sorry, just a clarification, Andy. I thought you said that you were talking about Medi-Cal plans, which I am asking about the Commercial plans. Because we know the Medi-Cal plans don't meet that 50th percentile standard as a general rule but the state has decided that they must, right, or be penalized like that. That is happening at DHCS so I would see no reason to lower that at DMHC. What I am asking about is where the Commercial plans fall? Like if you look at the Commercial plans on those same measures where do they? Is it similar like distribution in terms of whether or not

they meet that Medicaid 50th percentile?

DR. BASKIN: Yes, I only, I can only tell you whether they are meeting the Commercial 50th percentile. But I know -- we know from earlier information which measures where the Medicaid has higher numbers. So for instance, on the prenatal and postnatal care I see that only 9 out of 16 Commercial plans meet the Commercial benchmark of the 50th percentile. Even less of them will meet the Medicaid benchmark because the Medicaid benchmark is actually higher. So you will have I would venture to say more than half of the Commercial plans are currently not meeting that benchmark for that particular measure. Unfortunately, I don't have it for the other measures where Medicaid has a higher benchmark than Medicare so that is the only example I have.

MEMBER SAVAGE-SANGWAN: So that is really helpful, that answers the question. Because I think it just shows like the Commercial plans are going with this excuse of who their population is. They would have work to do to meet that measure too that has already, you know, been a state policy choice. So again, I would sort of endorse that as a direction to go, everybody meet the 50th percentile on Medicaid for all of the measures. And I will stop talking, thanks.

MS. BROOKS: Thank you, Kiran. Thanks, Andy.

A question for Palav just with respect to enforcement action for DHCS. How do you see it being the same or different given the discussion that is going on right now? I just wanted to ask you that question. Are you, are you still on? I am not sure.

MEMBER BABARIA: Yes.

MS. BROOKS: Yes, perfect.

MEMBER BABARIA: Do you mean like what we are doing at DHCS or how it interfaces with whatever we land on this Committee, or both?

MS. BROOKS: I think both would be helpful.

MEMBER BABARIA: Yes. So you know, obviously, I think that as people know, the 50th percentile minimum performance level was decided upon prior to the pandemic. The COVID-19 pandemic has disrupted our enforcement of those measures, for obvious reasons, but we are planning to resume with the current year, which would be measurement year 2021, for which we just received rates. And we recognize there are geographic variations for certain measures that, you know, a broad swath of plans are not meeting which suggests underlying issues which we are exploring. But in general we will be taking enforcement actions for all reporting units, which as I think someone, Alex or someone alluded to earlier, at the county level, do not meet that 50th percentile. Again with the intention that we recognize there is variation but we really do not want to be leaving individuals behind because of what ZIP Code they happen to reside in or were born into.

I imagine what comes out of this Committee, as alluded to earlier, would be a separate enforcement process. So, you know, there may be plans who get enforced by DHCS but meet the target for this and don't get enforced by DMHC. There may be plans that fail to meet both targets and then maybe there is double enforcement activity and, you know. I welcome DMHC colleagues to weigh in but we do obviously try to coordinate across the state departments on some of those activities.

MS. BROOKS: Thank you, Palav. Okay, that is helpful.

Nathan, your hand is up.

MR. NAU: Hi, Nathan Nau, DMHC. I would agree with Palav and just wanted to point out that there's other areas where we have requirements between DMHC and the purchasers where we don't align in. A recent one, I believe, is timely access. So I think DMHC is moving forward with a 70% compliance rate. And DHCS has either a draft All-Plan Letter or one that is recently gone final, I remember reviewing it, and I believe they are at 80% or something along those lines. So there's, there's other areas where we don't necessarily align but we try to coordinate as much as we can.

MS. BROOKS: Thank you, Nathan. So I think, you know, what I am definitely hearing from DHCS, DMHC, is that there is distinction between what happens at both departments. Obviously the two departments work together closely but there is some distinction there.

So I wanted to kind of circle back then I am hearing a little bit of shift in terms of thoughts, thinking in that perhaps, you know, we want to go with having the same benchmark for all plans to start and that that perhaps might be Medicaid to recommend. I wanted to open that up for discussion to see what thoughts are, if I am hearing that correctly or not, and just see what thoughts are from folks. And Cheryl, I see your hand is up.

MEMBER DAMBERG: Okay, thanks. Unfortunately my, the guy mowing my lawn has just arrived so if you can't hear let me know. I would definitely support a single benchmark across Commercial and Medicaid for a number of reasons. But I think we are trying to have a standard of care out in the community and it should be universal. And it also plays to simplicity and streamlining, what I call just the administrative burden on plans and providers in

terms of how many different things they have to keep track of.

I had originally taken the charge to this Committee to be a minimum floor. So I think the question is, is how aggressive we want to be and where we set that minimum. So if I understood correctly, in terms of what the Department of Health Services is doing, you know, in Medi-Cal, you know, by setting it at the 50th percentile. And I am assuming that is the 50th percentile within the California distribution, not the national distribution. You know, it means half the plans, at least on the Medicaid side, are going to not pass the benchmark.

And I am assuming that if we say the 50th percentile in the regulatory language, that that actual number, you know, whatever the pass rate is for any given measure at the 50th percentile, is going to change year-over-year. So it could potentially backslide like it did in, you know, the COVID period or it is going to bump up in any given year. So the plans are going to have to kind of beat that relative performance year-over-year; but recognizing they will have some advance notice and know what that absolute number is that they have to hit.

I guess I would probably lean in favor of if we are going to pick a single benchmark, setting it based on the national distribution as opposed to the California distribution. And so that, you know, we are really trying to hold ourselves to a standard that is happening sort of nationally as opposed to just what is going on in California, because I think in some spaces California is lagging behind the national and I think we should be working to improve that.

MS. BROOKS: Thank you, Cheryl. And Palav, I see your hand is up, you may have some comments with respect to that or others otherwise.

MEMBER BABARIA: I just wanted to clarify that we actually, we set the target nationally as well for all of the same similar reasons, because we don't want to set up half of our plans to fail, which is what would happen if we use California-specific benchmarks. But do expect, you know, I think our state is very committed to the health care and quality and equity outcomes for our Medicaid population and think that we can do better than the nation eventually.

MEMBER DAMBERG: Great, thanks for clarifying.

MS. BROOKS: And definitely something we have talked about a little bit during this Committee and so I think Committee Members are on the same page there, which is great. Thoughts with respect to kind of the single benchmark using Medicaid as the single benchmark. Comments, thoughts, feelings, all of the above? Ed.

MEMBER JUHN: Ed from Inland Empire Health Plan. Just to clarify. So if we set, for example, the minimum benchmark I am making at about the 25th percentile nationally for Medi-Cal or Medicaid for a measure are we saying that that is what we have to meet as a health plan for our entire population? Or do we require at a minimum that all the subpopulations based on race/ethnicity are at least receiving 25%? Not 25% but above the 25th percentile? Does that sort of make sense? Is this sort of an all quality measure sort of minimum or is it a, you know, ensuring that all the subsets based on race/ethnicity are at least above the 25th percentile in meeting that, that mark?

MS. BROOKS: Ignatius?

MR. BAU: So good question, Ed, and we are going to get to that when we get to measure stratification in terms of what's feasible and when we will have national benchmarks stratified by race and ethnicity, which I think is a

complicated question and an uncertain question at this point. But we will, we will come back to that.

MS. BROOKS: Thank you, Ed, thanks, Ignatius. Other thoughts about using Medicaid as the single benchmark, comments? Alex, your hand is up.

MEMBER ALEX CHEN: Yes, hi. I just want to give a quick feedback to Ed's question. I know Ignatius probably will address it later but I think the whole point of this effort is to make sure that nobody gets left behind, right. So by definition, every stratification, every race/ethnic group have to achieve at least the 25th percentile benchmark if that is what we are aiming for. And that is another reason why I think it is important that we don't get too ambitious and set the benchmark too high, right. Because if you think about it from a probability perspective, right. If you have one group meeting 25th percentile, let's say the chance of that is 1/3, right. And then you have two groups meeting 25th percentile and let's say the chance of that is 1/3. Then your chance of meeting both groups at that percentile is 1/9, right. It's multiplicative, right. So I think it is important when we are having that complexity of all groups and subgroups and stratification meeting the goal, that we have to be very careful of setting a benchmark that is really high. Because it is not, it is not just additive, it is multiplicative. It will make it that many times harder to reach at all.

MS. BROOKS: Thank you, Alex, I think great comments. And we will be circling back and having some more conversation about that a little later in the meeting today and so definitely will want to hear more from you at that time as well.

So I am not hearing and I don't see hands, I am not hearing

anything with respect to using Medicaid as the single benchmark. So I think what we are going to do is move on with the discussion and we are going to talk a little bit about common or measure-specific percentiles as the floor. And I am going to turn it back over to Andy and Ignatius.

DR. BASKIN: Yes, hi, it is Andy here. So, you know, this has been mentioned several times already. This is just obviously a sample that you can see here. But what we are talking about is common or measure-specific. Common we are talking about if we pick, for example, the 25th percentile, but that is only an example, or if it is the 10th or the 50th the same thing holds true; that we would use the 25th percentile for every measure. And here we just have an example of a couple of the measures, or a few of the measures. So if we were to pick the same one that would mean that the column that says National 25th Percentile, that would be the benchmark.

The other option is for us to -- I am not -- I don't mean this in a negative or positive way, micromanage this by measure essentially is what I am trying to say. Which if there is some reason to think that someone would say, you know, the well-child visits first 15 months should be at the 33rd percentile while the well-child 15 to 30 months should be at the 25th percentile, that would be managing it on a measure-by-measure basis.

Obviously your workbooks have all this information. For not just the 25th and 33rd percentiles, we have often, we have already, we have given it to you as well for the 10th percentiles. It is pretty obvious, by the way, that if we do this by measure-specific it will increase the level of complexity and it -- we would have to come to some sort of thought process as to why we would set a different standard of care, essentially, across different measures. But, you know,

that is for future discussion here and Ignatius I know has more to say about that.

MR. BAU: So if we can go to the next slide. Thank you, Andy. This is Ignatius. So obviously, setting a common benchmark based on national data. Again, if the Committee is moving towards using Medicaid as that common benchmark across all lines of business for all populations then that, again, from an enforcement point of view, not from a quality improvement point of view, would allow plans to see where they are relative to that national benchmark and the measures in which they would want to focus on to make sure that they get to that minimum standard. If they are doing better on some of those that is fine, we are not trying to move them to the highest. As Alex said, this is not a quality improvement initiative where we are trying to move all plans to the highest performance possible on all measures. And so, again, trying to come up with criteria, keeping in mind Sara Durston’s challenge of drafting these regulations that we would have to come up with pretty solid rationale for why we would be setting a different benchmark, a different percentile for a particular measure. Again, that would have to hold over time as well for as long as those regulations are in effect.

What it doesn't -- the challenge of setting the common benchmark, the disadvantage is that there are those benchmarks as we have already -- those measures, as we have already noted, where the gap in performance is pretty significant from where plans are today versus what the, what the benchmark is. And so sort of that delta of the room for improvement or getting up to the minimum performance may be different for different measures.

And so those are the pros and cons and we welcome your input into this. Some of you have talked about this a little bit as corridors or ways in

which we might separate out particular measures and so if you want to elaborate on what criteria that might involve we welcome that input at this point. So I turn it back over to Sarah Brooks.

MS. BROOKS: All right, thank you, Andy and Ignatius. Cheryl.

MEMBER DAMBERG: So I think I would still favor setting a common percentile as opposed to trying to do something that is very measure-specific. I think if you look at the distribution of performance for each of these measures you can see a lot of variation and I think that that is symptomatic of what I would call either the ease or the difficulty of achieving performance on a given measure. So some measures are harder to achieve. So whether that is, you know, blood sugar control is much harder than, say, getting people in for mammograms. But I do think that the percentile approach, setting a common threshold, you know, really is, again, it plays to easy to track, simple, sets the minimum floor, and takes into account the difficulty of achieving performance on a given measure.

MS. BROOKS: Thank you, Cheryl. Thoughts from others? Doreena.

MEMBER WONG: Thank you. Well, I think that actually, you know, as Ignatius pointed out and I can't remember the other Committee Member pointed out, there really are different differences between the Commercial and Medicaid plans in terms of the different measures. And I would hate to see if there's only 2 or 3 percentage points between Commercial and Medicaid and then 20% differences for another measure, it doesn't make sense to have the same percentile. So I would, I think I would lean towards having, even though I realize it is harder to impose, but I do think there is explanation for,

a basis for this, but to have different percentiles for the different measures.

MS. BROOKS: Thank you, Doreena. I am wondering if you have thoughts or others have thoughts about an approach for doing so.

MEMBER WONG: I guess I would look at, and I haven't had a chance to do this. But I would look at the -- well, and part of this depends on what the percentile is, right, to see what the differences between Commercial and Medicaid plans are. But I would look at, I would look at what the difference, what is achievable. So we look at the difference between Commercial and Medicaid plans that is not, let's say maybe less than 10 percentage points, something like that. But I would have to look at, I have to look at the comparisons again.

MS. BROOKS: Okay. Thank you, Doreena. Thoughts from others with respect to Doreena's comments? Palav.

MEMBER BABARIA: Doreena, I definitely I appreciate that perspective. I think to just play devil's advocate a little bit, we see wide variability obviously by plan so it is not like every plan is, you know, doing amazingly on one measure and the same plan is doing sort of poorly on another. Really there is a lot of variation. Our state is large and diverse. And so I do think, just from our experience with quality improvement and quality enforcement, I do want to underscore the simplicity piece of this. That setting a common percentile really, not just administratively makes it easier, but for the people actually doing the quality improvement work can often be much better.

And then also recognizing that where we have large gaps, that is a huge health inequity issue, right? Like, we don't necessarily, as a Committee want to say, oh, it is okay if you are a Medi-Cal child to like have far fewer infant

well-child visits than if you are a commercially insured infant. And I do think that, you know, for specific measures where it is a stretch or there is a bigger gap it is also an opportunity for those plans to really double down and invest in those areas, right. You know, we are not going to get to eliminating these health disparities by doing exactly what we have been doing today and I think it really is calling for different levels of investment and different ways of prioritizing those populations, which is a big part of why we are all here as a Committee.

MS. BROOKS: Thank you, Palav. Taylor.

MEMBER PRIESTLY: Thanks. Taylor Priestly, Covered California. At the risk of repeating comments by Palav, would agree. And I think the other thought that occurred to me is sort of stepping back from looking even at the specific measures. What occurs to me is the measure set is not, is not very small, there are a good number of measures there. And I think trying to even envision how we would approach recommendations on a measure-by-measure basis it starts to feel for me very like point in time, which is kind of post-pandemic but it is not maybe representative. But then how would we select a point in time that felt more representative?

