STATE OF CALIFORNIA

DEPARTMENT OF MANAGED HEALTH CARE

HEALTH EQUITY AND QUALITY

COMMITTEE MEETING

VIDEOCONFERENCE/TELECONFERENCE MEETING

HOSTED BY THE

DEPARTMENT OF MANAGED HEALTH CARE

SACRAMENTO, CALIFORNIA

WEDNESDAY, JULY 13, 2022

12:00 P.M.

Reported by: John Cota

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APPEARANCES

Voting Committee Members

Anna Lee Amarnath

Alex Chen

Cheryl Damberg

Diana Douglas

Lishaun Francis

Tiffany Huyenh-Cho

Edward Juhn

Jeffrey Reynoso

Bihu Sandhir

Rhonda Smith

Kristine Toppe

Doreena Wong

Silvia Yee

Ex Officio Committee Members

Palav Babaria

Alice Huan-mei Chen

Stesha Hodges

Julia Logan, represented by Lisa Albers

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

Reverend Mac Shorty
Community Repower Movement

INDEX

PROCEEDINGS

12:02 p.m.

MS. BROOKS: All right, good afternoon and welcome to the seventh Department of Managed Health Care Health Equity and Quality Committee. My name is Sarah Brooks. I am a consultant with Sellers Dorsey, the 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 forward to the DMHC in the form of a report developed by Sellers Dorsey and representative of the Committee's positioning.

During last month's meeting, we heard from Marc Elliott and Julie Brown from RAND well as well as Cheryl Damberg to discuss the challenges and benefits of CAHPS. We voted on measures and began the discussion on benchmarking.

Our last meeting was very fruitful. There was active discussion, as I just mentioned, by Committee, Members allowing for consideration of measures in priority areas. We were able to vote on the first set of measures and moved 13 measures forward to our recommendations list. I encourage you all to continue these dynamic discussions today.

As always we have a very packed agenda so we are going to go ahead and get started quickly here. I am going to go ahead and hand things

over to my colleague Janel Myers who is going to go through some housekeeping items.

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 or 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 are sometimes referred to as serial meetings. A serial meeting would occur if the 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 at the same time such as member one emailing member two who emails member three. Accordingly, we ask that all members refrain from emailing or communicating with each other about Committee matters outside the confines of a public Committee meeting.

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

So as Janel mentioned, this meeting is governed by Bagley-Keene. And just a friendly reminder about the Chat; I know we all love to use it but Bagley-Keene does not allow it and so just want to remind all of us not to utilize it. All right, let's move on to Slide 6, please.

All right, so Slides 6 and 7 walk through today's agenda, which includes a presentation from Sara Durston to discuss the DMHC's regulatory process, a review of selected measures, and narrowing those measures identified for further discussion during last month's meeting. We will also hear from Covered California, CalPERS and DHCS regarding benchmarking. We will vote on benchmarking methodologies and measure stratification; and discuss disparities reduction as well.

Once we conclude Agenda Item 5, Review and Finalize Remaining

Measures, we will vote on the seven measures which were identified in the last meeting for further discussion. So as you will recall, we had seven measures that were left last time for further discussion. We are going to go through all the information for those measures that we have to provide updates to you all on. You have seen most of that information before, but just a reminder, and then we will take a vote.

We will all also vote on a benchmarking methodology after Agenda Item 8.

And during Agenda Item 9, Disparities Reduction and Measure Stratification, we will vote on the measure stratification approach for the final recommended measure set.

So at this time I would like to do a quick roll call of DMHC representatives, Committee Members and introduce the Sellers Dorsey team. All right. So Mary Watanabe?

MS. WATANABE: I am here. Good afternoon, everybody.

MS. BROOKS: Nathan Nau?

MR. NAU: Good morning, Sarah.

MS. BROOKS: Hi, good morning, Nathan.

Chris Jaeger?

DR. JAEGER: Present, good morning.

MS. BROOKS: Sara Durston?

MS. DURSTON: Present.

MS. BROOKS: All right, next slide, please.

Anna Lee Amarnath?

MEMBER AMARNATH: I am here, hello.

MS. BROOKS: Hi, Anna Lee.

All right, Bill Barcellona?

(No audible response.)

MS. BROOKS: Dannie Ceseña? I believe Dannie is not with us today but just checking.

(No audible response.)

MS. BROOKS: Alex Chen?

MEMBER ALEX CHEN: Yes, I am here.

MS. BROOKS: Cheryl Damberg? I know she will be joining us; I think she is working out the link.

Diana Douglas?

MEMBER DOUGLAS: Here. Thank you.

MS. BROOKS: Lishaun Francis?

MEMBER FRANCIS: Here.

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

MEMBER HUYENH-CHO: Here.

MS. BROOKS: Edward Juhn?

MEMBER JUHN: Good afternoon, here.

MS. BROOKS: Jeff Reynoso?

MEMBER REYNOSO: Good afternoon, present.

MS. BROOKS: Rick Riggs?

(No audible response.)

MS. BROOKS: I believe he is not here. Just checking. Okay.

Bihu Sandhir?

MEMBER SANDHIR: Yes, here.

MS. BROOKS: Kiran Savage-Sangwan?

(No audible response.)

MS. BROOKS: I believe she is not here either. All right, next slide, please. Rhonda Smith?

MEMBER SMITH: Here.

MS. BROOKS: All right. Kristine Toppe?

MEMBER TOPPE: Here.

MS. BROOKS: Toppe, sorry about that.

Doreena Wong?

MEMBER WONG: Present.

MS. BROOKS: And Silvia Yee?

MEMBER YEE: Present.

MS. BROOKS: Next slide, please. All right, Palav Babaria?

MEMBER BABARIA: Present.

MS. BROOKS: Oh, sorry. Hi, Palav, thanks for joining.

Alice Chen?

MEMBER ALICE CHEN: Good morning, present, thanks.

MS. BROOKS: Stesha Hodges?

MEMBER HODGES: Here.

MS. BROOKS: Julia Logan. I believe, Lisa, you are on at this time; is that right?

MEMBER ALBERS: Hi, yes, Lisa Albers for CalPERS. Thanks.

MS. BROOKS: Robyn Strong?

MEMBER STRONG: I am here.

MS. BROOKS: Great, next slide please. And this is the list of

Sellers Dorsey members supporting this effort. All right, next slide.

All right. So these materials that are listed on the slide here today will be utilized throughout the meeting today and can be used as reference documents as well.

So the Workbook, the first item identified on the slide here received by Committee Members, contains performance data for the 25 percentile, 33.3, 50, 66.7 and 75 percentiles for NCQA measure stratification status and other relevant information. We ask that you please review this information while you are voting on measures today if you have not had the opportunity to look at it already.

Additionally, the epidemiologic and performance data handout has prevalence, incidence and mortality-related information for your review. These materials may inform some of the decisions you make during today's meeting, both in terms of measure selection and benchmarking. If data are not included for a measure it is because we have not identified any data at the national or state level that represent it. So hoping that you have had an opportunity to look at this data but then also use it as references as we continue through our discussions today.

So you should have received several documents ahead of this meeting for your review, which include the agenda, presentation, the meeting summary and transcript for the last meeting, Final and Further Discussion Measures Workbook and the Data Handout as well that is listed on this slide. Next slide, please.

We have Committee meetings scheduled through August at this time. You will see them on the slide here.

Today's meeting is for finalizing the measure status. We talked about benchmarking and measure stratification.

And should we get through all of that then the next meeting will be August 17 where we will review the draft report of Committee recommendations. You will receive that report in advance of the meeting for review.

Should we not get through everything today we will need to add an additional meeting and we will talk about that. What we will do then is have an additional meeting in September. So we will see how far we get today and just based off of that, that will determine our schedule moving forward. So next slide, please.

All right. So with that, I am going to open it up for the Committee to see if there are any questions from the Committee Members.

Not seeing any hands at this time. Shaini, can I ask, are there any public comment hands raised?

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

MS. BROOKS: All right, then we will move on. Next slide please.

All right, so the June 22 Meeting summary is included in the packet of information that you received from Alex. It is also posted online for -- I am sorry, it is not posted online. If there are no changes to the meeting summary then we will consider it final and move it forward and post it online. So just wanted to check with Committee Members to see if there are any changes to the meeting summary?

All right. And Shaini, do we have any public comment hands raised at this time?

MS. RODRIGO: There are none at this time.

MS. BROOKS: All right, next slide, please. Yes, I think you can move to Slide 19, please. Thank you.

All right. So in past Committee meetings there has been commentary on DMHC's regulatory process. The DMHC does measure and monitor health plans in many different ways and in many different capacities. Today, we are lucky to have Sara Durston from DMHC, she is a senior attorney with the Department, to provide additional information on this subject matter. And so with that I am going to turn it over to Sara who will talk us through the regulatory process.

MS. DURSTON: Great, thank you so much, Sarah. So Sarah mentioned, my name is Sara Durston and I am an attorney with the Department of Managed Health Care. I will be giving just a brief overview this afternoon of the regulatory process that the DMHC will go through after the Committee has been concluded. So much of this may be a review for you but I am hopeful that it will provide some context to keep in mind as you are making final decisions on measures and standards to recommend in the final report.

So as Sarah mentioned at the start of the call, AB 133, the budget trailer bill from last year that established the Committee, is really what we are implementing.

The relevant provisions from the bill are found in Health and Safety Code sections 1399.870 to 1399.874. And those statutory sections state that the Committee shall make recommendations to the Department about health and equity, health equity and quality measures and annual benchmark standards that will be applied to health plans.

Now, it is important to note the use of the word, recommendations.

The report that comes from the Committee will just recommend equity and quality measures and standards. The Department will consider these recommendations. But even if the Department agrees with the recommendations, they cannot immediately be applied to health plans because they will not have the force of law.

So you may be thinking, why can't the DMHC just apply these requirements to health plans? That would be great. That would be a lot easier for us. But the DMHC differs from other state agencies that contract directly with health plans. So the DMHC is a regulatory agency. We don't contract directly with plans but rather we license and regulate plans.

So for example, Covered California contracts with health plans on the Exchange and DHCS contracts with Medi-Cal plans. So these agencies have contract negotiations with plans and during the negotiations can require plans meet certain requirements as part of the contract. The agencies can also make periodic changes on their contracts without going through the formal rulemaking process and they can offer incentives for improving quality or meeting certain benchmarks.

The DMHC, however, can only require plans meet requirements that are in law. Thus, to implement any of the Committee's recommendations the DMHC will have to promulgate regulations. A regulation is a rule that interprets, implements or makes specific the law. So again, in this case, the regulation will interpret or make specific the laws enacted by AB 133 that are found in the Health and Safety Code. Note that the regulations will tell plans the measures on which they will be judged and the standards that they must meet, as this is the information that is being discussed in the Committee. The

regulations, however, will not tell plans how exactly to meet those standards, it will just tell them what the standards are.

As far as an overview of the regulatory process, during the process the DMHC must comply with the California Administrative Procedures Act or the APA. And the California Office of Administrative Law or OAL is the state agency that reviews the process to ensure that the APA is being followed. A little bit of acronym soup. The purpose of the APA and the regulatory process is to ensure that the public has a meaningful opportunity to participate and the APA requirements are being followed.

We refer to the regulatory process as the formal rulemaking process. So once formal rulemaking process has begun we have one year to complete the process. And during this year, for your purposes, it is important to know that once we begin the formal process the Department will not engage in ex parte communications with stakeholders such as yourselves. So this means the Department will only accept comments and suggestions via the formal public process. And this is to ensure that everyone has the same opportunity and information when participating. This is very similar to the Bagley-Keene Open Meeting Act requirements that we are following for the Committee meetings.

So to start the formal process we will publish a Notice of Proposed Action and we will send a notice to our listserv and post it on our website; so everyone should have information about the regulatory process beginning.

One of the documents that we publish at the start of the formal rulemaking process is an Initial Statement of Reason. This provides justification for the regulation including an explanation of the problem we are solving and the purposes and the necessity and benefits of the proposed regulation or changes.

We also have to publish an Economic and Fiscal Impacts form. This will include an estimate of the economic costs and those are the private costs such as to health plans, and the fiscal costs or the cost to the government.

So after publishing these required documents we engage in what we refer to as Notice and Comment periods. Now, these are the periods when the public, such as yourself, will have opportunity to submit comments on the proposed language. The first comment period is 45 days. So after we receive all the comments from that 45 day period we will summarize and respond to all the comments. Note that we don't send the responses to the party that makes the comment; rather, we submit all of the comments to OAL, the Office of Administrative Law, at the end of the regulatory process. OAL will review all of the comments to ensure that we responded to them adequately.

So the next steps of the process and whether we have additional comment period or a hearing depend on whether and to what extent the Department will make changes to the draft regulatory text.

So for your purposes it is important to note that the regulatory process, including comments and our responses to them, is really judged based on necessity. So the Department has to explain and justify the necessity not only for the regulation itself but for each individual line of the regulation. So if the regulation package lacks justification or specificity it will not be approved by OAL.

So for an example of this, one of the measures chosen by the Committee is breast cancer screening. So if we include this measure in the proposed regulation, we will have to explain why we chose breast cancer screening as a measure rather than something else. So we may list the incidence of breast cancer, how mortality or screening rates differ based on race

and ethnicity and other supporting data. We will also be required to identify sources that we rely upon for this information. We will also have to justify why we set the standard for improvement where we did. So if we choose a set percentage or a number that must be met, we will have to explain why we chose that percentage or number rather than one that is higher or lower. So we have to justify the specific number that we use. As we will discuss later today, if we choose an absolute benchmark versus a relative benchmark we will have to explain why we choose one versus the other.

So when we get comments we will often, in previous regulations we see we get comments where people suggest a higher number or a lower number or a different measure and we will have to justify your explanations. And again, that is part of the package that OAL will review to ensure that we responded appropriately to all of these and really justified our conclusions.

So these detailed requirements are important not just to ensure that we meet APA requirements and the regulation is approved at the end. But it will also, it is also helpful for the DMHC's enforcement of the regulation once it goes into effect.