Even kind of approaching how to think through that approach feels complicated. And it started to feel to me like we were getting away again from kind of the goal here and I find it helpful to continually remember as I sit in a purchaser seat that the conversation right now is around a regulatory approach and again kind of setting a floor. And I think it makes sense to come at this from a common percentile that applies, and again, enables the plans who are subject to the regulations and the regulators who need to enforce to focus and to really achieve that minimum performance while other players in the healthcare

ecosystem are focused on the improvement and are focused on other approaches to get closure and are focused on the more aspirational side of the equation. And I do have concerns about, you know, the potential for a system that ties both plans and regulators up in a lot of enforcement action. And I think trying to come at this from an approach that enables just working towards achievement and then a reassessment in five years. Did that work? Was that the right way to get to where we were trying to get to? Makes a lot of sense, particularly kind of for this first time out.

MS. BROOKS: Thank you, Taylor. Ed.

MEMBER JUHN: Yes. So I too am in favor of a common floor; the word being, common. Because if our goal is to get to 100%, meaning everyone is equitably getting to where we need to be, starting as a common sort of a starting point for all 13 measures I think makes sense, especially if we are going to, you know, sub-stratify for all 13 measures to make sure that everyone is meeting that minimal performance level. So for me, again, with all the points that, you know, were shared, again from a health plan perspective that will be held accountable, just in terms of the data collection, the assessments and the interventions, having a common floor as a starting point might make sense.

And, you know, if this Committee decides to up that floor, let's just say we start with 10% now, in five years it is 25%, in 10 years it is 50% and in, you know, 15, 20 years we are at the 75th percentile nationally. I think it is just an easier sort of minimum floor that will raise performance across all measures.

MS. BROOKS: Thank you, Ed. So I think I am hearing some common consensus around using a common floor or a common percentile but want to ask if there are other Committee Members that support a measure-

specific approach? Just wanted to raise or ask that question.

Palav, your hand is up but I think it is from before, is that?

MEMBER BABARIA: (Gestured.)

MS. BROOKS: Yes, okay. So I think then what I am hearing from you all is that we would go with -- that the consensus is that there would be a common percentile approach and so we will include that into the summary slide that we will look at the end of the meeting for voting purposes.

And I think we will move on to talking a little bit about fixed or annually adjusted benchmarks as the floor.

And just want to thank you all again for your continued contributions and discussion. I know this is a deep dive into the world of benchmarking and stratification and just appreciate it all. So I am going to turn it back over to Andy and Ignatius and they are going to take it away with respect to fixed or annual adjusted benchmarks.

DR. BASKIN: Thank you, Sarah; it's Andy. Can we go the next slide though, this is not the correct slide. There we go.

So fixed or annual. I just want to make sure we all understand, you know, the basic terminology here of what we are talking about. So when we are talking about fixed, this sort of came, this did come up earlier and so here is our chance. It means that the targeted performance will remain at, in this case the example is the 2022 Quality Compass performance rate throughout the entire five year period. So this is -- and it could be a different year but here we put 2022 as the, only because that is the next year this information will be available for so it will be the most up to date. So this goes back to what I was saying before that if you are at the, if the 25th percentile performance is 44.21% and

met the goal then the fixed benchmark would be the 44.21%. And it would remain for the entire five year period, it would not change as the average went up or down in Quality Compass.

Of course, the annually adjusted is literally the difference and that is to say, okay, in the first year we will use the 2022 year quality performance rate. In the second year we will use the 2023 quality performance rate, which may go up a percent or up 2% or it may go down a percent as the plan's performance fluctuates. So that is at least that terminology. Let's get to the next slide.

So this also came up and, Cheryl, thank you for bringing this one up. This is actually very complex. I think we will be first asking the question of fixed versus annually adjusted and we will ask for your comments on that.

But there are two ways to do this. And one is to use the Quality Compass data that is the most recent available and use that performance data for that next year's performance. So what you have to understand is that here we are in 2022. The plans are doing what they have to do, getting people screened for breast cancer, getting their hemoglobin A1cs improved. The Quality Compass results that come out in July of next year, which is actually 2023 -- well let's go, let's do it this way. The Quality Compass data that just came out just recently on July 29 of 2022 reflected the care that was given in year, measurement year, which is what MY is, 2021. Now obviously, we didn't know what the quality, how that measurement was. I mean, how the results were in 2021 until sometime in 2022. The whole year has to pass, the data has to be collected, and then it has to be validated. And then eventually these calculations have to be done of what the different percentiles are and that takes

until July for the Commercial plans, it actually takes longer for the Medicaid plans. So this year we still do not have the Quality Compass percentile results for last year's activity, for last year's breast cancer screening, last year's well-child visits, last year's immunizations, that will come out later this year.

So, you know, we will be talking eventually about, do you want to have the Quality Compass information from essentially the prior year and use that for the next year so that you will know what the number is? Or do you want to wait until the year is over, have the information come out and retrospectively apply that to the measurement year? But just so you understand the timing here; there's two ways to do it. But either way, we still have to decide whether it is going to be fixed or annually adjusted and the next slide will bring that home in a picture.

So here you go, fixed. As I said, if the, if the Quality Compass -- in this case the National 25th percentile for Controlling High Blood Pressure example, in 2021 was 50.6% adherence to that measure. We would just keep that 50.6% as the target or the benchmark for the entire five years if we fixed it.

If we did annually adjusted it would change. In year 2022 when the information came out we may find that overall the average plan did better and therefore the 25th percentile crept up a little bit and did so each year. As you know, it is also possible that that benchmark could decrease when something happens like a COVID. Or it may naturally fluctuate up and down around the number so one year it may go to 50.8, the next year it goes down to 49.9 and back and forth and sort of fluctuates around the number.

So any of those things are possible; but those are the two basic methodologies that can be used for setting the fixed or annual over the five year

period of time. Thank you.

MR. BAU: This is Ignatius; so then if we can go to the next slide.

Obviously having a fixed benchmark as a floor for the entire five year period does contribute to that certainty that the plans don't have to be constantly looking at seeing where the benchmark might be for either the following year or based on the prior year if you are using a retrospective or -- a prospective or a retrospective approach to this. But the downside is that it doesn't then reflect over that five year period, if there was significant improvement at the national level would you want to keep raising that floor moving forward. Next slide.

If we did annually adjust it then you could account for that variation if you were doing the retrospective. So again, just as DHCS is now taking a look at how COVID impacted the measurement of the Medi-Cal plans in the COVID years and not holding them to the same level. Again, you have to, you would have to use a retrospective way of doing that. What the advantage is that if, again, there is significant improvement. If we are hopeful then the floor keeps being risen or rising so that the plans are also being expected to keep up with that rising floor. Plans are used to looking at Quality Compass every year, especially on the Commercial side for seeing how those benchmarks do drift up or down, as Andy said, usually not pretty significantly. But there again, if everybody is working on quality improvement then we are also hopeful in an optimistic way to see that improvement over time in as short of a period as five years.

So then finally, the downside of annually adjusting - next slide - is that it does create that additional complexity, especially since the Medi-Cal or the

Medicaid numbers don't come out until pretty late in the year. September is usually when that available, that data is available again for the prior performance year. So let's stop there and see if we can go to the next slide. Actually no, let's stay one slide back and open it up for conversation.

MS. BROOKS: Thank you, Ignatius and Andy. Nathan, your hand is up.

MR. NAU: Thank you, Sarah. Nathan Nau, DMHC. Just more of an interest, I am interested if does anybody know of anybody using the fixed methodology?

MR. BAU: Covered California is in its current contract and Taylor can speak more to that.

MEMBER PRIESTLY: Hi. Sorry for the delay getting off mute. Taylor Priestly with Covered California. We are using fixed benchmark years for both our Quality Transformation initiative and also our Plan Removal Policy. So both sort of for our floor and for our incentive program.

MS. BROOKS: Thank you, Taylor. Bihu.

MEMBER SANDHIR: Thank you. Bihu Sandhir, AltaMed. I am more for the annually adjusted benchmark as a floor because I think I stated earlier, I think it really helps us when we have problems such as pandemics which, you know, Ignatius just mentioned.

My question really is I have concerns only about the fact that we get these benchmarking data so late in the year and we don't really know, you know, until September it sounds like, what we are really being held accountable for the whole year, literally. And it is very hard to make changes at the last minute to suddenly catch up. So is there anything that you propose to kind of

help with that? Because that is, I think, the challenge in this really, for me. Otherwise it makes more sense because you are actually trying to at least improve most of the time and it is also realistic. But is there some thoughts of how we could, you know, is there anything that has been done that could actually help us there?

MS. BROOKS: Thank you, Bihu. Andy.

DR. BASKIN: Yes, let me just speak to that because that is really the issue that Cheryl brought up and that middle slide talked about is whether you set -- you can still have annually adjusted and have it be prospective, that you would know ahead of time, versus retrospective. It just means that the adjustment would occur the year before from -- you would always be a year behind on any changes in rates that occur in Quality Compass, essentially, because you would be using last year's Quality Compass number for this year coming up. But that number would have reflected the changes over the prior couple of years so you would get part of the changes in the fluctuations of rates over time but you wouldn't get them all unless you did it retrospectively. So there are ways, there are ways to consider doing that.

MEMBER SANDHIR: Maybe if I -- just to understand a little bit better. So say if you are doing ‘22 benchmarking would you actually use ‘21 data or 2020 data or is there just another methodology?

DR. BASKIN: Well, so let me, let me say, there is, there is, there is three ways to do it essentially. One is let's say it is performance year 2022. The activities occurring, this is what you are going to be measured on. And you want to know at the end of that year whether you met the mark. You could set the mark based on the Quality Compass results that came out in July or September

of 2021 so that you would have known in advance and have it. Or you can set it based on the Quality Compass results that came out in July or September of 2022, which was partway through the year that you are being measured on but you will still have some time to make up the difference and you could have maybe predicted what would have happened. You knew approximately what the result would have been in advance so you sort of partially know.

Or the third is, you wouldn't actually get measured until the Quality Compass results came out in July of 2023, which is the year -- which is measuring the year of 2022 for which you are being measured.

So that is the three options is you could do it ahead of time. You could do it based on the actual, you know, the information that comes out that year and you would sort of be you know, you just wouldn't find out until later in the year but, you know, you could, you know, make plans in advance anyway and sort of predict where it is going to go. Or you could just be retrospectively measured. I think people here are -- well, you can tell us what you want to do but all those things are possible to resolve your issue.

MEMBER SANDHIR: Thank you for clarifying. So just a comment on that. I would, you know, just looking at the practicality of that, the first option seems more realistic. To actually know what your benchmark is as you start the year because it really does help us, you know, I think going, moving forward. I don't think there's that many changes in the benchmarks as we could see. But that would be my recommendation, thank you.

MS. BROOKS: Thank you, Bihu.

Kristine, I wanted to know if your comment was with respect to this conversation or something else.

MEMBER TOPPE: Yes, no, it is it is related to this. And I was just listening to that and kind of going through a little timeline in my head or on paper as I was listening to Andy and Bihu. And I completely just forgot what my comment was going to be. I will lower my hand and come back to it.

MS. BROOKS: We will come back to you, no worries. All right, Diana.

MEMBER DOUGLAS: Thank you, Diana with Health Access. So I guess I just maybe wanted to back up a little bit for a second and see, are the annual adjustments something that are practical within regs in terms of setting those initially and not needing to revisit each year? Essentially being able to have in regs that the annual adjustment will take place without having the specific numbers included. I just was wondering if there are examples of this already, you know, functioning in this way or if that would be a potential roadblock?

MS. BROOKS: Sara?

MS. DURSTON: I can, I can take that. This is Sara Durston from the DMHC. I don't know that we have something exactly like this in regulation but we do have an example in regulation where as CPT codes change what plans have to report on. This was from AB 72, balance billing. What plans had report on changed as the most frequently reported CPT codes changed or something like that. So we have done something in regulation. And again, it is just the key is making sure that it is clear enough so that plans know what they are being held accountable to. And that kind of goes to what Andy was talking about, what year we would apply this to. But I think, I think this is feasible.

MS. BROOKS: Great question and thank you, Sara. Cheryl.

MEMBER DAMBERG: Yes, thanks. So I would be in favor of not having fixed thresholds over the five year period. I do think that they need to be allowed to adjust annually to take into account improvement over time. I think I am probably, you know, of the three options in terms of what it is pegged to, I recognize that plans want to have some understanding of what the target number is in advance. The only way to do that is, you know, per your example spreadsheet, you know, we are looking at the distribution from 2021 that could inform 2023 performance. So there would be that two year gap. I think I would personally prefer only a one year gap but I think, you know, either the one or two year gap could certainly be written into regulation and tie it to say the 10th and the 25th percentile, you know, with that one or two year look-back in terms of determining what the actual pass rate is based on that prior distribution.

MS. BROOKS: Thank you, Cheryl. Taylor.

MEMBER PRIESTLY: Just a couple of comments on a couple of points. I totally agree with sort of operationally Cheryl's comments from just a moment ago. I think that is the value of using a percentile is that, you know, what it is can actually change but you have identified for the purposes of regulations what we are looking to. I think, and I am speaking for Covered California, sorry. I think we would lean towards fixed so that plans aren't looking at 13 moving targets. I will say I think five years is probably on the long side for us in terms of using fixed but given the choices we would probably lean towards fixed.

And then the last comment I wanted to make but maybe this is more appropriate for Kristine or others to speak to is, we have used COVID-19 as an example of sort of what can happen that disrupts. And maybe for both

DMHC to speak to and for Kristine maybe to speak for NCQA's perspective. We also saw that when major public health emergency disruptions to health care happen there are other kinds of external adjustments. So things could be held constant or there might be other ways around it. So I would just, again, just a note of caution that we all learned quite a bit from that and there would be paths forward other than either sort of expecting some continued performance or trajectory from the plans.

MS. BROOKS: Thank you Taylor. Kristine.

MEMBER TOPPE: Sure, thank you. So I remembered my comments. I favor the annual adjustment approach for the reasons that Taylor and I think maybe Cheryl also mentioned.

And to the point about flexibility, part of the value of the annual adjustment is that, one, you have things like COVID and accommodations that can be made when we are analyzing the data, when there are issues with data collection, there is a whole variety of things that went into kind of the COVID protocols that were applied to HEDIS over the course of time. So I think that that is an important flexibility that allows, you know, given this is a relatively inflexible kind of set of policies that are going to be put into place, that would allow you to have some wiggle room, if you will, for such, for such scenarios. So I would support the annual adjustment option.

I think also having the benchmark in advance of the year that is being used for enforcement is really important and so just want to reiterate that as well from my perspective. So I think that may have answered Taylor's question. If not, Taylor, please clarify.

MEMBER PRIESTLY: Yes, I think from the NCQA perspective on

kind of how adjustments are feasible. And just a note that I think we would lean towards fixed but the approach described by Cheryl and Kristine to annual adjustments makes sense I think as long as that, that the value of the target is known in advance. So I think the two year gap would be acceptable if we were going to annual adjustment.