So the statute says that starting in Measurement Year 2025 the Department will take enforcement action for plan deficiencies or failures to meet standards set forth in regulation. To take enforcement action it is really helpful for the department to have a specific standard to which plans will be held accountable. So for example, it is better to say, 'Plans must improve to X percentage' versus 'Plans must show a significant improvement' as 'significant' is kind of a mushy legal standard, it is hard to prove what 'significant' really means.

So that is just a very brief overview of kind of next steps after the

Committee has concluded and kind of our end goal for this. I am happy to answer any questions. I will turn it back over to Sarah for the formal question process.

MS. BROOKS: Thank you, Sara, that was very helpful and very informative, we appreciate it. I will open it up to Committee Members for any questions or comments. Kristine.

MEMBER TOPPE: Thank you. Can you hear me okay?

MS. BROOKS: Yes.

MEMBER TOPPE: Okay. Thank you, Sara, that was very, very helpful and addressed a lot of the things that I think have come up along the way as kind of needed for clarification on kind of how the decisions we are going to make today are going to play out. If there is, if we get to, I guess in the report production process, and this may be a question for Sarah, the other Sarah and team, but as the report is being developed are those questions about justification going to be explained in the report?

MS. DURSTON: I --

MS. BROOKS: Oh, go ahead, Sara.

MS. DURSTON: I was going to say, I will defer to you on that, Sarah.

MS. BROOKS: Okay. Sara defers there. Yes, at this time I don't believe we would be including that type of information in the report but maybe you can talk a little bit more about that just in terms of your thinking.

MEMBER TOPPE: Yes, thank you. So given what Sara said about once the rulemaking process begins if we cannot provide kind of additional clarification, justification, or maybe I misunderstood what we could provide. I

would think we would want to have that kind of documented going into the recommendations process so that it is not a question that comes next year after, you know, this part of the process is done and then the Department is going back to be able to answer those questions. So that's, that's my rationale.

MS. BROOKS: Got it, okay.

MS. DURSTON: Sarah, I do have a brief response. It is -- I was anticipating that once we begin the regulatory process, we have a whole team of people at the DMHC that will work on the regulation and I anticipated that we would be providing the justifications. And obviously we would be looking back at some of the materials and the charts that have been discussed. And this is just helpful information for you all to keep in mind and that you have been keeping in mind with some of the discussions saying, you know, I don't really see where there is a disparity in this so this is a better measure to include because there seems to be more of a disparity and more of a possibility for movement, we can move the needle a bit more on this. So we will be looking back at some of the conversations that you all have already had and some of the materials that have been provided to include with our justification during the regulatory process.

MEMBER TOPPE: Okay.

MS. BROOKS: Just to add real quick, Kristine, I think, because that helped me think a little bit about responding also is just that given the magnitude of discussion that the Committee has had I think it would be very difficult to include all of that in the report itself. We will be including as attachments the meeting summaries, the meeting transcripts, all of that information so it will come through. And then we have sections that include kind of like the themes that we are hearing from you all. So we may not be, you

know, specific on every measure, for example, but the content will be there. I hope that helps a little bit.

MEMBER TOPPE: It does, it does. I just am anticipating once it is published if there's reactions for folks that weren't able to kind of track the work of the committee, if they want to be able to understand why one measure was selected over another that there's that kind of justification and reflection on what was raised by the various, you know, folks at the table. Thank you.

MS. BROOKS: Thanks, Kristine.

MS. WATANABE: And if I can just add really quickly, Sarah. I just want to remind everybody that once we start the formal rulemaking process there is lots of opportunity for public comment, it just needs to be on the record. So a lot of the times what will happen is you might reach out to me or to Nathan and say, I wish you could have tweaked this, or can you do this, and like we can't talk to you, everything needs to be very formal and on the record and public. But just a reminder, we often will have a number of comment periods so there is an opportunity for continued dialogue. But kind of the committee process and the informal process will stop. Part of the reason we had these transcripts and the meeting summaries and a lot of documentation it to help us support our regulation process and the volumes of justification documentation that Sara will be working on. It is a lot of work to put these regulation packages together and that regulation process takes about a year. So hopefully that helps a little bit, Kristine.

MS. BROOKS: Thanks, Mary.

I see your hand is up, Diana.

MEMBER DOUGLAS: Thank you; Diana Douglas with Health

Access California. I really appreciate the presentation, Sara. I think it was super helpful for me and also, Mary, for your clarifying comments just now.

I think I just wanted to maybe take a second to talk about the sort of, I guess the responsiveness of the regulatory process and as Mary noted that it takes quite some time. And also, just as we are thinking about, you know, the measures that we are selecting and the benchmarking process we will be voting on that. This is really kind of, you know, sets. Once the regulatory process has happened it doesn't obviously set them in stone but it does take quite some time and process to complete. Is there -- as we choose measures is there any opportunity for revision or any revisions that would happen would go through the full regulatory process? I guess is a question.

And then more of a comment is just to make sure that we are keeping in mind that as we select these, there is not as much opportunity as there would be, say, through contract provisions to go back and be responsive to, you know, new issues that come up or sort of changes in the research environment in terms of,, that might impact which measures we'd want.

MS. DURSTON: I will respond briefly to that, just again for another overview of the process. So the Committee will make recommendations that will then be put into a report and submitted to the Department. And then -- so that process will have kind of a finite set of recommendations that will be included in the report. And then after that the Department will take the report and decide what it wants to do with it. And it is our under, it is our impression that we will then go through the regulatory process.

Again, these are the statutes as these will be recommendations so the Department is not held to implementing all of the recommendations that are

included in the report. So the Department does have some, some leeway in what it wants to propose to be included in regulation. I would anticipate that we would probably include the measures that are included as recommended in the report. But then, again, as Mary mentioned, we will go through the regulatory process.

So if for some reason if you were a Committee Member and you voted against a measure that was included in the final report you could always comment during the regulatory process, during the formal rulemaking process saying, I don't actually think this should be included and here is why. And then during the regulatory process we have to respond to all of those and justify, you know, why we should or why we should not include it.

And sometimes the Department does make changes in response to comments if we get a volume of comments or if points are made that we hadn't considered before.

And then once -- you are right, that once a regulation is established it is difficult, we have to reopen the regulatory package to make changes. Sometimes in regulation there are sunsets or we say, you know, it is difficult. We have already considered, you know, as measures change, you know, how we would address that. So that's something that we might consider including in regulatory language. That is just a little bit trickier to kind of give a way to reopen it if something changes with the way, you know, standard measures like NCQA measures, if they change. It is hard to include that language, OAL doesn't like seeing that type of language, so usually we do have to reopen a regulatory package. I don't know if that responds to your question.

MS. BROOKS: I am going to take that as a yes with silence from

Diana. I see Silvia has raised -- Diana, did you have a follow-up?

MEMBER DOUGLAS: That is correct; thank you.

MS. BROOKS: Okay. Silvia, go ahead.

MEMBER YEE: Thank you. This is Silvia from DREDF and following up on this last conversation. Thank you, the information is really helpful that has been given. I am thinking again about that, that edge between flexibility and the making of regulations. And I am thinking specifically about stratification. The final population health management plan came out on July 5 and it is, it did indicate that it would be getting race and ethnicity information and SOGI information in terms of stratification. I sincerely believe and hope that the possibility of disability functional status information will also be addressed in future at some point. Will the DMHC regulations in terms of what it requires from plans and how that information is provided, how it is stratified, will it contain room for adapting future stratification requirements as they are raised in the population health management or by other departments in California? And if, let's say in contract language, plans have to come up with stratification or other detailed information would, is there room for the DMHC regulations to incorporate that data and to use that data?

MS. DURSTON: Thank you for the question, Silvia. This kind of piggybacks on what I was saying in response to Diana's comment that it is hard to include flexibility in regulatory language, saying it is hard to keep a regulation open-ended and say, we will consider things that should come up in the future such as some of the things you mentioned. That is pretty tricky to include.

But for some of the standards, if the standards say, health plans should be at 50% or 75% of the national average for XYZ. Those are some

ways where we are not choosing a static number, but as the percentage changes health plans would be required to meet that. That is one example where there is some movement. But usually to make changes we do have to reopen the regulatory package.

One thing I will note is that generally I think of the regulation as the floor so that will be the base that health plans have to meet, they have to meet the requirements of the regulation. But other departments or contracts can require more of health plans, they can kind of create a ceiling. So the regulation will always be the floor that they are required to meet. But if DHCS or Covered California in contract wants to require more of them and include some of the more kind of flexible measures you mentioned, that is something that they could do, but it is difficult to include flexibility in a regulation.

MEMBER YEE: Right. And thank you for that answer. I think, so this is not, this is not a change in the measure that I am I am thinking of, the measure will be what it is.

MS. DURSTON: Mm-hmm.

MEMBER YEE: And the required, the percentage will be what it is. It is how the plan provides the information that meets the measure, whether it is going to be stratified. What if, what if there is a greater requirement in the Asian Pacific Islander population, greater granularity and more -- or disability or any of the others. It is like the interaction between stratification of the information that is provided to meet the measure, it is a little bit different, and I would, it seems like it is not exactly a change in the regulation, which will say, you have to give us information on this measure and it has to meet this requirement. It is the reporting, which may come from somewhere else. And that's what I was

wondering if there was room to build in some flexibility around that?

MS. DURSTON: Yes. That's something, that's something that we can look at. And that's also where, again, this is kind of our informal process where we can have more dialogue and discussion about these things and once we start the formal process we really have to stick with the formal rulemaking. But we do always encourage formal comments. And oftentimes, I mean, we create a comment chart and they are hundreds of pages long where we get comments and we respond to them. And we really do rely on advocates and stakeholders looking and giving us suggestions for things that maybe we hadn't considered and that's where we do make changes. That's why the process takes a year because we make changes, and then we submit the document for another comment period so you all can respond to the changes that we have made.

MEMBER YEE: Thank you. And I partly made that comment so that question would be in the record as well, so thank you.

MS. DURSTON: Thank you.

MS. BROOKS: Thank you, Silvia. Jeff.

MEMBER REYNOSO: Thanks. Jeffrey Reynoso with Latino Coalition for a Healthy California. I am a little bit more familiar with the Federal Register process around public charge and I am curious, with the Department are there any requirements as it relates to outreach and receiving of comments in languages other than English, around threshold languages? If they are not just curious what those requirements are as we engage in this public comment period?

MS. DURSTON: That is a great question. I should know this

answer but I will admit that I don't, I am guessing. So we are governed by, governed by the Administrative Procedures Act and I am not sure what the requirements are in there. I would say that, again, even if we are not required to, I would anticipate that we would encourage comments in all languages but I don't know that we provide our initial regulatory documents in languages other than English. If requested for a translation I would think that we would try to meet those requests but I am not sure of the exact answer. I don't know if Mary or if anyone else has a better answer.

MS. WATANABE: I don't. I will just say that I don't think, like if you go to our website, our website is in English and we typically post things in English, we don't offer translations. But I will say that many of you on this call are kind of our extension into those communities to try to help us solicit information. I will note that this is a very, this will be a very technical regulation package so I think, you know, you are a great representative for the communities that you represent and so we would look to you to kind of help us get that feedback. But we can certainly follow-up. I don't know that there's any requirements through the APA that we do something different.

MS. BROOKS: Thanks, Jeff. I don’t --

MS. WATANABE: Sarah, Sarah, if I can just --

MS. BROOKS: Go ahead, Mary.

MS. WATANABE: If I can just note too, I think later in our presentation today we are going to talk a little bit about the measure stratification, to Silvia’s question.

MS. BROOKS: We are.

MS. WATANABE: So, you know, I think this is the big question of

what is reported and where there's not requirements around the collection of some of this data or the data is not robust then the question is, you know, at what point do we apply the benchmarks or the standards. And so I think we will have some discussion later today about kind of the data collection and at what point we actually would be able to do something in terms of enforcement and then how that feeds into the regulation package that Sara is going to craft for us. And again, the regulation process doesn't really lend itself to flexibility but sometimes we can get creative in the crafting of that and just what we collect and at what point we can apply those standards. So more to come on that. We will be looking forward to that discussion as well.

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

Not seeing any other hands raised from the Committee let me just check with Shaini to see if we have any public comment hands.

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

MS. BROOKS: Great, thank you, Shaini.

All right, we will move on to the next slide; and the next one. So we are going to now review the selected measures for the final set, we will move to Slide 22. So Slide 22, hopefully this legend and the information looks familiar. So the caret is performance data is currently available and the asterisk, NCQA stratification by race/ethnicity is occurring or will occur in the future. So as we go through the next slides you will see these symbols used.

So this is the measure set that you all voted on at the last Committee meeting. We will just go through it quickly in terms of I will read them because you can read them as well. Breast cancer screening; colorectal cancer

screening; hemoglobin A1c control for patients with diabetes; controlling high blood pressure; asthma medication ratio.

I think on the next slide we have depression screening and follow-up for adolescents and adults; prenatal and postpartum care; well-child visits in the first 30 months of life; child and adolescent well-care visits; childhood immunization status, which is Combo 10; immunizations for adults, Combo 2; and then plan all-cause readmissions.

So that was -- and then we also voted on a CAHPS measure. This was the CAHPS measure that was voted on by you all at the last meeting: Getting Needed Care, which included two different questions which are listed on the slide here for your reference.

So we did a great job and got through a vote and included all these measures. There was a set of measures that that we did not vote on but before we move on to that I believe the next slide, let me just see what the next slide is. We are going to open it up real quick and just see if there's any questions or comments from the Committee Members with respect to the slides we just went through in terms of the measures that were moved forward last time. And I see Doreena has her hand up.

MEMBER WONG: Yes, thank you; Doreena Wong, ARI. And I apologize about asking this but, you know, in that last CAHPS measure when it is talking about getting needed care. And I didn't follow-up properly, I think. Was there part of a section of that question that dealt with being able to communicate with the doctor, or some kind of aspect related to language access? Because I am a little worried. I know, we are going to be talking about those two additional language access questions but I am worried that if those don't get in then we

won't be addressing language access at all in any way. So I am trying to, you know, see, if there is some aspect of that CAHPS measure that can capture that in case one of the other measures might not get included in the final set.