MEMBER TOPPE: Thanks. I didn't mean to mischaracterize your --

MEMBER PRIESTLY: (Shook head.)

MEMBER TOPPE: Okay. Thank you.

MS. BROOKS: Anna Lee.

MEMBER AMARNATH: Hi, Anna Lee Amarnath, Integrated Healthcare Association. I think I echo a lot of what I have heard so I won't repeat some of the reasons why but really do support kind of an annual adjusted benchmark and that information being available to those who are accountable ahead of that accountability period of time, for all the reasons that have been previously stated.

I think an additional area where DMHC will have to potentially be creative in how regulations are worded in order to ensure appropriate flexibilities has to do with things that will -- the pandemic is a great example. But even just more generally, things change in clinical medicine on a regular basis after technical specifications have been established, after benchmarks have been established; and those changes in clinical medicine to take time to translate into those specifications and into those benchmarks. And there may be times where those changes actually might mean that if we were to look at that benchmark perhaps it might be considered easier to hit that benchmark. Maybe what is

needed to hit that benchmark is something less. An example might be instead of a vaccination recommendation change from needing three doses to two doses. You know, that would be easier to get those two doses in. But if I am still being held accountable to getting three doses, I am now potentially being held accountable to doing something more than what is clinically recommended. And as a provider I don't necessarily, I am not necessarily going to do something that is not clinically recommended so now I am being held accountable to a specification and a benchmark based on clinical guidelines that have changed.

So there's ways that this has happened in the past with immunizations as an example or changes that happen throughout the year from the American Academy of Pediatrics, US Preventive Service Task Force, for example. Other examples, just we have seen changes in recommendations around Pap smear screening and we have seen changes in recommendations around colon cancer screening.

And so there, I know that we can't be a part of that process as you are packaging those regulations and you go into that cycle, but really thinking about allowing for there to be some flexibility when there is appropriate breaks in trending based on clinical practice changing that is not yet reflected in the specifications for measures, that is not yet reflected then in the benchmarks you are being held accountable to, and that can play out a number of different ways.

MS. BROOKS: Thank you, Anna Lee, great comments. Let's see. I am hearing some consensus from the group but let's move to you, Silvia, and then I will kind of circle back on what I am hearing. So Silvia.

MEMBER YEE: Thanks, Sarah. This is Silvia from DREDF. I am jumping on the flexible bandwagon as well and I am thinking about that. I

understand why plans would want to know in advance what the benchmark will be. I am also thinking there is that, there is that two year period of sort of data gathering for plans to sort of figure out the accuracy of their data before they are actually going to be held accountable to meeting the benchmarks. I believe that that is, that is what Mary said, before the corrective actions and the penalties and et cetera will be will be put into place. And I am wondering if that that two year period will help, realizing these are these are regulations that need to be set now, but will help plans to sort of figure out how they are going to be meeting the adjustments. I think there is some value to seeing the benchmark not as a floor but as you have two years of figuring out where the problems are. Let's try to exceed, let's try to fix where the problems are, let's identify the gap areas.

And in particular if we get to stratification, plans may be getting data that they never have really had before in terms of racial and ethnic, the kinds of detailed information about the groups that are being left behind or the groups that are falling in the gaps. So in some ways I am not so worried about whether it is going to be a two year gap or a one year gap, I am, I really want to find a way to incentivize Commercial and Medicaid plans to focus on, you are getting this great new data, you have a new benchmark, let's match these things up, figure out what you need to do. And maybe that just sounds very Pollyanna of me, it probably does, but I would just raise that as like bringing us back to this is what our aim is.

MS. BROOKS: Great point, Silvia, thank you. All right. So I feel like I have heard from a number of you all, not feel like, I have heard from a number of you all great comments, great, great input, feedback. What I am hearing from you is that the recommendation would be that there would be an

annual adjustment and that -- let's see, I am looking at my notes here. That we may be leaning towards the two year lag so that we would use, for example, for measurement year 2022, correct me if I am wrong, we would use 2021 benchmark based on 2020 performance is what I am hearing from you all. Bihu is nodding so I am hoping I got that. Sorry. And I am seeing other nods. So that is, that is what I am hearing in terms of -- I am seeing other heads shake, okay. So let's talk a little bit more.

First of all, let's take the annual adjustment off of the discussion because I think we have we have talked about that piece of it. So let's talk a little bit more about the, I have heard that the data is wanted in advance but maybe there are other comments so please go ahead and raise your hand if you have got comments there. Andy has a comment, okay.

DR. BASKIN: Yes, I just want to make a quick comment. Because I also -- I mean, coming from a health plan which is where I worked for many years I certainly understand the need to have a clear benchmark in advance of the year. But I worry a little bit about a two year lag; and certainly that is up to you guys. But it is not unusual for health plans to look at last year's, you know, benchmark, assume it is going to go up a percent or a percent and a half like it has for the past few years, use that as their goal during the year because they don't really know what the final benchmark will be until later in the year. Having it later in the year meaning in July or August of September actually still gives them a few months to, you know, make a change of course before the end of the year and you get sort of more recent data.

To be honest with you, health plans also have experience with retrospective benchmarks as well because that is what occurs in the Medicare

STARS program. You don't know whether you have met a Medicare STARS benchmark for three stars or four stars until the year is over. And the next year, you know, Medicare tells us in July or August whether we hit three stars in, you know, the year before and there is nothing you can do about it, the work has already occurred, the year has passed and you are working on the next year. And I am just pointing that out to say that not necessarily that we do it that way here because it would, it would be a real delay in the enforcement ability by DMHC.

But that the middle ground of finding out in the same year during the year is not so horrendous for health plans. It is not something they are, it is not something totally foreign to them. And they could pretty much guesstimate what that, you know, what that number is going to be that year anyway and already put things in place to know that they are, if they are far behind or not far behind. They can plan ahead anyway. So I am just putting it out there to make sure it gets an honest, you know, look at that possibility.

MS. BROOKS: Thank you, Andy. Cheryl.

MEMBER DAMBERG: I agree with everything Andy just described. I would not favor a two year lag. I think we should try to use as recent of data as possible. And I think the plans are quite familiar with having sort of that year lag across a number of programs and I don't think it will, you know, present any kind of hardship. You know, clearly I am imagining plans today are already looking at these 2021 benchmarks recognizing this is coming down the path and trying to, you know, plan ahead for, you know, what they might encounter.

MS. BROOKS: Thank you, Cheryl. Alex.

MEMBER ALEX CHEN: So I want to start off by saying that I don't

have a preference, I am kind of torn between a one year versus a two year lag. There are advantages and disadvantages from a health plan perspective but I would like to point them out. So I agree with everything that Andy and Cheryl has said. I was asking myself, do I hate a two year lag more than do I hate not knowing my target at the beginning of the year when I was formulating my plan to improve, right. So I hate them both equally so there is no preference on my part.

But there is one thing that I wanted to call out is that when health plans set goals that they need to achieve, you know, prior to the year starts, let's say in September or October, they also set incentive plans for providers, you know, for achieving some of those goals. And not having a target would not allow health plans to set those incentive plans, which takes away a very effective tool in my mind on how we can all work together as a provider and health plan community to make improvements.

So even though Andy is right that it gives you a quarter or maybe two months to adjust, you know, toward the end of the year and it gets rid of a two year lag, which I hate. But it gives you very, very little time and room to maneuver because we all have to remember, right. You have to cascade that down to the providers. The providers have to cascade it down to the frontline providers if it is a medical group or MSO or PPG. By the time all that cascading is done it is pretty much November and people are going off to Thanksgiving and people are going off to Christmas and there is nothing you can do practically, even though on paper you still have a month and a half. But practically speaking, you know, everything shuts down at the end of November, in my opinion, in my many years of experience.

So again, I don't have a preference. I am okay with either one. I

don't like either. But I do think that it is easier to execute on something on achievement and reaching and improving a goal if you have a target before the end of the year to set for the following year. So that is just my comment.

MS. BROOKS: Thank you, Alex. Bihu.

MEMBER SANDHIR: Alex, I appreciate your comments very much, actually, because I think I represent those providers. And that is where I can tell you the STARS program, which we just referenced, it is frustrating for us that we don't know until it is actually now in August that we are finding out where we were and how we did last year. And there is nothing you can do about it. Providers are all goal oriented. That is how we are, we look at data all the time, that is what we do with patients all the time. And I don't think anybody comes to work thinking they don't want to do well. And I think what we are asking for here is how do we set us up to succeed, not to fail, that is what we are saying. I don't, I don't disagree that it is not easy when we are not looking at data, that we are looking at two year old data. But the practical part of that is having a goal that we can achieve, or at least we know what we need to work for and not changing it in September of the year when we actually don't have enough time to make much of a change. These are not small changes. That is frustrating and it is actually not helping us in the long run.

I do like the thought though here, which I wasn't aware of, Andy, where you said that the health plans can model this out, which I think we needed to understand. And if they can model it out and give us a benchmark which they stick with for the year, then that is fine because I think that would still be practical and it makes some sense. But at the provider level changing something in September which is for that year does not work. It is not -- It is frustrating and

exactly for all the reasons that Alex stated. I do agree that I see both sides of it. But the practicality for me, I would say from us it is good to have a benchmark, at least some kind of benchmark early in the year. We are doing that with incentives for our providers. It is all, it all cascades down in multiple levels to get this work done. It is not all done by the health plan. I think we have to understand that. It is done by the provider and the patient level, a lot of this work. Thank you.

MS. BROOKS: Thank you, Bihu. Ed, I see your hand is up.

MEMBER JUHN: Right. So just adding to those comments. I think ideally as a health plan that has to work closely with the providers, you know, having those benchmarks sooner than later would help just to operationalize what we have to do. You know, also, you know, for us as a health plan, when we try to identify what those targets are, they are our best estimate of what that target might look like. I think we can comfortably, you know, forecast where that range is. So for example, if the prior year mark was some percentage or some percentile we are pretty confident that for the following year it would be around that area, it is not that there is a huge swing. For us though, adding back to Alex's point, if we do set incentives and incentives programs, you know, it is easier to have solid benchmarks that we could tie ahead of time so that when we are calculating and rewarding our providers with specific incentives that that is fixed to sort of what that floor looks like for us. That would make it a lot easier for our providers and our partners as well.

MS. BROOKS: Thanks, Ed. Andy.

DR. BASKIN: Yes, I was just going to comment on Bihu's thought about, you know, this whole forecasting thing that I, that I kind of alluded to and

that, and that Ed here kind of alluded to it as well. But if you look at any given measure, every health plan knows what the last, you know, the 25th percentile number was for the last five years for a measure. So let's pick breast cancer screening. Let's say it was 64%, five years ago, then it was 64.5%, then the next year it went to 63.9. You can see that me knowing in July what it was for last year's work, I can sit there and say with reasonable assuredness that if it is 63% this year, it is not going to be over 64.5% next year. And if I am making my plans on quality improvement for next year or to try and hit that bar, I don't think I am going to be doing anything different whether my goal is to hit 63 or 64.5% in terms of, you know, what I am going to put in place to try and get there.

And therefore that is why I am saying knowing in advance, you do know advance, but you only know with 97% certainty what the number is going to be advanced. There is a little bit of a corridor wiggle room there that it may go a little bit higher and may go a little low and you won't know until July. So that is what I was pointing out by forecasting. I think Ed said the same thing, that they can do the forecasting. Now, which you folks would prefer is your decision but that is how it is done. It is not like you are guessing that it is going to go up by 10% next year because historically it doesn't happen. I mean, they are very mild changes from year to year and you can see the trend for year-over-year. Everybody has the last five years' worth of Quality Compass results. So I am just clarifying what that, what that looks like.

MS. BROOKS: Thanks, Andy. Bill.

MEMBER BARCELLONA: Okay, I want to agree with Bihu's statements and kind of pick up on what she said. You know, from the providers' perspective, one of the complexities here is that if you get the data earlier in the

year, a provider organization can focus on how it is going to handle downstream bonus payments to providers based on the quality data. That is a big consideration, we need to remember that. We need to make sure that the data is flowing down from the plans to the providers so they have the longest possible time to adapt for that. One of the biggest provisions in OCA is this measurement going forward of a move away from fee-for-service to value-based payment models. So timely data and making that data actionable for the providers is going to be critical. All right, thanks.

MS. BROOKS: Thank you, Bill. Doreena.

MEMBER WONG: Yes, thank you. Yes, just listening, this is all very helpful for me to kind of understand the different issues. And I guess I am leaning towards what Andy, you know, Andy's arguments and Silvia's arguments, you know, especially Silvia's arguments that the plans will have at least two years of information before any type of action is being taken. And that it doesn't look like the swings, the adjustments would be that great, at least, you know, and so it seems like the plans have to kind of guesstimate or forecast in advance. So the two year lag time does seem a little long given that there is already a two year lag time in the beginning so I guess I would lean towards, you know, having the one year lag time because I think the plans could probably, that would be -- there should be enough time for the plans to, to have a good plan in place and to include the providers.

MS. BROOKS: Thank you, Doreena.

So just reflecting back on what I am hearing from the further discussion from the group is that we would still have an annually adjusted benchmark but that, you know, there would be a one year as opposed to a two

year, is what I am hearing from the group. I see some heads shaking, yes. Please speak up if you think otherwise. Ed, I see your hand is up.

MEMBER JUHN: Just one thing to consider back to the incentives and back to what Bihu was sharing. You know, for a health plan, you know, even 1% matters a lot because it impacts the downstream payments that go to the provider. So for example, if a provider, if a health plan has 5 or 6 or 1,000 different providers, some of them may or may not be below that 1% threshold. So I just want to be mindful that as we ask our providers on behalf of the health plan to make sure that we are meeting all these 13 measures equitably, that when we do tie incentives to that, one percentage point equals a lot of dollars that these providers may be able to or may not be able to actualize. So I just wanted to just share that from a health plan perspective that, yes, we know where we should be and it would not necessarily change the initiatives, the focus and the heightened sense of urgency of what needs to get done. However, practically in terms of the dollars and the payments, it can make a big difference to these providers, especially if there are 13 measures where they have to be above and below a threshold. Because if you look at the numbers, sometimes as close as a half a percent or a percent. So I just wanted to kind of share that because we want to also make sure that we set up our providers and our partners in a position to succeed.

MS. BROOKS: Thanks, Ed. All right. I wanted to just circle back with what I hear from you all. And I see, Taylor, you have got your hand up so we want to touch on what you have got to say and then I think we are going to go to break. I know everybody is waiting, waiting, waiting. So just hearing from the group from consensus that we will do an annual adjustment and that there would

be a one year advance period for providing the information. I don't see heads shaking, no. Taylor, if you want to go ahead and take us into the break that will -- well, I'll take us into the break but go ahead, please.

MEMBER PRIESTLY: Just hearing, I think, similar agreement in the direction of the one year lag and wanted to just make one final comment in support of the two years. I think, again, if the -- I just keep thinking from what I think a regulator's perspective is and what I worry about is there is not an enormous difference I think between one and two years but if I am wrong we will hear from others. If the two years gives both plans and providers the information they need to successfully and consistently meet those benchmarks, the end result is they are meeting the benchmarks and we don't have plans and regulators tied up in a lot of enforcement action that could have potentially been avoided with just a little bit more time and a little bit more information. So with the caveat that I am coming from this perspective as originally advocating for a fixed benchmark for stability, for consistency for this kind of long term planning, that that is where I come down on really advocating for that two year lag. And not speaking for me, I should say for Covered California's perspective as kind of more information upfront and more time for planning and implementation. And I think particularly thinking about this from that regulatory perspective. We want the plans and the providers focused and successful. And that would be my argument for the two years.

MS. BROOKS: Thank you. Thank you, Taylor. All right. I think we are going to go into a break now. I am sure that everyone is really ready for the break. We will take a 15 minute --

MR. NAU: Sarah?

MS. BROOKS: Yes, go ahead, Nathan.

MR. NAU: Sorry. We probably need to take public comment before we go on a break.

MS. BROOKS: Okay, okay, my apologies. Thank you, Nathan. Shaini, do we have public comment?

MS. RODRIGO: There are no hands raised at this time.

MS. BROOKS: Okay, all right. Thanks for flagging that, Nathan.

All right. So we will come back at 3:05 from break and look forward to continuing our conversation then. Thank you all so much.

(Off the record at 2:49 p.m.)

(On the record at 3:05 p.m.)

MS. BROOKS: All right. So we have had a lot of good conversation so far today and have made several decisions, I think, based on or you all have made several decisions based on the discussions that we have had. Wanted to kind of just circle back to where we are now and then talk about a couple of things that we will likely vote on in the remainder of the meeting here.

What I have taken away from our conversations this morning, or this afternoon, sorry. That gives you an idea of what time of day and how hot it is here. This afternoon is then that we will utilize Medicaid as the benchmark. We will use the same benchmark across all measures. We will have an adjusted benchmark that changes annually. And so just wanted to see and make sure that there is no other additional concerns with anything that I just said there with respect to kind of summarizing what we talked about this afternoon.

Okay, not seeing any hands raised. What we are anticipating or what I did hear a little bit of dialogue around that I think we may need to vote on

is really the difference between how far in advance the health plans will receive the data and information. So we heard in advance was what was wanted but whether it is one year or two years is something that we talked about so I think we will vote on that. But we also want to talk a little bit about the percentiles with you and we have some slides to present to you on the percentiles. We will have some discussion around that and then we will lead into a vote from there. So just wanted to kind of give you a little preview of what we will do. And then we have some discussion on stratification as well following those discussions.

All right. So with that we are going to, let's see, we are on Slide 39 right now. We are going to move to Slide 40 and we are going to talk a little bit about using the Quality Compass percentile as the floor and what the percentile might be and I am going to pass it back over to my colleagues, Andy and Ignatius.

DR. BASKIN: Yes, hi, this is Andy. And I think this is pretty much what we have already stated, that we are going to use a common percentile, so we have gotten there. I think the issue here becomes, you know, setting the actual percentile so let's look at some information that may help you do that. So let's go to the next slide, please.

Okay. Now you have some information in your, in your booklets. This is, this is pretty basic, you know, what does it actually mean. So if you set the 25th percentile you can see the screening rate for colorectal cancer is 56.11%. And that would be, you know, that may fluctuate from year to year with our annual adjustment but I think let's get to the next slide.

MEMBER SANDHIR: Andy, may I just comment on this? The age range has been updated as of March of this year.

DR. BASKIN: Yes.

MEMBER SANDHIR: So this does not reflect that. It is 50 to 75. So how does that work?

DR. BASKIN: So it was mentioned a couple of times earlier today that, you know, from time to time, the specifications on a HEDIS measure change. Some of those specification changes are rather big in that they change the results considerably, significantly, and others have some minor effects of maybe, you know, maybe plans would go up or down 1 or 2%. But they would do so kind of in concert, they would either all go up or all go down based on most of the specification changes. This is something that I think DMHC will have to determine as to how much change in the specification of a plan would make them, you know, change their enforcement in that given year because we can't predict what the changes will be.

This particular one, you know, going from age 50 to age 45 or something like that could, we don't know how much that is going to be until the data actually comes out and we see whether plans just generally all go up or plans all go down because of that specification change. So I think that is the kind of flexibility that DMHC is going to have to have and I think has kind of already been kind of recommended by this group in some of the earlier conversations that, you know, should something significant happen like that. That, you know, you add an immunization to the adolescent immunizations, obviously the rates are going to go way up or way down depending on what you have done. They may have to wait a couple more years to set a new baseline and I think that is, that is some flexibility they will have to have. But thank you for pointing that out.

MEMBER SANDHIR: Okay.

DR. BASKIN: This is just a snapshot, this particular slide, of a bigger performance slide that you have in your -- not slide but performance data that you are given in your workbook which has these numbers for all of the measures, this is just as sample, but just so you understand what you were looking at. And basically what this is saying is that, for instance, for breast cancer screening, if we use the 25th percentile benchmark -- Commercial plans, if we use the 25th percentile benchmark for Commercial plans as it turns out, all of them would have hit it in this particular year.

If they had used the next column, which is 33.33rd percent benchmark, only 14 out of 16; and that looks red, of course, because not all of them would have met it. So two plans would have, you know, one would have been below the benchmark.

And as you can see when you get down to the measure of, you know, well-child visits first 15 months, now it is only 7 of 16 Commercial plans would have made it. And on the Medicare side, you can see it is 2 out of 18 for the 25th percentile.

Now we actually -- you have this information across all of the measures and there are only -- for the 25th percentile on the Commercial side there are only 3 measures for which no plan would have had a corrective action in this particular year. And there are some measures where half or even more than half of the plans would have corrective action. So if we did the same thing on the Medicaid side, as it turns out, at least for the Medicaid plans, there is no measure for which all of the Medicaid plans are currently would be in compliance with the 25th percentile. And certainly not the 33rd percentile, of course,

because that is even a harsher hurdle for them.

I think the point I am trying to make here is that even setting at the 25th percentile there will be considerable activity on the part of DMHC in terms of requests that, you know, incentive for plans to try harder, obviously, so they don't have to go and be enforced through a corrective action plan or some other enforcement mechanism. And I think, you know, if there was any concern that that level of percentile wouldn't produce enough activity on the plan side to essentially raise the bar on the minimum bar, I think that is, we can show here that there would be considerable activity. Let's go the next slide because I can sort of point this out.

So I went through two examples here and I did a little bit of math based on the plans that have -- now I am talking about all the individual Commercial plans in this particular case, their actual results. Now that is not in your booklets because it is information that is on the Quality Compass website. But if you were to set, for example, the 25th percentile, if every plan below the 25th percentile, this is of the 16 plans that reported publicly their results on Quality Compass, which not all plans do. If everyone below the 25th hit the 25th percentile the overall rate across all the plans would go from 79.63 to 80.43 so almost go up a percent, which is actually pretty considerable and a measure that is already good results.

If you will look at the next slide, another example, the child and adolescent well-care visits, the same thing. If every plan, at least in the Commercial plans, that was below the 25th percentile got to the Commercial 25th percentile, the overall average rate across all plans together combined would go up by a little over 2.25% from 44.78 to 47.04%. That is a very, very

significant rise. And once again, I am trying to point out that even setting a benchmark as low as the 25th percent, and I by no means think that necessarily has to be the lowest for you to consider and certainly you can consider higher. But even, for example, if it was set at the 25th percentile, there would be considerable improvement if everybody that was below the 25th percentile got there.

I could say assuredly that had I known that we were going to go with Medicaid I could have done these same calculations and I can assure you that the same things would happen. That for every measure there would be some improvement. Some obviously would improve more than others but those improvements would be significant. And that is if everybody got to the floor that we were putting out there. So I think that is the point I was trying to make. If we get to a higher percentile I think it is pretty obvious that it will be very difficult for plans to meet that higher percentile because so many would be below it today and so many would be below it for more than one measure that the amount of resource and activity and the ability to focus in would be very difficult because they would be working on a half a dozen measures at the same time to try and improve them up to, let's say, a 33.33rd percent. Or a 50th percentile would once again be, you know, a degree even more difficult and I would venture to say, very, very difficult.

I did look just briefly at the 10th percentile and actually there is some reasonable activity in the 10th percentile. Not as much as was at the 25th percentile but it is not negligible. There would be multiple plans and most of the measures for which at least some of the plans would have been below even the 10th percentile. And you would just see, obviously, less degree of improvement

overall. But even that would be considerable enforcement action or at least a benefit into the care of people in California if everybody got even to the 10th percentile however they got there. So I will stop there. I think that is my last slide. Yes, okay.

MS. BROOKS: Yes, that is right. Thank you, Andy.

All right, I saw your hand come up, Alex.

MEMBER ALEX CHEN: Yes, I really want to -- first of all, Andy thank you for that thorough summary and I really want to echo and reinforce the point you have been making throughout the session today. But I think you are such a gentleman, I would just push it one step further, right. I think what you are looking at, Andy, is overall aggregated rate for all populations, right, for that particular Medicaid or Commercial benchmark.

But we have to remember, in this case we are going to be asking every single racial/ethnic population to hit the 25th percentile, let's say for breast cancer. And I can assure you even though today, it looks like 16 out of 16% -- 16 out of 16 plans are hitting the 25th percentile, I can assure you there will be more. I would say there will be less than 16 for sure, maybe by a lot, that would have some racial/ethnic subpopulation that is not hitting, that is not hitting the 25th percentile, right. So the enforcement actions from DMHC would be more numerous and there will be a lot more activity if our requirement is that no one gets left behind; meaning that we would sanction and enforce any health plan with any subpopulation racial/ethnic-wise, and/or if we are going to talk about SOGI, that are not hitting those 25th percentile benchmarks.

So I would take it even one step further by saying that I think 25th percentile is a very, I shouldn't say very. It is an ambitious benchmark, it is not a

low bar at all, based on the data you just presented.

DR. BASKIN: Yes, Alex, thank you very much. And I just want to echo what you are saying and making it clear to folks that if and when, well when that disparities data, you know, racial, ethnic, and whatever else is available at a later time becomes available, and when some sort of disparities reduction targets are set, you know, in the future, whether that is three years, five years, or the next rendition of this after five years, you are correct, whatever I have said, multiply that by you know, several magnitudes about how difficult it will be for the plans and how aggressive this would be. And the significant improvements you will see even if every plan had to get to the 25th percentile.

And I also would agree with you, once those numbers are available I am also 100% sure that even at the 10th percentile you would see very significant improvements when it came to disparities in the individual subgroups involved. So thank you very much for pointing that out.

MS. BROOKS: Thank you, Alex and Andy. Thoughts from others? Specifically, just with respect to what percentile the Committee should consider for potentially moving forward with -- Bihu.

MEMBER SANDHIR: Bihu Sandhir, AltaMed. Andy, one question. Is this based on 2020 data or what is the -- where is this data coming from, what is the year? Because the pandemic has had quite an impact. Have we looked back a few years here or is this just really 2020 data, or '21 data?

DR. BASKIN: Yes. This is the last date available so it would be the 2021 Quality Compass.

MEMBER SANDHIR: So what we have got --

DR. BASKIN: There would be some reflections but I think that this

would hold true any year, in all honesty. And, you know, while I could go back three years ago before the pandemic and try and recreate this I would have no doubt in my mind that we would have similar. Significant, once again, the significant number of plans who, who are currently would be put under some sort of corrective action or would have to do be doing some obviously performance activity to get to that floor, it would not be trivial.

MEMBER SANDHIR: Okay. Thank you.

MS. BROOKS: Other thoughts? Well, just reflecting back, I know that we have had conversation, in prior meetings we had discussion around the 25th percentile. I heard Alex talk a little bit about that, that it potentially could be ambitious. You know, wanted to put that on the table for consideration and discussion. Concerns? Kristine.

MEMBER TOPPE: I had a question because we haven't started the stratification discussion yet and I think there was an assumption that whatever percentile we were choosing would be then applied across future stratification results. And I just, I wanted to pose the question if that is, if that is what the decision has been or if there is another option that we are going to be talking about in that portion of the meeting? Since the stratified data is, you know, we are not going to have that -- NCQA won't have benchmarks for a few years. I know, you know, California has been down this road for a while, right.

MS. BROOKS: Ignatius, did you want to speak to that?

MR. BAU: Sure. So we will have a longer, fuller discussion of this when we get to measure stratification. That we are expecting that there would be reporting because it is now part of the HEDIS specifications. And yet we wouldn't necessarily be setting at this point until we see those national

benchmarks, actual disparities reduction, sort of sub-requirements underneath. So it would just be reporting showing that the potential disparities that we believe are there do exist and then having to come back in five years with more specific strategies to hold the plans accountable in terms of reduction.

MEMBER TOPPE: Okay, thank you, that is helpful. It is just trying to kind of make that, make that informed recommendation about what a good enforcement, you know, percentile is. And then separate but obviously importantly related, the kind of implications without knowing what these data are going to really look like in a few years. Hopefully they will be a lot better because we are going to have more, better data collection on all of the populations being served. Thank you.

MR. BAU: And I think where Alex is going with his comments is obviously the goal would be that eventually somewhere down the line we would get to a place in which we do eliminate those disparities in a first in the nation sort of effort to say that these benchmarks being set are really for all populations across whatever demographic characteristic.

MR. NAU: Hi, this is Nathan Nau from DMHC. So I just wanted to clarify and Mary can hop in too. But we see this as obviously a Health Equity Committee and so when we set benchmarks we are looking to set benchmarks for the measure overall and stratification options at this point.

MS. WATANABE: Yes, and maybe let me jump in and I will tell you, give you a visual of what is in my mind is and you all can weigh in on this. But we would have the plans report their overall score for each measure or their performance, but also report their performance by, at a minimum, race and ethnicity. And this is the future conversation. But this is, this is about reducing

disparities so there is something besides overall quality that we will look at.

And to Alex's point, in my mind, whether if it is the 25th Medicaid percentile, or the 50th, whatever you all recommend to us, we would look at whether the plans fall below that for their overall as well as for any of those racial or ethnic groups that are reported. That kind of package of performance that falls below the benchmark is what would be referred to our Office of Enforcement for enforcement action. So, you know, this is, this is about raising all boats. So if the boats are not rising we are looking to have that corrected and that is where the corrective action plans about what are those interventions to improve not just overall quality but the performance for each of the racial and ethnic groups.

And again, I think later in the presentation we have some slides about like what that would mean. But I just want to be clear that has been kind of our vision from the very beginning for this.

MS. BROOKS: Thank you, Mary, thank you, Nathan. Okay, Doreena.