So let's take a look at Slide 25 real quick again. Thanks, Doreena, for your question. So this is the question that was voted on. Let's see. Easy for the respondent to get necessary care, tests or treatment. And then, respondent got appointment with specialists as soon as needed. So these are the questions that would be asked of the individual. Cheryl, I know you are on. Is that right?

MEMBER DAMBERG: I am finally on, yes.

MS. BROOKS: Great. I am so glad you were able to join. I know there were, there was a little --

MS. DAMBERG: Some technology issues.

MS. BROOKS: Yes, always the technology. So I don't know if you have any comments with respect to Doreena's question, just wanted to check with you.

MS. DAMBERG: So I think Doreena's question Is a really good one. These couple of items do not capture that particular aspect of access so I think that is still sort of an unaddressed issue. This is really honing in on an area where there tends to be significant gaps in terms of performance overall as well as by subgroup in terms of just being able to get out access to care. But it does not talk about anything to do with language.

MS. BROOKS: Thank you, Cheryl. So hopefully that is helpful, Doreena, and we certainly will be talking a little bit about those other measures in just a minute here as well. Ed, I see you have your hand up.

MEMBER JUHN: Ed, Inland Empire Health Plan. I know when we

first convened the Committee, you know, one of the -- well, one of the comments that were made is potentially focusing on a parsimonious set of measures. Now that we have 13 that have made the final set should we continue to kind of keep that in mind as we go through the seven measures that need further discussions or should we think differently?

MS. BROOKS: So I think you are making an excellent point. I mean, you have heard us from Sellers Dorsey talk a little bit about, you know, numbers of measures that we might be looking to narrow down from, from the 800-plus that we originally started with, and looking to get to maybe a measure set of 10 to 12 or something of that sort. And you are right, we are at 13 now and we have another seven, I think, to vote on today. So you know, I think that you are making a good point in that it is important to consider what measures have already been voted and move forward as we move forward and vote on the remaining measures themselves. Okay, Alex.

MEMBER ALEX CHEN: Hi everyone, Alex Chen from Health Net. I think I missed the last session because I was away. I just want to make a quick comment about plan all-cause readmission sort of for the sake of consolidation or streamlining sort of a more compact measure sets. I don't believe there's any data that I am aware of, and Cheryl may correct me if I am wrong, but I am not aware of any data that indicated that readmissions are disparity sensitive or there's sort of racial/ethnic reasons for readmission. I actually think it may be more age sensitive than disparity sensitive, unless we are considering age as a disparity factor for this measure set.

MS. BROOKS: That is very helpful, Alex. And I think, yes, I know that we unfortunately didn't have you at the last meeting but I know there was a

lot of good dialogue on the different measures and that's helpful as we move forward and think about the measure set as a whole. Let's see. Diana, I see you have your hand up.

MEMBER DOUGLAS: Yes. I think just kind of echoing the comments that were just made on the plan all-cause readmissions. And as we are looking to narrow down I think looking at that, as was mentioned, that it being more age sensitive. I think I am curious about what number of folks under the age of 65 that are likely enrolled in DMHC plans are admitted and then, you know, would be facing potential readmission, to see whether that is really even a valid measure given the population that we are targeting? Thank you.

MS. DAMBERG: Well, I do think we know that individuals with certain social risk factors tend to have higher rates of readmission. And the readmission measure, I would have to remind myself of the specification because it is an outcome measure. It does adjust for certain characteristics like age, if I am not mistaken, and other comorbidities. But I think it would be worth taking a look at the measure specification itself. But we do see differences based on social risk factors in terms of, you know, readmissions.

MEMBER DOUGLAS: Yes, I think I was -- thank you, Cheryl. I think I was more getting at just, you know, of the population that are enrolled in DMHC-regulated plans, given the age, the age range, how many of those are admitted in the first place even?

MEMBER DAMBERG: Sure. Yeah. I mean, I definitely think that that's worth taking a look at. And particularly as the numbers get small then it gets, you know, more and more difficult to do things like stratification.

MEMBER DOUGLAS: Yeah. And with, I think, you know, we have

seen numbers of about maybe 5% under 65 are admitted so I think that is just something to consider as we go forward if more narrowing needs to happen of the number of measures.

MEMBER DAMBERG: Thank you.

MS. BROOKS: Thanks, Diana. So I don't see any other Committee hands raised at this time. Let me just check to see if, Shaini, if there are any public comment hands raised?

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

MS. BROOKS: Okay, well, then we will move on to Slide 27, I believe. Yes, Slide 27. All right, so, and then let's move on one slide. Sorry, I said 27 and I really meant 28. All right.

The following measures fell within the 40 to 59% range during last month's meeting and further discussion was required is what was determined by the Committee. They are listed here: cervical cancer screening follow-up after emergency department visit for mental illness, pharmacotherapy for opioid use disorder, adult immunization status, obesity, prediabetes and diabetes A1c control. We can move to the next slide.

Meaningful access to health care services for persons with limited English proficiency. And patients receiving language services supported by qualified language services providers.

All right. So these are the measures that we have, that we are going to go through. And so as I mentioned before, we are going to go through and provide some background information that you have seen before and then we will take a vote on these measures. So we will move to the next slide.

So for measures that received a 40-59% vote, as I mentioned, we

will take another vote now. So if the measure received, similar to how we voted before, if the measure receives a “yes” vote from 60% or more of the Committee it will be considered for the final measure set. If it is less than 60% then it will be removed from consideration for the final measure set.

And then I think as, you know, we talked about, as Ed maybe just mentioned, just thinking about the measures that have been selected already as we move forward through this vote to kind of think about how, what measures we have that represent different populations already, but also do we need another measure? Just making, and I know you all will, but just making thoughtful choices as you move along and I know that you all have been doing that all along.

So we are going to now move through those remaining measures and just briefly review them as I mentioned. I am going to go ahead and turn it over to Ignatius who is going to start with cancer screening data.

MR. BAU: Great, thanks. Thanks, Sarah. Hello, everybody. And again, this data we have already presented. It is also, especially for the public members, in the other handout, the epidemiological and other background information about all the measures; and so we have extracted the relevant information for each of these seven measures.

So we generally know that cancer screening across all the different types of cancer is important and this is something that we do regularly, have measures and reporting and data on.

We do know that there are disparities in mortality rates, at least for breast and colorectal cancer among Black Californians compared to other Californians. Next slide.

And then comparatively across cancers we have already, the Committee has already voted to include breast and colorectal cancer screening as recommended measures and so the cervical cancer screening would impact the least number. Obviously, any number is important. But just in terms of comparison, this data shows the relative incidence of cases of cancer. Then let me turn it over to my colleague Andy Baskin to discuss the actual measure.

DR. BASKIN: Thank you, Ignatius. You can hear me okay, Sarah?

MS. BROOKS: Yes.