MEMBER WONG: Doreena Wong from ARI, thank you. So just as question for clarification, excuse me. So now we are talking about the actual percentile that we may choose. And could you correct me if I am wrong. Is this -- we are going to choose one percentile for all the lines of business, correct? So this would apply to Medicaid plans and Commercial plans. And we had a discussion before of DHCS's use of the 50th percentile and I am trying to go back to that and see how that compares to this discussion we are having now about the 25th and 33 percentiles. Is there a way that we could understand how that aligns?

MS. BROOKS: So when you ask how it aligns, I just want to

understand that a little better; and I apologize, everyone else probably understood and I just missed it. You are asking how DHCS and DMHC's efforts here align with respect to oversight of the health plans. Can you help clarify that question for me, I'm sorry.

MEMBER WONG: I'm sorry, I'm sorry my question wasn't clear. I am trying to, you know, when we are talking about alignment, I guess I am trying to see if the Medicaid plans, the plans are held to the 50th percentile, you know, under DHCS. But ours, let's say DMHC's would be at the 25th percentile. I guess I am trying to -- I am just trying to understand how that, how the -- if we chose the DHCS 50th percentile as a benchmark how that might compare with choosing what we are discussing now around choosing the 25th and 33 percentile as a benchmark? If it can be, if there can be some kind of comparison between those two.

(Several people speaking at once.)

MEMBER WONG: Maybe I'm really off.

MS. WATANABE: Go ahead, Sarah.

MS. BROOKS: Oh, no, go ahead, Mary.

MS. WATANABE: No, I think this is back to Nathan's point earlier of it is, it is not unusual for us to have different requirements in the Medi-Cal contract with the managed care plans and the Covered California contracts, CalPERS plans. So they can, they can coexist, so to speak, we can have different requirements. I think we have really tried to stress with this initiative, this is about really addressing the poor performers, looking at equity. It is an enforcement approach. So it is, if you don't reach this, we are going to take enforcement action that could be a financial penalty.

And maybe Palav can talk a little bit more about on the DHCS side, for those plans that don't reach the 50th percentile, the different steps that they will take. They also through a contract could say, well, we have got COVID, we have got, you know, whatever other public health emergency, so through contract we can adjust that or through other guidance. For the DMHC, once we codify that in regulation we would have to change our regulation to change it. So just to be clear, they can coexist. We could pick the 10th percentile for Medicaid for this initiative and DHCS could pick 50, Covered California can have their fixed benchmark tied to 2020. As the regulator we have different enforcement authority and it is just a different approach. And others jump in and clarify if that, if that wasn't clear.

MR. NAU: So a couple --

MS. WATANABE: Yes, go ahead, Nathan.

MR. NAU: Yes, Nathan Nau from DMHC. So a couple of points that I would, I would make and I have worked at DMHC and DHCS, is that throughout the Committee we have talked about a floor, which I have become fond of. Mary talked about DMHC's role and what we do. DHCS and even CalPERS and Covered California, they can do additional things that we can't do, that are more nimble. So besides the things Mary has mentioned, they can incentivize improvement by providing financial incentives to the plans. They can also impose corrective action plans without taking enforcement actions that would be fiscal penalties. So for example, they can impose a CAP and require the plan to improve by steps and if they don't hit those steps they can take punitive action against the plan. So there's different roles between the two entities, which we have discussed throughout this Committee but those are some

of the other points from seeing it on both sides that that I would like to mention.

MS. BROOKS: All right, thank you, everyone, I think that is helpful clarification. Let's see, Cheryl, your hand is up.

MEMBER DAMBERG: Yes, I just want to make sure that we are clear that we are picking a single benchmark. So for example, if we pick the 25th percentile nationally in Medicaid, that whatever that pass rate is, given whatever year it is pegged to, that becomes the standard for both Medicaid plans as well as Commercial plans. Did I hear that right?

MS. BROOKS: That's right.

MEMBER DAMBERG: Okay.

MS. BROOKS: So yes.

MEMBER DAMBERG: Okay, great. So I realize per the earlier comment that 25th percentile seems like a stretch goal, but I think I would advocate for using the 25th percentile per the National Medicaid. I think that stretch goal is appropriate here and I think if we really want to work to reduce disparities I think we need to make some significant inroads. I mean, I am just looking at the controlling high blood pressure measure and, you know, I was really struck by the difference, you know, particularly for the Commercial population. It seems like we should be doing a better job there given that this is sort of the number one risk factor for stroke and other, you know, heart disease issues.

MS. BROOKS: Thank you, Cheryl. Kiran.

MEMBER SAVAGE-SANGWAN: Yes, I mean, I think I would continue to advocate for the 50th percentile to align with DHCS. And I understand the differences in terms of how enforcement authority or the flexibility

that different departments may have with enforcement authority depending on whether they are regulators or purchasers, but I think it would be very odd to me that we set, we set a significantly higher standard for our Medi-Cal plans in the state as a whole than we do for our Commercial plans. That doesn't, that doesn't make sense to me given the populations that they serve.

And I think the other thing is, you know, I do -- a pandemic, it is my understanding that, you know, in something like a public health emergency even DMHC gets additional flexibility to sort of waive things and do things differently and so I don't want us to set, make a policy decision based upon that when, you know, there are other flexibilities that are made available in that situation for different things.

So, again I really, you know, the 50th percentile for Medi-Cal was hard fought for many years by us and others saying, you know, it is not okay that we as a state have set the floor for our plans as the 25th percentile nationally. We should at least be in the middle of the pack nationally. And to sort of let our plans fail again and again and again is really failing our communities and failing our members and we don't want to continue to do that. So I would again advocate for the 50th percentile.

MS. BROOKS: Thanks, Kiran. Jeff.

MEMBER REYNOSO: Jeff with LCHC. Yes, just to piggyback off of Kiran's comments. You know, I think -- I appreciated also Doreena’s question around alignment and that is kind of where I was, I was sort of headed. You know, I think for us it made a lot of sense to think about alignment with DHCS so a lot of the measures there is a lot of overlap. And the 50th percentile just seems to make sense with, you know, I think all of the caveats that are very real

and valid in terms of the different enforcement and regulatory authority that our Committee is charged with in providing recommendations to DMHC.

But I do think, you know, and just to go back a couple of meetings. You know, I think, you know, I shared that, you know, I think part of our charge in this work as a Committee is to set the bar, is to set the tone, not only within California, but nationally. You know, I think if the result of this work is 25th percentile that doesn't sound bold and audacious to me and so, you know, I think we would be supportive of thinking of a, that 50 percentile alignment. Open to the discussion from the Committee Members but I think that is sort of where we are currently.

MS. BROOKS: Thank you, Jeff. Alex.

MEMBER ALEX CHEN: Hi, sorry, for not getting off mute. So I am honored to be on this Committee because I think there's many, many altruistic people here that really is fighting for the greater good for every member in California, you know. And I certainly appreciate what Kiran said about there is not a logic behind having a set of goals at 25th percentile yet having DHCS set MCAS goals at 50th percentile, so I certainly appreciate that.

But I think from an operational perspective and someone who is been both in the provider space as well as in the health plan space as well as in a measure development space, I think what I would like to share is that it is good to set ambitious and very ambitious, high-reach goals, right. I think that is, that is admirable, that is the right thing to do. But sometimes that is actually more detrimental to your cause than actually setting a realistic, yet achievable goal, right.

I think the way I look at DHCS MCAS goals today is that there are

certain things I can do and I will still achieve the 25th percentile first on those that are below 25th percentile and I won't worry about the 50th percentile because I am going to get sanctioned anyway, no matter what. So my effort is more focused still on achieving the 25th percentile if we are not there yet, right. But if we are above the 25th percentile, we have nothing to do. I wish there will be a day that is the case. It is not like we just stop, you know. The machinery is still there, we will continue to push.

But I think the way it is set up today, in certain counties for us is that I just budget the sanction, basically. I am not, I am not saying that everybody does that, I am not saying that we should do that. I am just saying that if it is not realistic the only purpose you are achieving is not benefiting the members, the only purpose you are achieving is punishing the health plans by paying fines for not reaching an impossible goal. So I think there is a fine distinction there between doing what is good and what is doable and what is helpful for the people that we want to help, the members, versus punishing the health plans. I am not saying that that is not okay. I think -- if that is our goal is to punish health plans, then I think we can do that.

You know, I was talking to my son about this because I wanted to make it easily understandable for him. So I told him, you know, you see all those A, B, C, D on restaurants, you know. If we set the restaurant rating at A for, you know, 50 percentile, let's say 50% of the restaurants have to be A or above, you will close half the restaurants in California, basically. And that really doesn't help anybody, in my opinion, because then you don't have enough restaurants for people to go to and there are certain counties that there will be no restaurant, except maybe McDonald's because they are standardized and they will go to

McDonald's instead, right. So, you know, I just think that it is important to consider our purpose here. I mean, what's our ultimate goal is to make things better. Our ultimate goal isn't to try to make things look good, necessarily.

MS. BROOKS: Thank you, Alex, those are very helpful comments. I see a few hands up. So I am hearing different, I am not hearing consensus. I am hearing different feedback from you all, which is okay, that is good, that is the purpose of the Committee. I think we will go through these comments that we have now and then what we may do is think about a potential vote on this issue here specifically. Diana.

MEMBER DOUGLAS: Thank you, Diana Douglas with Health Access California. I would like to echo some of the previous comments made by other advocates that the 20 -- that setting the floor at the 25th percentile seems incredibly low and not really adequately serving the purposes of this Committee and this work, which as I understand it, are frankly, to be a little bit ambitious and to increase our standards and make sure that California can lead in plan quality and services delivered the way we do in many other areas. So I would push for us to raise the bar a little bit. The intention is not merely to, you know, exact punishment but it is to make sure that we are at least starting from a place of really looking for meaningful quality and making sure that the work we do here is living up to some of the original goals.

I don't, I don't think that, you know, it is hard to justify to me setting the floor so low when we know that these are achievable. I don't think, you know, looking, I looked back through the set of measures that we have chosen here and, you know, I think because of many of the constraints in data and what measurements are available, frankly, the measures aren't even as maybe

ambitious or cutting edge as maybe I would have liked to have seen or some of us would have liked to have seen in an ideal world. I think many of these are basic measures that should be achievable or at least, you know, within the realm of achieving over time. So I think that we should, you know, I caution against setting the floor or the bar too low for us here. Thank you.

MS. BROOKS: Thank you, Diana. Ed.

MEMBER JUHN: Yes, just, you know, I want to just maybe echo kind of why we are all here and I think everyone on this Committee is actually committed to improving, you know, our members' access to high quality, equitable health care. You know, what's interesting, you know, hearing both these perspectives, is that even setting a universal sort of benchmark in itself is pretty ambitious and groundbreaking because it hasn't been done before. So I just would like to at least get that, you know, share the fact that we have agreed as a Committee that there is going to be a common floor for all 13 measures, in itself is pretty ambitious and something that I think we can all be proud of.

I think, you know, in terms of setting what an acceptable floor is, this is going to be the first time we are setting a floor or even a bar. So I know we are talking about raising or lowering the bar, but the fact that we have a bar in itself I think is key, especially as we start out and we recognize and understand how to get to eventually more than whatever we set the bar to be because at some point we want 100% of our members to get 100% of what they should be getting. I just, you know, echo some of the comments that were made earlier that when we think about operationalizing something that is new, that will be new for the state of California, that we consider all the factors in order to make this a successful program so that this becomes something that everyone can get

behind, rally around, and again, collectively prove, you know, overall performance.

For me personally, the 25th percentile, because this is a health equity focused quality approach, whereas the DHCS MPL is more focused on overall quality, the fact that we are going to be requiring, you know, all the subpopulations to meet a performance level, I think for me makes sense as a starting point, again, to be, you know, something achievable. And again, for me when I hear the 25th percentile, again, that is a national percentile. That is not saying that 25% of our members are getting a service, that is just the national percentile that it is still, you know, to some degree a stretch if we are requiring all 13 measures to address that floor with all subpopulations being above that level. And again, while certainly that is not our desire or end state goal, again, this is just more from a starting point perspective as we learn how to collect information to operationalize this and be effective.

MS. BROOKS: Thank you, Ed. Taylor.

MEMBER PRIESTLY: Taylor Priestly with Covered California. Ed made a number of points that I would agree with completely and I just wanted to add two thoughts. One is my concern with pushing to the 50th is that I think is something that is incredibly unique and bold about this approach is common percentile across lines of business for both Commercial and Medicaid and for all racial and ethnic subgroups. That is in -- I am a little speechless. Like that is a really, really big deal. And my worry if we push to the 50th is that you might have some plans hit the 50th on some or even all measures. I am very concerned about what we could do to make existing disparities worse in pursuit of that overall threshold.

And maybe we are, maybe at Covered California we are a little bit unique; would want to hear from Palav certainly or CalPERS. We have pretty good race and ethnicity data for our members and we have been at this with our plans with our originally very ambitious, aggressive goals. And you can have really ambitious goals; but if they are too ambitious and the plans can't hit them in the time you have allotted you haven't improved equity. And that would be my concern and my personal most painful lesson learned over the last few years in trying to do this as a contract holder, as a purchaser. So I do hear the alignment and the push for equity. I think where this Committee is headed is already completely at the forefront of those efforts and I just want to make sure we don't do anything with the unintended consequence of exacerbating disparities.

MS. BROOKS: Thank you, Taylor. We are going to go to Dannie and then -- I am so sorry, Bill, Bihu and Palav, I think we need to move on just because of time with the Committee and want to make sure we get through everything. But Dannie, please take it away.

MEMBER CESEÑA: Hi, Dannie Ceseña with the California LGBTQ Health and Human Services Network. I just really want to echo what my colleagues Diana and Kiran had stated with the 50% mark. I do think that it can be attainable and we should go for something that is higher reaching. I completely hear the facts and recognize the fact that this is groundbreaking what this group is doing and that we really are setting a bar and that this is a starting point. But just to kind of go on top of what Diana said and I agree 100% that these measures really aren't cutting edge. These are measures that should already be exceeding the 25th percentile, you know. I, you know, had hoped that there would be more advanced measures here where we are expanding

beyond what should already be, you know, the lowest setting bar. So for myself and everything, you know, I really agree with that 50 percentile bar. And, you know, I recognize everyone's point of views and everything but I think that we can be ambitious in this.

MS. BROOKS: Thank you, Dannie. Palav, I did want to just make sure you didn't have any additional comments given your DHCS representation.

MEMBER BABARIA: Absolutely. I just wanted to echo everything that Taylor said. Hopefully as is evident, like, we absolutely from DHCS like care about equity and ensuring that we can get to this quality and this standard for our Medi-Cal members. We do think that the 50th percentile minimum performance level that we have set is challenging and a stretch in some areas, but achievable. But I think part of that is for reasons that other folks have commented on, that we know there is variation with the subgroups and so in aggregate many plans can hit that target. But I think if we are really looking at you are not leaving anyone behind by the various stratifications I do think that that 50th percentile becomes infinitely harder to achieve. So also advocate for us setting people up for success and starting lower but then having a clear plan for, you know, if 95% of our plans are hitting that lower target like we shouldn't be satisfied with that, right. Like we should be over time increasing the bar for everyone and especially, you know, for all of the consumers of health care across the state.