DR. BASKIN: Okay, thanks. Okay. So the measure is cervical cancer screening. It pertains to women aged 21 to 64 so certainly in the age group that we are, that falls under this effort. It is currently reported in Medi-Cal and IHA and certainly some national measure sets. It is not scheduled to be stratified by NCQA and I suspect that is because of the prevalence of this cancer is low relative to some other conditions that are, that are being stratified. There will be benchmark data, however, because it is obviously reported and is a NCQA HEDIS measure.

I might add quickly, because we did present a little data on the prior slide, that checking with the NIH National Cancer Institute 2022 data, cervical cancer is actually the 20th, ranked number 20, 2-0, in terms of prevalence of different types of cancers so it is certainly not one of the more common cancers. It represents 0.7% of new cases of cancer in a year and represents 0.7% of cancer deaths in a year, so relatively small when compared to certainly the colorectal and breast cancer and many, many other cancers in between. So I thought it would be important for you to be aware of that. Next slide. That doesn't mean it is not important, by the way. I hope it is taken in the right light. I

am just giving you some relativity in terms of the impactfulness of this measure.

There is some performance data here. As it turns out, the state in both the Commercial and Medicaid plans is actually currently performing slightly better than the national average at the 50th and 75th percentile. It is numbers you can see nationally and you can see that the state is consistently slightly above. It is small, but small is a relative term and it is not easy to be across the board better than the national averages. Thank you.

MS. BROOKS: All right. So I am going to just turn it back over to Ignatius. I will let you guys go back and forth in terms of presenting the information here and then we will move to discussion and a vote. So next slide, please.

MR. BAU: So the next measure is about mental illness and particularly follow-up after an emergency department visit. And we know that mental health is an issue, certainly depression, but also more serious mental illness is something that affects a lot of Californians. Next slide. Back to Andy.

DR. BASKIN: So follow-up after an emergency department visit for mental illness. The age range here is six and older. It is, there is actually a 30 day follow-up and a 7 day follow-up so there's actually two numbers reported that roll up to the measure. It is currently reported by Medi-Cal but not the other two programs that we have represented here. It is not expected to be stratified by race and ethnicity, at least not identified so far for the current and the upcoming year. And since it is a current HEDIS measure there is some performance benchmark data available, which I suspect is on the next slide.

Yes, okay. And you can see here that by the red, as opposed to the green on the prior one, that the state is performing a little bit lower across the

board than the national numbers for both 30 day and 7 day. If you want to see the real spectrum including the 25th, the 33rd percentile, et cetera, 66th, to see what kind of variation there is across the state it is in your workbooks. Obviously it was too much to be putting on these slides. The fact, however, that the performance is a little bit lower in the state may or may not be something that affects your decision as to whether this should be included or not.

MR. BAU: So if we can go to the next slide. The next measure is a measure that measures treatment for opioid use. Again, we know a common and increasingly problematic challenge for many Californians that does affect millions of Californians in terms of substance abuse. And then we do know that there are disparities in this area by race and ethnicity. That American Indians and Alaska Native Californians do have the highest rate of opioid overdose deaths. Next slide.

And you can see some of that data. Again, we are we are drawing from the California Health Care Foundation Data Almanac, which compiles data from different sources, public health sources, health departments, other surveillance data that is collected. And you can see the differential rates among American Indians, Alaska Natives, Black and White Californians. So then to Andy for the discussion of the actual measure.

DR. BASKIN: So this measure is, the age group that is involved is 16 and older, so a nice wide range. It is currently reported by Medi-Cal of our three, once again, representative groups. It will be stratified, or is currently or will be, I can't remember, but it will be certainly either currently or in the 2023 set requiring stratification by NCQA. There is some performance data, which we will take a look at. This measure has not been around as long as many other HEDIS

measures so there still may be some volatility in those performance data over time until it settles down.

The one thing I want to point out about this measure, though, that perhaps people may not realize is that this is not a measure of whether pharmacotherapy is used in terms of what percent of people with opioid use disorder receive pharmacotherapy. It is actually more, it is actually a narrower measure than that. It is of those that receive pharmacotherapy for opioid use disorder what percent of them actually stay on the pharmacotherapy for 180 days or longer, which is thought to be at least an adequate trial of pharmacotherapy for this disorder. So it is not how often somebody is offered or receives pharmacotherapy. It is, you did receive pharmacotherapy so now you are in the denominator. How often did you working with your provider as a team been able to maintain that treatment over a period of 180 days? Because certainly there are many patients who quit pharmacotherapy before an adequate trial of 180 days. So I just wanted to make sure people understood that. It makes it a little bit narrower focus for this measure.

And I think we do have the next slide with some performance data. And as you can see by the red, the numbers are lower than national averages. Once again I want to point out that this is a relatively new measure. The collection of this measure is not so simple and there may be some issues with the data collection and that may have to sort itself out over a couple of years' time. And that's it for that slide, we can move on.

MR. BAU: So the next measure is about adult immunization status. Obviously, one of those immunizations is going to be the flu vaccine. We have all learned through COVID the importance of vaccinations and yet many people

don't get vaccinations, only about a third nationally as well as in California. A little bit higher, fortunately, for those with chronic conditions. And next slide to explain the measure, back to Andy.

DR. BASKIN: So the adult immunization status measure is a HEDIS measure. It is not currently reported by any of our programs in California; and that may be because it is actually a new measure. There was a measure of some adult immunizations but the measure had changed. So this measure now includes four vaccines. And the one that had been specifically added, which makes it essentially a new measure for adults, was the influenza vaccine. It additionally includes the tetanus, diphtheria, pertussis, you know, the Tdap for those of you familiar with that, that combination vaccine, as well as the herpes zoster, which is the shingles vaccine for those who don't know that, and then the pneumococcal vaccine for protection against pneumococcal disease. And it is that combination of the four vaccines. So once again, no current benchmark data because this measure, because it had been updated significantly and the old data around adult immunizations would not make any sense going forward with these new specifications.

The next slide? I don't know if there is a next slide. No, go back then for a second. I do want to point out that there will be some data issues here. I think someone in the Committee actually spoke to it in one of our prior meetings. Is that the inclusion of influenza vaccine is a really tricky issue into an administrative data measure. The prior influenza vaccine measure was it was a solo influenza vaccine and it was based on a result of a question in the CAHPS survey which basically asked patients whether they received the vaccine. That, of course, was questionably accurate and the decision was to move this into an

administrative measure using data, whether it be claims data or, you know, or registries of vaccines. But as was pointed out, there are many, many, many people that get their vaccinations outside of their health insurance through worksite, that's the biggest one, through worksite immunization programs. Or people, believe it or not, and I know this from experience, they go to the pharmacy and get it and pay for it and it never even gets charged or billed sometimes to their health plan. So there will be a shaking out period here as to how accurate the influenza portion of this measure will be and I think just people need to be aware of that. It may not be terribly reliable in the next few years in terms of the data and future benchmarking. Thank you.

MR. BAU: And the next slide is related to obesity and diabetes. Both are chronic conditions that are really important. Obesity obviously affecting a significant portion, over one in four Californians. And next slide for the discussion of the actual measure.

So we also know, sorry, there is the disparities. A higher prevalence of obesity among American Indians and Alaska Native Californians and Black Californians and also Latino and Latinx Californians as well. Next slide.

DR. BASKIN: So the obesity, prediabetes and diabetes A1c control. If you can recall, this was a new measure developed by the Minnesota Community Measurement and The Endocrine Society within Minnesota. It is a new measure. As far as I know the specifications were only finalized in late 2021 so I believe if any measurement is occurring this year it would be the first year that they are collecting it. It is not a measure that we could find is being implemented anywhere outside of the Minnesota Community Measurement at

this time. And it is not necessarily a measure that is being applied to MCOs, even in Minnesota, because a lot of the reporting there is done directly by the providers themselves.

The measure itself in terms of the detail of the measure, this is patients with a diagnosis of obesity and either prediabetes or diabetes and then do those folks have hemoglobin A1c control? Once again, there was someone on the Committee I recall that pointed out that one of the issues with this measure is prediabetes, and how would a health plan know that someone has prediabetes, and is the definition of prediabetes one that is standardized around the country, which I don't think is quite the case. So there's going to be some difficulty here with collecting the data and the accuracy of the data. And that will shake itself out over time in Minnesota, and I am sure they will solve those problems but it is not going to happen in one year's time.

It is not an NCQA HEDIS measure as I pointed out so therefore there will be no stratified data for us to look at. In fact, currently there is no data to look at, at all, even unstratified. And there's certainly no benchmark data because this measure hasn't even completed its first year of measurement. So I will stop there, thank you.

MR. BAU: And then the next two final measures are dealing with language access. We know that there is a significant portion of Californians who have limited English proficiency or speak languages, primary languages other than English and so this is an important issue in healthcare. Andy will discuss the two specific measures for consideration.

DR. BASKIN: So the first one here, as you can see the name, I guess I won't read the entire name off, is a measure of whether interpretive

services are actually provided where needed. Let me just make sure I got the right one for it, yeah, within the doctor's office or within the provision of health care wherever that may occur. But certainly, it is by the provider of care as to whether they are providing it. So this is not whether the health plan is providing interpretive services as needed, it is whether the providers are providing interpretive services as needed. So the collection of this data is really tricky, at least for the health plan. This is a measure developed by the Oregon Health Authority. As far as we know, we don't know where else this measure is being used. We certainly don't have any benchmarking or performance data at this period of time. It is not an NCQA measure so therefore there is no stratification information for us to look at and will not be in the future.

As I stated, this will be a difficult measure for health plans to obtain accurate information about what is actually happening in a provider's office because there is currently no way that doctors report when they got a request for interpretive services and whether they filled that request or did not fill that request or how they handled that request.

I think I should also point out because it came up in our prior Committee meetings that the DMHC already has some requirements within California regarding access to interpretive services and there are potentially other means for that to be enforced by DMHC outside of this particular initiative, thank you.

The next one is a related measure in the fact that it is once again a language service; so the next slide.

This is a measure that was developed by the Health Policy Department at George Washington University and as far as we know is only

being used in that setting. We don't know of any other setting currently. This is whether there has been an assessment and the use of essentially interpreters at the time of discharge for discharge instructions. I believe it is discharge from a hospital specifically, that it is. So once again it happens at the provider end of it. Very, we have no experience with this one for an MCO having reported this or whether an MCO could even get ready access to the data needed to report upon this. Once again, no stratifications by NCQA because it is not a HEDIS measure and we don't know anything about the current performance or benchmarking. And if we could go the next slide. I think I turn it back to you, Sarah.

MS. BROOKS: That's right. Thank you, Andy and Ignatius, and appreciate everyone listening to all that very informative information.

I did see some hands pop up during the presentation. Palav, I did see your hand up first, you took it down. I just wanted to make sure you didn't have a comment.

MEMBER BABARIA: I did but then thought I was being too pushy keeping my hands up throughout the entire presentation. So Palav Babaria from DHCS. Just a few editorial comments as obviously I know I am not a voting member, on cervical cancer screening. I would just point out I think since when this measure first came into existence and it has been used for many years, the HPV vaccination was a relatively newer development. And the HPV vaccine is included in that combo too for adolescents measure, which is already on the shortlist. I will say, when I have looked at Medi-Cal specific data, our adolescent vaccination rates in general are quite low with a lot of regional variation as well as racial and ethnic disparities. And so, you know, personally, as a physician, I think cancer screening is great but if we can actually prevent cancer altogether

through vaccination, that is definitely, I think, a better use of efforts and interventions from a public health and medical perspective.

And then trying to look at. What were the other measures that we just covered? Because I had two other comments but I now I don't have the list in front of me.

MS. BROOKS: Why don't we pull back up the -- I know we are going to have to go back quickly but pull back up the list that has the seven at the very beginning. Sorry.

MEMBER BABARIA: Thank you. Sorry, I tried to take notes and clearly did not succeed very well.

MS. BROOKS: It is a lot of information. We are going to have to go back a little bit further, sorry. There we go.

DR. BASKIN: Two measures, the two measures that aren't on there are the language measures. Oh, there they are, they are on the next page.

MS. BROOKS: Yes.

MEMBER BABARIA: Yes. So I think just on Measures 2 and 3, these are both measures that we have added into the Medi-Cal program, both for reporting and are slowly moving to adding them to the accountability set. I will just underscore, I think especially for follow-up after emergency department visit for mental illness, that is of significant interest to us just given the rising rates of behavioral health and mental illness across our state pretty much in all groups and all ages. We also see this as a really effective care coordination measure because we have such fragmentation between our physical health delivery system and the EDs and sort of our county-based behavioral health systems, at least for those with severe and persistent mental illness. And a lot of

times those, you know, delivery systems are not always coordinated or have effective communication and data exchange so a big part of why we are really pushing this measure, it is on our county behavioral health, sort of, measure list as well as on our Medi-Cal managed care plan measure list, is to really foster that collaboration and communication for better care coordination for members who are accessing physical and mental health services.

Similarly, for the pharmacotherapy for opiate use disorder, we recognize, you know, I think Andy as you covered, it is it is a very limited measure. That being said, just given the opiate use crisis, we very purposefully moved away from some of the other measures that we found had been promoting patient dumping, like looking at the use of high dose opiates, in favor of this measure. Really trying to track and support expanded MAT therapy, although, for the reasons stated, it is not as robust a measure as we would like.

And then, you know, I think the language access remains a major area of interest for us. And we have been looking for better measures in that space but I do think there are challenges for all the reasons that have been already described. Thank you.

MS. BROOKS: Thank you, Palav. Lishaun.

MEMBER FRANCIS: Hi, everyone. Thanks so much for the presentation, I found it really helpful. One thing that I am struggling with though as we think about the measures, and maybe this is something that Andy or Ignatius can help us all think through, is the relationship between the equity disparities that we are seeing and the measures that are being recommended or voted on. So for example, I think on the first one there was a screening and then there was the factoid about, you know, how many black and brown folks are

suffering from cancer screening, but I am not -- from cancer, but I am not sure what that relationship is. Is it due to the fact that we are not screening them or is it due to some other factors? So that was my general question for all of them. It's like, what is the relationship between the measures that are being presented and the equity metrics that we are commenting on or saying we need to close gaps on?