MS. BROOKS: Thank you, Palav. All right, so we are going to move on to measure stratification. I know it is getting late in the day and do appreciate everyone hanging in there. We will have a vote after measure stratification, the discussion on measure stratification. I am going to quickly turn it over to Ignatius.

MR. BAU: Great, thanks, Sarah. So if we can go to the next slide.

So this is getting to the heart of trying to move equity. That we know that quality improvement is needed across the board for these measures regardless if they are in Commercial or Medicaid plans. More significantly, we simply haven't had the data.

Taylor mentioned that Covered California has started to do some of the stratification and had a lot of challenges so we are really at a great point in time in which other systems, other incentives, other requirements are coming into place where we might actually for the first time be able to stratify these kinds of measures across at least race and ethnicity and get a better, more accurate picture of where the disparities are and how we can advance equity.

And so just to repeat this last point, we are assuming by adopting these 13 measures that because HEDIS and NCQA as the steward of those measures will be starting to require race and ethnicity reporting and stratification that DMHC will also have that expectation. So next slide.

So out of the 13 measures that the Committee is considering recommending, 8 of these measures will be required for stratification once the regulatory process is completed by DMHC and the plans are starting to report on the actual data from their own plans and members.

What that leaves are the other 5 measures, next slide, in which they are either not yet required by NCQA to be stratified. They may be at some point in the future while the five year period moves forward. Or in the case of the immunization, because it is not an NCQA measure, then it is not, again, necessarily going to be stratified. And so the question is open for this Committee of what recommendations they would want to make regarding these 5 measures

because it would not be built in to the specifications for the quality measure itself. Next slide.

And then just to remind folks, these are the categories. They are the Office of Management and Budget large aggregate categories and does not include the disaggregated data for subgroups like Asian subgroups or breaking out Native Hawaiian from Pacific Islander groups. It does allow a Asked but No Answer, so essentially a declined to respond response. Next slide.

And then for ethnicity, again following Office of Management and Budget, Hispanic or not Hispanic, next.

And so one recommendation the Committee might want to make is that for those additional five measures, that they would recommend to DMHC in the regulations to also requires stratification by the same methodology. Especially for those that are the HEDIS measures they could apply the same methodology. And so that would be one potential recommendation from the Committee is to, again, essentially go ahead of what NCQA might require and actually require it for the California plans under the jurisdiction of DMHC to also report the data stratified by race and ethnicity. Next slide.

And then looking ahead we know that that's, again, just the beginning of how measures could be stratified and so I just briefly wanted to do this quick, again, refresher overview. Many of you are very familiar with this. That the sources that we have for standards of how we might do additional stratification of race and ethnicity as well as stratification by sexual orientation, gender identity, language, disability and tribal affiliation, we would look to these federal standards that are both for electronic health records. We also want to move eventually just in the field of quality improvement to having more quality

measures that are based on electronic health records that come from providers rather than just on administrative or claims data that the health plans have so that we actually have the up-to-date real-time data that comes from patients and actual patient care.

There are also the standards for interoperability that have been developed by the Office of National Coordinator in versions that continue to also be refined and that will also be important when I talk about the California Health Data Exchange. Next slide.

And so if we look at these EHR and these Interoperability Standards then we do see that both those standards would allow further disaggregation by race and ethnicity and it would use a Centers for Disease Center code set that has over 900 different race and ethnicity categories, so it is the full comprehensive list of all potential races and ethnicities. And so again, if these standards are adopted then that would be how the coding would happen. That would be how the data would be collected and then used for the stratification of the 13 measures that the Committee is reporting.

Similarly, next slide, for language. Those standards for electronic health records and interoperability use something called the International Organization for Standardization code set, which again has over 500 spoken and written languages and so a pretty comprehensive list of every language that you can think of. Next slide.

In terms of birth sex, sexual orientation, and gender identity. Again, this is where the Interoperability Standards come in. That the I Interoperability Standards Version 1 includes birth sex differentiations. Version 2 then built out the requirements for sexual orientation and gender identity using

the SNOMED or HL7 codes that are pretty standardized. And so again, there are some critique of those standards but at least they are the ones that are currently being used for electronic health records and now for interoperability. Next slide.

Then for disability, this is where Version 3, which was just adopted last month, comes into play. That unfortunately, the EHR standards do not include disability and so we would have to pick up these standards from the Interoperability Standards. And they do have a coding system that is similar to the six part census question for disability so there would be a way to code it in a way that, again, the plans could use to then extract the data for measure stratification.

Final slide on this set. And then finally, we are really glad to see that the Interoperability Standards again, this is not in the EHR standards, the electronic health record standards have also now adopted tribal affiliation. They have not yet specified what the coding is and so we are going to have to keep watching to see what coding is used for that. But that will also give us some additional data, again, important for California and our indigenous tribal populations here in the state. Next slide.

So how does this relate all to California? As we heard the presentation at an earlier Committee meeting, California is now implementing this Data Exchange Framework and the Data Exchange Framework will over time adopt these coding standards for demographic data starting with race, ethnicity, sexual orientation, gender identity, and birth sex and language; and will eventually be adopting as the Interoperability Standards have now been finalized, the disability and the tribal affiliation standards as well.

Health plans are all required under this Data Exchange Framework to agree contractually to exchange the data by January of 2023 and begin to actually exchange the data by 2024.

So in that period of time, plans are aware that they will need to be increasing their efforts to collect this data from their members as well as their providers in order to be able to by January 2024 begin exchanging this data. So again, a lot of work for the plans as well as the providers throughout the state of California would be doing to increase and improve their data collection so that they are able to meet these requirements starting in 2024.

So final two slides. Next slide.

So to sum all this up, while there are these barriers to collecting the data now, the state requirement under the Data Exchange Framework as well as the other initiatives that are happening, NCQA will continue to designate measures in the future that will be required in the specifications for race and ethnicity stratification. Kristine has reported they are also thinking about language stratification, potentially sexual orientation and gender identity stratification at some point in the future. Again, probably not for all measures all at once; that it will be a phased-in approach, again, that will happen in this five year period as the first set of regulations by DMHC are being implemented. And so that other demographic data, just to remind folks and summarize again, will include disaggregated race and ethnicity data, as well as these other demographic data that are actually referenced in the statute that created this Committee. So finally, last slide.

So one recommendation that the Committee could then make is that when those requirements kick in, for example in January of 2024, to give the

plans some time to collect that data and set another date in the regulation that says, we would then have expectations that now that plans have the data and more data, that they would also be required to stratify by these other additional factors. And again, some discussion by Committee Members as to what is that reasonable timeframe. It is not going to be January 2024 because that is when they will just be beginning to have the data and it probably will take a couple of years for there to be sufficient data collection so that it actually makes stratification meaningful. So that is up for this Committee's conversation. That is clearly the direction that this is all going. And then the question really for this Committee is what is realistic in this five year period to recommend.

Clearly, to recap, there will be race/ethnicity stratification for those 8 measures that NCQA requires it as part of the specifications. The Committee could recommend additional race/ethnicity stratification for the remaining 5 measures, and then decide what it wants to recommend for these other demographic variables. And so with that I will turn it back over to Sarah.

MS. BROOKS: Thank you, Ignatius. All right, so I will open it up to the group for comments, questions. Cheryl.

MEMBER DAMBERG: Thank you. In terms of the 8 measures versus the 5 measures, I would certainly encourage right from the start that the 5 that are currently not stratified as part of NCQA's work move in that direction. I know at least the CAHPS measures, I believe, are stratified for Medicare Advantage plans on the Office of Minority Health's website so I definitely think that that is feasible. And so I would encourage alignment across all the measures that are included for the race/ethnicity.

I think as, you know, the state builds more capacity and the plans

start collecting data across a broader set of social and economic characteristics of patients, I would certainly like the DMHC to have flexibility to be able to build those into future stratified reporting and performance requirements. But one concern that I would have is, depending on sort of how finely you slice and dice any of these categories, you are going to end up with very small numbers. And so I think the DMHC has to, you know, spend some time looking at the data, you know, alongside with the plans and figure out what's feasible moving forward. So, for example, in that Asian/Pacific Islander category as you start to break that into component parts, you know, the numbers are going to get quite thin. So, you know, that is just, I think, one of the unfortunate realities of that space.

And I also would say that probably certain variables are going to be easier to do stratified reporting in the near term versus the longer term. So for example, disability status. Once that, you know, is being collected systematically, I mean, Medicare already has it. It doesn't seem like that would be a hard lift.

MS. BROOKS: Thank you, Cheryl. Doreena.

MEMBER WONG: Yes, Doreena Wong, ARI. I don't think it would be a surprise to anybody that I would be advocating for not only stratification of the 5 measures that aren't required by NCQA at the moment but for, you know, all the measures to be at least stratified at a minimum with the OMB standards. But ultimately, you know, we cannot get to equity without having disaggregated race and ethnicity data. I think I have been -- many of us have been saying that and I think there is just a general recognition that we cannot get to, you know, addressing health disparities and equity in our healthcare system without disaggregated data. So, to the extent that we can get to that and DMHC can

include that flexibility as soon as that data is available I would strongly support the collection of disaggregated race and ethnicity data.

As far as language data, I believe the plans already have to, you know, have a lot of -- they are required to provide language access plans and so I would think that they already have data around their -- and do language assessments of their enrollees so they should have the language data.

And as to the other, as to the other demographic factors like the SOGI data or the disability data. I think DMHC should also strive for that because those, those factors really impact on other kind of accessibility and equity issues. So I am happy that, you know, there is just a general movement towards the disaggregated data and I think California can lead in that effort, especially since we have one of the most diverse populations, you know, in the country.

MS. BROOKS: Thank you, Doreena. Diana.

MEMBER DOUGLAS: Thank you. Diana with Health Access. And yes, would definitely like to see the stratification of the 5 measures that aren't currently stratified. I think this is a place where it is kind of a no brainer for us to be a leader in this area and not to wait. And also as more measures are required to be stratified, of course, would hope to see those included with appropriate stratification as well. Thank you.

MS. BROOKS: Thank you to you and your little one.

MEMBER DOUGLAS: Thanks.

MS. BROOKS: All right, Silvia.

MEMBER YEE: Hi, Silvia with DREDF. I am sure it will be no surprise that I echo my, my altruistic fellow Committee Members in, in wanting to

see stratification, as much as possible, of the 5 measures that are not yet stratified and along also along the lines of SOGI and disability data in addition to race and ethnicity.

I guess something, I do appreciate the need for simplicity and for having one, one target percentile across the measures and what --but also the difficulty of like enforcing, especially once we get into these thinner numbers and smaller numerators and data. Could, could the enforcement part, at least for this initial period, possibly five year period, be aimed towards an aggregate? Like an improvement towards the requested percentiles, I mean the target percentile.

And then also be looking at the process when it comes to data. That plans will be disciplined as such when they fail to provide the information, when they fail to get into the, into the disaggregated data points. It is not so much tied to, in this first part, the actual improvement. Pulling up a group to what may be very, very high and far distant target. But at the very least providing really transparent information because that will help us formulate a solid basis for what is needed for improvement. And I don't mean to be just sort of backing off from the need for improvement across disaggregated groups but trying to elucidate an understanding that DMHC is in a difficult position of enforcement and what can you really require. What can you make a plan do that they are not doing. And it seems to me the very first step is getting good disaggregated information in areas that they haven't gotten before. Thanks.

MS. BROOKS: Thank you, Silvia. So hearing -- we are going to go -- I see Dannie's hand is up so we will take him next, Kristine, and Bihu. And then I think I am hearing consensus from you all and so I think we will move from there. But Dannie, do you want to go ahead?

MEMBER CESEÑA: Sure, Dannie Ceseña from the California LGBTQ Health and Human Services Network. I will keep it very short. Basically, I agree with my colleagues for the stratification of the 5 measures and including SOGI, disability, et cetera. Thank you.

MS. BROOKS: Thank you, Dannie. Kristine.

MEMBER TOPPE: Thank you. I was writing it down just in case I was lower in the queue. I liked Silvia's point a lot and it made me think about one of the things that we have been focused on, which is getting to direct data about people's race and ethnicity and sexual orientation and so on and so forth. So that might be something to consider also as kind of a process measure along the way that the Department could consider in terms of getting at, you know, good data in about how people are self-identifying, which is a major priority for us and we have kind of a soft target of hoping to get to like 80% direct data within I think, you know. We haven't put any kind of teeth around that because we know that there is a lot of complexity to it and appreciate that it is not necessarily easy but it might be something to consider in terms of a good interim process measure. Yes, thank you.

MS. BROOKS: Thanks, Kristine.

MR. BAU: And Sarah, if I could jump in?

MS. BROOKS: Yes, please do.

MR. BAU: Maybe calling on Taylor to explain, again, the Covered California requirements also using an 80% goal.

MEMBER PRIESTLY: Sure, thanks, Ignatius. Taylor Priestly with Covered California. I think I mentioned earlier and Dr. Chen has probably spoken previously, we have had a race and ethnicity -- members self-report race

and ethnicity threshold requirements in our contract. When the original contract requirement took effect in 2017 with a 2019 deadline to hit that 80% threshold, that work was done in a collaborative stakeholder process that probably folks in this call participated in. But our -- you know, it was really informed based on the voluntary response rate to the Covered California, which is a shared application for Medi-Cal and Covered California. And we see a voluntary response rate kind of between very high 60s, around 70%, up into the high 70s depending on the year, other factors, other. But that kind of overall rate has been pretty, fairly steady. And I will just note on that topic that we -- I think those of us that had worked on this early contract requirement had anticipated potentially moving that 80% threshold up when we refreshed our contract, which will go into effect in 2023. But looking at the data and looking at kind of how consistent that voluntary response rate was we didn't feel that there was justification or need or that that would really reflect our member preferences around sharing that information.

MS. BROOKS: Thank you, Taylor. Bihu?

MEMBER SANDHIR: Bihu Sandhir from AltaMed. I actually appreciate that comment, Taylor, because that was my question, are we going to put a benchmark, you know? We can collect data but is the question is, are we going to have -- so first of all, I am I am definitely for, you know, stratifying the 5 measures. I do think that would be the groundbreaking part I think that we would be definitely doing in California and it would actually help NCQA I would think in the future. Catching it early, nothing wrong with that.

The other part is I do think a benchmark, should we consider that? Maybe at least for the measures that we can measure for now. You know, it is a

process we are all starting. It is a new process for I think everybody.

The other part, though, I do think is to consider what Ignatius said was, there is some reporting problems with some of these new measures, the 5 measures. And we need to keep, we need to factor that in when we put these regulations because if we can't report on it, we don't have a consistent way to report, I don't think we can hold the plans accountable for that. So I do think there has to be some language in there that at least confirms that we have to have a way to report it consistently. Working with EHR these codes are very, this is the best way that we know, EHR, you know, data to get it across. But it the codes don't exist they could get delayed. We have to be ready to accept that. And I don't want, I don't think it is fair to hold plans accountable if they can't report it in a consistent way or in a standardized way. So that is I think something we just need to be thoughtful about when we, when we, if we decide that we are going to measure on all 5, ask them to report on all 5. Thank you.

MS. BROOKS: Thank you, Bihu. So not to put you on the spot but do you have a recommendation with respect to a benchmark or would it just be a recommendation to the DMHC that there be something put in place?

MEMBER SANDHIR: You know, it is nice to me when we set benchmarks; it is always nice to see where we were. Now, it is very helpful with where, with what Covered California, you know, gave us, but is that really the population we are completely covering? Medi-Cal is different, you know, and there are more challenges sometimes. So I don't know if we have any baseline for Medi-Cal but what I would recommend is we look to see how much are already reporting, I mean, what do we have? Do we have any information on this? If not find something in the middle which is, which is achievable and, you

know, and then we could always stratify it further and increase the goal further. That would be the recommendation I would give is find something that we can maybe at least a place to start. Not necessarily 80% from the beginning. I don't know if that, I don't know if that is realistic for Medi-Cal, I actually just don't have that information. So I would recommend that we do it that way. I don't know, Taylor, do you have that information?

MEMBER PRIESTLY: I don't know, Medi-Cal's. My instinct is that it is similar. What I would -- I think we have to talk about Commercial because even for Covered California, you know, we had a three year, you know. There were several years for plans to set a baseline, hit an interim target and then eventually meet that 80%. And for some of our plans it took longer than those three years. My understanding for Commercial is that it is much, much, much lower and so --

MEMBER SANDHIR: Oh, okay.

MEMBER PRIESTLY: There other folks on the phone who could better speak to that, but this -- you know, Covered California works with Commercial plans but it is under the Covered California contract that that requirement applies, just my understanding as to our line of business. So you will see very significant variation and we might, we might need to be thoughtful about what those benchmarks would look like, for Commercial especially.

MEMBER SANDHIR: That would be my recommendation, Sarah, that we have to look at where we are currently and be, you know. And gradually I would recommend increasing the benchmark on this but start maybe a little bit lower so we can -- it is a new process. That would be the way I would recommend it.

MS. BROOKS: Sorry, I just took myself off video while I was trying to unmute myself. Okay, any additional comments on Bihu's commentary?

What I think I have heard very strongly from the Committee is that for the 5 measures currently not required to be stratified by race and ethnicity that the Committee is recommending requiring stratification using the NCQA stratification methodology for reporting. So I have heard that.

And then also heard that as additional demographic data and other such data becomes sufficiently available for quality measurement stratification that the Committee recommends that the DMHC then require additional stratified reporting by such demographic data on the recommended measures.

And then also hearing from Bihu and not seeing concerns from others that there will be some language included in the report that the DMHC look at what currently is happening with respect to in the world such as what Taylor described for Covered California, looking at what is currently occurring and looking at potentially having some sort of requirement and a gradual increase associated with that if, if possible.

That is what I am hearing from you all. Cheryl has got her hand up. Go ahead, Cheryl.

MEMBER DAMBERG: Sarah, I just wanted to get clarification in terms of the reporting of other demographics, social risk factor information. Are we recommending to the DMHC that they move forward with collecting or requiring plans to collect and submit that information and set some, you know, targets or is this kind of something that it is more forward looking past the first five years? I guess I am just trying to understand it, given the timing of when a lot of these standards go into play.

MS. BROOKS: Yes, I think, and I will look to my colleague Ignatius to talk a little bit about this but I think, you know, largely it has to do with some of the presentations that have been brought forth to the Committee. But Ignatius, I don't know if you want to comment on that.

MR. BAU: So what we are not proposing as a recommendation is actually setting disparities reduction targets that will be different. And again, we are trying to hold everybody to whatever the percentile floor is and so it really is a reporting requirement as opposed to a specific let's close the gap for African Americans versus Asians versus Latinos. De facto what that means is we are really moving to a zero disparities goal and that is very, very ambitious.

MS. BROOKS: Thank you, Ignatius; and Cheryl for your comments.

MS. WATANABE: Sarah, can I just --

MS. BROOKS: Go ahead, Mary.

MS. WATANABE: Can I just pause for a minute because I am not sure. I think, Cheryl, are you asking are we going to collect SOGI data, language, disability status, starting with the next measurement year and see what we get or apply the benchmarks?

MEMBER DAMBERG: Well, I think I was tracking that in the beginning this group is recommending that all of the measures that are included there be stratified reporting along race/ethnicity. But then I am a little less clear on the other factors, say in like this first five year period, would be recommending that the Department of Managed Care require the plans to report on that information. In recognition of the fact that, you know, the standards are still sort of being developed and put out into the community and there needs to be some

time for the plans and the providers to adopt those. So I am just trying to figure out where we are in that space because that that still feels a little murky to me as to what we are advising.

MS. WATANABE: And I want to make sure that we have the right, that we understand your expectations. Because I don't believe it is our intent to take enforcement action, again, related to performance on anything beyond race and ethnicity in these initial years. I think whether we collect and do a process measure on the completeness of the other factors I think, is what -- I am listening here to see where we are headed with that. But it is not our intent to stratify the 13 measures by SOGI or disability status, because we know those standards are not in place yet and the data is probably very, very iffy in small, very small sample sizes.

MEMBER DAMBERG: Yes. And I think I am still trying to figure out, if you are setting some standard that, you know, they have to collect it and it has to be like 50% completed or something like that, whether that is part of this initial set of recommendations or this is like a second five years kind of activity/

MS. BROOKS: So I think that for purposes of what I have heard from the -- well, the data that is available and I think what we know is going to be available is that that would probably be in the second five years or in the future. I think the recommendation here is really just as data becomes available that it be collected. Ignatius, I don't know if you want to speak more to that but it is, yes, I think we are looking more towards the future.

MEMBER DAMBERG: Yes, I think it would be helpful when you write the report to kind of signal what the expectation is in terms of when those data might come available.

MS. BROOKS: Okay.

MEMBER DAMBERG: Because right now it feels a little nebulous to be about, let's say disability information became available in the next two years, you know. Would the expectation be that plans are reporting on that and doing stratification? Even if they are not held to a performance standard, meaning, you know, they have to get blood pressure for disabled and non-disabled to the same, you know, rate.

MS. BROOKS: Got it. That is helpful feedback and certainly we will want to include something like that, thank you. Okay, Silvia.

MEMBER YEE: I am happy to speak but I also do recognize that Robyn hasn't spoken, I think, in this and so I -- can I, can I have a place after Robyn? But I just --

MS. BROOKS: Of course. That is very kind of you. Robyn, please go ahead.

MEMBER STRONG: That is very nice of you, Silvia. So I just had a question kind of to Cheryl's ask there on a potential process measure. So I am wondering if you are thinking more along the lines of the recent CMS measures that came out where it is more of a process measure of check the box, yes, we asked. Or if you are asking for plans to include the full array of their distribution of their members in the report so that you can see not just on the particular measures that we are asking about but also across the whole plan, here is our demographic distribution for these different stratifications.

MS. BROOKS: So I am going to let Ignatius speak to that if that is okay.

MR. BAU: So again, part of the difficulty of bringing a more specific

recommendation is we know that the requirements of the California Data Exchange Framework don't go into effect until January 2024 so that would be the earliest that there would be expectations that plans would have enough data to start exchanging. And I just think that it is going to realistically be a couple of years before there is enough completeness and accuracy of that data and then even then you have got small sample sizes. And so, again, I think we want to be in alignment with those efforts that plans as well as providers and hospitals will all be improving their collection and exchanging with each other the data that they do have and so we want all of the California health care sector to be moving in this direction. It is just hard to give us give a firm timeline and say, you know, give them a year, give them two years.

We just know that, again, back to the Covered California example, even when a lot of that data came in through enrollment it was still really difficult to then make sure that that was accurate and tied to the quality measures that they needed to be reporting on. And so I think realistically we want to keep signaling that that is the direction we want to go; to actually pin down a timeline is going to be a little bit tricky.

MEMBER STRONG: Thank you. Yes, I just wondered if, if we had a known of how the entire enrollment or book of enrollment was stratified then we'd know, you know, what percentage of completeness they have in each of the plans. And then could, you know, see the difference, hopefully, over time with improvement of completeness overall as well. Thanks.

MS. BROOKS: Thank you, Robyn. All right, I see Silvia and Doreena I have their hands up. We are going to take those two comments and then we are going to move to public comment and then we are going to vote.

Everyone is excited, I know, yes, we are going to vote. So Silvia, please take us away or go ahead, please.

MEMBER YEE: Okay. This is Silvia at DREDF. I appreciate that it is hard to come up with a process measure and that we may be sort of wading into unknown territory to some degree. But five years is a long time. And if you think about this as a relay, there is so much that can be done to figure out how to accurately collect SOGI or disability or more granular race and ethnicity data. From figuring out how to ask questions, how to train people that are asking questions, from pilot projects. I don't want to find ourselves in five years with developments happening at ONC (phonetic) and interoperability and so forth and then the baton is sent off to plans and plans are standing still because they haven't had to do anything for five years. I have had a conversation with people at SASIO (phonetic) and CMS. And for many of them in terms of data collection there is a lot of benefit to having individual innovation in plans about data collection.

We talk about -- there are problems with the US healthcare system. But we talk about plans as being an incubator of innovation, of new ideas of how to do things and how to get information and get things done. This is one of those things that DMHC as a regulator, they cannot offer carrots. But to the degree that regulation can be used to encourage what needs to be done so that we eventually get to a point where we can collect the kind of data we know is critical to finding out and rooting out disparities, health and healthcare disparities, it just needs to start. It needs to start somewhere. And waiting another five years, I feel very passionate about this. Waiting another five years means more people die. That’s all so thank you.

MS. BROOKS: Thank you, Silvia. Doreena.

MEMBER WONG: Thank you. Doreena Wong, ARI. I went to really echo Silvia's concern about waiting five years and not, you know, not having any more guidance for DMHC on this issue. I think I would love to be able to provide feedback and input. I think, probably many of us would, you know, and not have to wait five years through some other kind of a stakeholder process. Because I think things are happening at a very fast pace, especially around collection and collection and reporting of data and disaggregated data, other demographic data, that was we could get a lot further along and provide additional recommendations around how that might be done. And so I think there is an opportunity here that I don't want to let go of or want to take advantage of.

But I just had another additional comment about the collection or the stratification around language because it is my understanding that the plans already should be collecting the language data, as I said before, under SB 853 for their language access plans. And I know that it might be difficult because the language populations might be small but I am wondering if we could stratify some of the measures across language just to see how the impact of language has on these different measures. And I would -- I don't -- I know that it would be, it is hard to raise this now and discuss it now, it is just that we haven't talked about the stratification until, you know, until this meeting. But I would like to see if that might be possible.

MS. BROOKS: Certainly I think something for further discussion in the future. We will take that into consideration, Doreena, as we work on the report. Okay. So we have had a lot of great discussion today, conversation.

We are going to move to public comment now so let me just see, Shaini, if there are any hands raised for public comment?

MS. RODRIGO: There are no hands raised at this time.

MS. BROOKS: Okay, all right. So we are going to transition to a vote now and we have two items to vote on. The first would be with respect to the percentiles and whether or not we should select the 25th percentile or the 50th percentile based on what I heard from you all today. The second would be whether or not the advanced data should be one year or two years with respect to when the adjusted benchmark occurs.

So we will start with voting on the percentiles; I think that is a little bit more clear and easier. Alex, what is easiest? Is it for you to call the roll, I believe, and then just have people say either 25th or 50th; is that correct?

MS. KANEMARU: That would be great, Sarah.

MS. BROOKS: Okay. Before you start let me just see if there are any questions. I see Doreena has her hand up, yes.

MEMBER WONG: Thank you, Doreena Wong for ARI. So I understand that there was -- most of the discussion was around either the 25th or the 50th percentile but I don't know. I think for some of us -- I guess I am wondering if we could, if we can include the 33 percentile? I don't -- I am not sure if those two were the only options?

MS. BROOKS: Certainly there were a number of options that were made available and data was included in the workgroup. I didn't hear 33.3 come out from the discussions today. Is there a strong feeling about that? I just want to look at people's -- it looks like, it looks like Diana has her hand up.

MEMBER DOUGLAS: I mean, I would say if -- it might be nice to

have an intermediate option just rather than choosing between the lower and high. Given that we had the data for the 33% as well that seems like a logical, logical point for potential inclusion.

MS. BROOKS: Okay. Alex, are you able to set up the vote to allow for that?

MS. KANEMARU: Sure. So when I -- sorry, I know public comment is coming up, comment is coming up, but I will set it up to be 25, 33 and 50th if that is what I am hearing.

MS. BROOKS: Okay. Alex.

MEMBER ALEX CHEN: Hey, Sarah, I just want to make a comment. This is a statistical game theory comment. I don't think it is fair to set 25, 33 and 50 because 33 and 25 may dilute the vote for 25 versus. So I think that the way to go is to do 25 and 33. If 33 end up getting the vote then you can do 33 and 50. That would be my suggestion.

MS. BROOKS: Say that one more time; I am sorry. Not the whole thing, the last part of your sentence, I'm sorry.

MEMBER ALEX CHEN: I would say we take a vote first on 25 versus 33. And I agree with Cheryl. I think even though I think 25 is practically challenging, but I think we are altruistic enough to want to reach for 25. So I would say just go 25, 33 for a vote. And then if 33 wins then we go 33, 50 for a vote.

MS. BROOKS: Okay. Thoughts from -- or just concerns, anyone have concerns?

MS. WATANABE: Sarah?

MS. BROOKS: Mary.

MS. WATANABE: I was thinking the alternative would be to have three choices and then we vote again on the two that got the most votes.

MS. BROOKS: Let's do that, we'll go with what Mary said.

MS. WATANABE: It's the same outcome but --

MS. BROOKS: All right, thank you, Mary.

MS. WATANABE: Sorry, you have to vote twice no matter what.

MS. BROOKS: That that makes it -- thank you.

MS. WATANABE: If anybody has any concerns with that raise your hand and tell us now but I think that might be the easiest. We will vote for three options, narrow it to two and vote again.

MS. BROOKS: All right. So Alex, I am going to turn over to you.

MS. KANEMARU: Okay, so I will start off with Silvia Yee. If when I call on you, you could just say your preference for 25th 33rd or 50th.

MEMBER YEE: Thirty-three.

MS. KANEMARU: Okay. Doreena Wong?

MEMBER WONG: I'm sorry, this is, this is, this is hard for me. I quite, I don't quite understand the process. I would -- this is how I would vote. I would say 50%, if I can't get 50% then I would vote for 33%.

MS. BROOKS: So, we would --

MS. WATANABE: So, Doreena, I think in this case you would vote for 50.

MS. BROOKS: Yes.

MEMBER WONG: Okay.

MS. WATANABE: Then whatever is left over.

MEMBER WONG: Okay.

MS. WATANABE: The top two votes, then we are going to vote again. So you may have a second shot at this.

MEMBER WONG: Okay. I would vote for 50.

MS. KANEMARU: Thank you, Mary. Next up is Kristine Toppe.

MEMBER TOPPE: Shoot, I am looking at the numbers and I am like trying to do the math. I am going to go with 33.

MS. KANEMARU: Rhonda Smith?

(No audible response.)

MS. KANEMARU: I'll come back to Rhonda. Kieran Savage-Sangwan?

MEMBER SAVAGE-SANGWAN: Fifty.

MS. KANEMARU: Bihu Sandhir?

MEMBER SANDHIR: Twenty-five.

MS. KANEMARU: Rick Riggs?

MEMBER RIGGS: Twenty-five.

MS. KANEMARU: Jeffrey Reynoso?

MEMBER REYNOSO: Fifty.

MS. KANEMARU: Ed Juhn?

MEMBER JUHN: Twenty-five.

MS. KANEMARU: Tiffany Huyenh-Cho?

MEMBER HUYENH-CHO: Thirty-three.

MS. KANEMARU: Diana Douglas?

MS. DOUGLAS: Fifty.

MS. KANEMARU: Cheryl Damberg?

MEMBER DAMBERG: Twenty-five.

MS. KANEMARU: Alex Chen?

MEMBER ALEX CHEN: Twenty-five.

MS. KANEMARU: Dannie Ceseña?

MEMBER CESEÑA: Fifty.

MS. KANEMARU: Bill Barcellona?

MEMBER BARCELLONA: 25.5 (laughter).

MS. KANEMARU: And Anna Lee Amarnath?

MEMBER DAMBERG: I think she jumped off the call.

MS. KANEMARU: And then circling back to Rhonda Smith?

(No audible response.)

MS. KANEMARU: Okay. So our top two voted on items here were six votes for 25th and five votes for 50th with three votes for 33.

Okay, so in this next round -- Sarah am I good to go to the next round? Yes?

MS. WATANABE: Can I just pause and say did that work out how everybody thought it would?

MEMBER SANDHIR: No. No.

MS. WATANABE: Okay. Okay.

MEMBER SANDHIR: Yes. Wow, okay.

MS. KANEMARU: So I will start off with --

MS. WATANABE: Can I just pause maybe for those that voted for 50 because I know there's a number of you that voted for 50 that could have gone with 33. And I just want to make sure we are being fair and have ended up with the outcome that you all want. Kiran?

MEMBER SANGWAN-SAVAGE: I don't have a comment on that, I

still strongly believe in 50. But my question is, do we have to make like a here's the full Committee's recommendation or can we say like this, the Committee was split between, you know, fairly evenly split, and here are the reasons that the Department might consider for choosing each one of these.

MEMBER SANDHIR: That's better.

MR. NAU: Mary, I was going to suggest that if we want to do that.

MEMBER SANDHIR: Yes.

MR. NAU: We can have robust information in the report on the points for each side. We can even get feedback on that, on those points through our normal process from the Committee to include in the report.

MEMBER SANDHIR: Yes.

MS. WATANABE: Yes, I am comfortable with that. You are going to leave me with a tough decision but I am comfortable with that.

MS. BROOKS: All right.

MR. NAU: I am personally excited about you having to make that tough decision.

MS. WATANABE: I thought you would be.

MS. BROOKS: We will put in the opening page, a gift for Mary, in the report. Okay. So thank you, okay. So we have come to a conclusion there with that vote so thank you all.

MEMBER YEE: Oh.

MS. BROOKS: Go ahead.

MEMBER YEE: Oh, you don't want just a final decision between the 25 and 50 amongst everyone? It is not really ranked voting without that but it is (laughed).

MS. WATANABE: I mean, we can, I don't know that it is going to change a whole lot. I mean, it is basically the three people that voted for 33, we need to know where they land. I am okay voting again, just so we have an accurate record of between the two. But, I mean, I think we will reflect all three.

MS. BROOKS: Okay.

MS. WATANABE: That were considered.

MS. KANEMARU; Bill Barcellona? Oh, sorry, Rick Riggs has his hand up. Rick.

MEMBER RIGGS: Yes, I was, I was just going to say -- can you hear me?

MS. BROOKS: Yes.

MEMBER RIGGS: Yes, okay. So I was just going to say that I think that, you know, the reflection of a lower percentage number of votes actually should be reflected if we are going to reflect that. I mean, I guess in the titling there were nine that were 25 and 33 and there were five that were 50, right? So I think that that is also an important piece to reflect somewhere.

MS. WATANABE: Rick, if we vote again, I think we will get there; is that?

MEMBER YEE: Yes, maybe --

MEMBER RIGGS: That's fine, yes, that's fine. I just wanted to if we're not -- yes, yes.

MS. KANEMARU: Okay. Bill Barcellona?

MEMBER BARCELLONA: Twenty-five.

MS. KANEMARU: Okay. Dannie Ceseña?

MEMBER CESEÑA: Fifty.

MS. KANEMARU: Alex Chen?

MEMBER ALEX CHEN: Twenty-five.

MS. KANEMARU: Cheryl Damberg?

MEMBER DAMBERG: Twenty-five.

MS. KANEMARU: Diana Douglas?

MEMBER DOUGLAS: Fifty.

MS. KANEMARU: Tiffany Huyenh-Cho?

MEMBER HUYENH-CHO: I am just going to say that I really see both sides of this question and I think it is a hard decision but I am going to go with 50.

MS. KANEMARU: Ed Juhn?

MEMBER JUHN: Twenty-five.

MS. KANEMARU: Jeffrey Reynoso?

MEMBER REYNOSO: Fifty.

MS. KANEMARU: Rick Riggs?

MEMBER RIGGS: Twenty-five.

MS. KANEMARU: Bihu Sandhir?

MEMBER SANDHIR: Twenty-five.

MS. KANEMARU: Kiran Savage-Sangwan?

MEMBER SAVAGE-SANGWAN: Fifty.

MS. KANEMARU: Rhonda Smith?

(No audible response.)

MS. KANEMARU: Kristine Toppe?

MEMBER TOPPE: Twenty-five.

MS. KANEMARU: Doreena Wong?

MEMBER WONG: Fifty.

MS. KANEMARU: Silvia Yee.

MEMBER YEE: Fifty.

MS. KANEMARU: Sorry, I have to do a recount, one second.

MS. WATANABE: I think it is seven each.

MS. KANEMARU: Okay. I thought that is what I had as well so I just wanted to make sure. Okay.

MS. WATANABE: You don't help my decision but thank you for voting again.

MS. BROOKS: All right. Thank you, everyone. Okay, so we have one more vote, which has to do with -- as you will recall, we had the conversation about whether or not the benchmark should be fixed or annually adjusted. And we decided that it should be annually adjusted but there was discussion around whether or not there should be a one year or two year look-back period for the data purposes and so we are going to vote on that as well. So the vote would be whether or not you want a one year look-back or a two year look-back. I guess look-back is not the right word, it is probably lag on the data. So let me just make sure, are there any questions before we get started? Kristine, yes.

MEMBER TOPPE: Yes, I feel ignorant given who I work for but I am tired so I am going to ask. So when we are talking about one year versus two year what -- like just using 2022 as our like, say, say this was the performance year we were talking about. It would be like the performance for 2022 calendar year reported in ‘23 and used for -- so that target would be reported in ‘23 for a set and then -- and then when would it be used for enforcement?

MS. BROOKS: So I am going to let -- Andy and Janel both raised their hands really fast so I am going to, I am going to let them talk a little bit because I may have confused things.

DR. BASKIN: Hi, it's Andy. So I think what -- the way I explained it earlier and I will repeat it because I think that it, I think this is what we meant by one and two year, though. The one year actually means that the performance in 2022, so the activity that is going on today, how many mammograms are being done, how many whatever it is we are counting. The target will be what came out in Quality Compass in this year, in, you know, August for Medicaid Quality Compass numbers. So the Quality Compass performance number of whatever it is, is based on measurement year 2021. But we don't get that information until obviously July, August of 2022 and we will apply that to the performance for measurement year 2022. So it is one year behind.

MEMBER TOPPE: (Overlapping). That is the one year.

DR. BASKIN: Yes. The two year behind would be we would use the data for let's say the 2022 measurement year, we would use the Quality Compass that came out last July because that would have been known even before the beginning of this year. So that would be a two year lag. That was the two choices that were given. There is a third one but we -- nobody wanted to do that one, which is the retrospective. So that is the one year and two year, okay?

MEMBER TOPPE: Okay, thank you.

DR. BASKIN: Sure.

MEMBER BARCELLONA: And Andy, you had said that a lot of plans are comfortable with that, that kind of a structure?

DR. BASKIN: I think multiple people mentioned that, you know, it

is feasible. And a couple of the guys from the plans said, well maybe they would prefer the two year but they, they are not, or they are, they are kind of equal about either one, there's pros and cons to each. But, you know, the one year one requires you to do a little forecasting because you really don't know until July or August what the target is going to be. But you knew what it was last year and you could predict it is not going to be too far off. But, you know, obviously the two year lag means you know exactly what it is because the number is set prior to the beginning of your measurement year. And the comments were made, of course, that, you know, if you wanted to change course in terms of your activities it is a little late in the year to do that. So you balance that against, you know, how recent you want the, you know, the target to have been from, what recent activity, so that is the balance there.

MS. BROOKS: Did that answer your question, Kristine?

MEMBER TOPPE: (Nodded.)

MS. BROOKS: Thank you, Andy, for clarifying that. Alex, your hand is up.

MEMBER ALEX CHEN: Yes, I just want to make a quick comment because Andy reminded me of something. And I hope this is not influencing votes so if I am please, you know, stop me. But I think in terms of forecasting, Andy, we don't know. I mean, the racial/ethnic breakdown of all the populations and their performance in different counties, you just don't know. There is no way for me to know was it Asian that is going to be at the most disadvantaged where their target is going to be versus a Hispanic woman on breast cancer screening, I just don't know. So actually I don't think we would feel comfortable forecasting. I think we feel comfortable forecasting the overall aggregate rate, like you said.

Over the last five years we have data that doesn't change. But we would have the first set of these racial/ethnic data in 2023 or 2024. I don't think we can forecast accurately at all in the racial/ethnic stratification. So I do want the voters to consider that in their, in their consideration.

DR. BASKIN: Yes, Alex, I 100% agree. My comments were only based on the aggregate results across all, you know, the entire population. And this was not meant to be setting a benchmark for each individual subgroup because you are right, there is no way to forecast that at this point in time and it may take five years or more before that forecasting could be done. But I, but I also heard that we are not intending necessarily to do any enforcement upon disparities reduction on each subgroup in the first five years anyway so it is kind of a little bit moot; and that, that decision could be made on the next round when there is some type of enforcement on disparities reduction as opposed to just reporting.

MS. BROOKS: All right. So real quickly before we take the vote here just want to check, Shaini, no additional public comment?

MS. RODRIGO: No, there are none at this time.

MS. BROOKS: Okay, all right. So I will turn it over to Alex.

MS. KANEMARU: Thank you, Sarah. Okay, so for this round of votes if you could just say one or two for the one or two year lag. I will start with Bill Barcellona.

MEMBER BARCELLONA: Two.

MS. KANEMARU: Dannie Ceseña?

MEMBER CESEÑA: Two.

MS. KANEMARU: Alex Chen?

MEMBER ALEX CHEN: I will go for two.

MS. KANEMARU: Cheryl Damberg?

MEMBER DAMBERG: One.

MS. KANEMARU: Diana Douglas?

MEMBER DOUGLAS: One.

MS. KANEMARU: One? Okay.

Tiffany Huyenh-Cho?

(No audible response.)

MS. KANEMARU: Tiffany, I'll come back to you.

Ed Juhn?

MEMBER JUHN: Two.

MEMBER HUYENH-CHO: Oh.

MS. KANEMARU: Oh.

MEMBER HUYENH-CHO: Sorry, it was one.

MS. KANEMARU: Okay, thank you.

Jeffrey Reynoso?

MEMBER REYNOSO: Go with one.

MS. KANEMARU: Rick Riggs?

MEMBER RIGGS: One.

MS. KANEMARU: Bihu Sandhir?

MEMBER SANDHIR: Two.

MS. KANEMARU: Kiran Savage-Sangwan?

MEMBER SAVAGE-SANGWAN: One.

MS. KANEMARU: Kristine Toppe?

MEMBER TOPPE: Two.

MS. KANEMARU: Doreena Wong?

MEMBER WONG: One.

MS. KANEMARU: And Silvia Yee?

MEMBER YEE: One. Did you get Ed?

MS. KANEMARU: I did. Ed, you were two, I believe.

MEMBER YEE: Okay.

MS. KANEMARU; Thank you, Silvia. So with eight votes towards one year lag it will move forward for consideration in the final report.

MS. BROOKS: Thank you, Alex. All right.

So that brings us to the conclusion of, don't leave quite yet, but to the conclusion of our discussion today. We have had a long meeting. I appreciate everybody's contributions. As always, thank you so much.

Moving to Slide 66. Just a reminder that public comment may be submitted to publiccomments@dmhc.ca.gov until 5:00 pm on August 24.

And let's see, the September -- next slide. The September 12 Committee meeting will be held virtually, the same as this one; we look forward to that meeting. That meeting will be a review of the draft report and we look forward to receiving your comments. You will receive the draft report in advance of that meeting for your review. We look forward to that discussion. Let's see.

And I think that is it for today. I wish everyone a wonderful rest of your day and thank you again for your time.

Kristine has her hand up, I'm sorry.

MEMBER TOPPE: I'm sorry.

MS. BROOKS: Go ahead.

MEMBER TOPPE: A logistics question. I can't come to that

meeting but what is the best way to -- just provide comments in writing?

MS. BROOKS: Yes, please, yes.

MEMBER TOPPE: Okay, thank you.

MS. BROOKS: Thank you. All right, have a great day.

MEMBER TOPPE: Thank you.

(Goodbyes.)

(The Committee meeting concluded at 4:51 p.m.)

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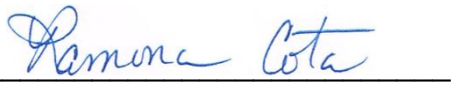
CERTIFICATE OF REPORTER

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

That I am a disinterested person herein; that I recorded the foregoing California Department of Managed Health Care Health Equity and Quality Committee meeting and I thereafter transcribed the recording.

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

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



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