MS. BROOKS: Ignatius, did you have any comments?

MR. BAU: Sure, I can take a first try at answering that. So, Lishaun, again, you know, we eventually want to get to a place where we have stratified race and ethnicity and other demographic stratification so that we can better understand, is it screening, is it treatment, is it outcomes, is it patient experience, and sort of track that all along that continuum. Right now it is very imperfect because the state of that data collection is still in a very early stage. The fact that more of these measures, including a significant number of the 13 that the Committee has already voted on, will be stratified by race and ethnicity. It is still going to take some time to get enough baseline data on that to really understand those dynamics. But I think in quality improvement overall we know that it is never a linear relationship, that there are multiple causes. And so I think it is a good question to be asking for thinking about are we choosing the right measures in terms of screening versus treatment versus outcomes versus patient experience because all those things are responsible for disparities as well as access, to add that as well. On this particular one, we don't have that data at that specificity for cervical cancer.

MS. BROOKS: Andy, did you have something to add?

DR. BASKIN: Well, just briefly to say, I mean, you know, having

spent a lot of years actually at of health plan, you know. The whole idea that Ignatius talked about in quality improvement, this is what we would be doing is looking at this data to say, geez, if we have a low cervical cancer screening rate is it across the board, is it is it more in some communities than others, some ethnicities than others, and then we would develop the quality improvement activities, you know, aimed at that particular population to try and get the total screenings up. But as Ignatius said, it is a little too early to do that.

And as a result of these new stratifications by NCQA, and of course by DMHC once this goes into effect, those opportunities will start to show themselves. But right now it is the chicken or the egg and unfortunately we can't, we can't tell you the answer to that. As was mentioned by Palav already, you know, cervical cancer screening as one of them, is it really a screening problem or is there also disparities in the uptake of HPV vaccine? Which would be the two major ways to potentially improve the outcome, which is basically, you know, mortality or morbidity from cervical cancer. So still to be determined, unfortunately.

MS. BROOKS: Great question, Lishaun, and thanks, Andy and Ignatius.

Let's go back to Slide 28 just so everyone can see the measures that are listed. Bihu, you have your hand up.

MEMBER SANDHIR: Bihu Sandhir from AltaMed. I just had some comments, I think some things to keep in perspective as we vote. I completely agree with the comments on cervical cancer screening. I think that is, you know, it is I think, luckily we are covering that with the Combo 2. Which really is, it is not an easy measure, actually, because there's three shots for HPV, I think we

have got to keep that in mind as well. So there's a lot of reality at the ground level when you are trying to actually, you know, achieve these measures.

The second measure, follow-up after emergency department visit for mental illness, it is an important measure. I know that we are seeing that with DHCS, that it has become -- and Medi-Cal plans. But the reality for us is, I can tell you, is we don't have data. It is a very -- our Health Information Exchange right now in California, I think we heard that when we had a presentation I think a couple of meetings ago, it is still, it is really not completely defined. There is a lot of work to still be done. And I think that really does impact that measure for us. And so my concern with that is, you know, is are we really ready for it right now? That is the concern. I do think we need to get ready for it but I don't think it is going to be something that we are going to be really available to do well on even in a year or two, it is going to take longer than that.

Regarding the opioid use disorder. I think my concern with that is the cohort is very small compared to the impact compared. But there is now a follow-up from emergency room visits for substance abuse, which is also a Medi-Cal measure, which is a HEDIS measure. And that is something that we are already finding that, you know, they are measuring, we are measuring it again. The concern is the same regarding data.

And with adult immunization status. There are now changes in guidelines as of now, they have just occurred. The PNEUMOVAX has changed to PCV20 and that is going to take us time to actually adopt this, to get it out. And so the guidelines continue to change, the vaccines are changing in that measure, and I don't know how that is going to impact that actual NCQA measure. So I think we have got to take that into account. There's a lot going

on in some of these measures that it is going to, I think, affect our data, the ability to get data and the ability to actually be successful at that.

And then I agree with the, with the part about the language services. I think I am not sure if that is the right measure. I don't think there is enough information there regarding that. But I do think it would likely be a step in the right direction to least pick up something that would hopefully get us, as long as we can get data. So just a few comments. Thank you.

MS. BROOKS: Thank you, Bihu. Kristine.

MEMBER TOPPE: Trying to get unmuted. Thank you, Sarah. This is great. My question I have actually was wanting to tee up the question back to Palav and I think she covered it. But I think Bihu raised a question too around the data exchange. Because the two measures that I think are interesting of this remaining set are ones that are going to be dependent on that data, that data exchange. Palav, I don't know if you have anything more you want to, like you have said in previous meetings that, I think, that you felt like the future state of data exchange will create an environment where we are going to have better data for those types of measures. So I want to make sure that if I have heard that correctly, if that is what the vision is.

And I wanted to address the point I think that Lishaun asked around kind of why we pick certain measures. And a number of the measures that have already been chosen, the point of the NCQA stratification kind of value, if you will, is that we will be asking plans to report these data in a way that are already stratified. So you are building in that stratification to those existing measures. It is not a secondary step, it will be built into the measure reporting process so there's reinforcement there, and several of the other agencies who

are on the advisory committee have spoken to that, Covered California, DHCS and CalPERS, to varying degrees. So I just wanted to kind of connect those two pieces because you are getting kind of like a two for one, if you will, with some of those measures.

And then I actually looked at, you know, taking a step back at the set we have agreed on with the 13. Of those, we are really covering kind of prevention, chronic disease, specialty. We are covering a lot of different things in that set that has already been chosen. So I just wanted to kind of make those points from my perspective.

And also if I didn't say it, sorry, I may be repeating myself. The measures that NCQA picked for stratification, both in the ones that will be reported on Measurement Year 2022 and those selected for Measurement Year 2023, were done so based on the fact that there is a known need for addressing disparities. So we looked at a lot of different things when we selected the measures and proposed measures to be stratified and one of the critical pieces was, you know, whether or not there was kind of a known issue in terms of how care is being provided for those various conditions. So just wanted to provide that context.

MS. BROOKS: Great, Kristine, thank you, that was very helpful.

Ed.

MEMBER JUHN: Hi, Ed from Inland Empire Health Plan. So really appreciate the comments and the presentation. I am just building upon what was said earlier. I think for, you know, measures number 2 and 3 specifically, my one call-out would be that in our own data today with our 1.5 million members, it is a small population. And so one thing that I did want to at least

share is that potentially with other smaller Medi-Cal plans that volume might be even smaller. So a consideration is for measures 2 and 3 the volume itself might be smaller or lower than expected, which potentially may or may not impact the ability to appropriately, you know, close any disparity gaps that we would like to.

For the other measures, I think, measure number 4, 5, 6 and 7, for me, the benchmarking potentially might be something that may be a little bit more challenging with these given that for some, especially for I think to 7, you know, no clear benchmarks yet exist; and if they do I think, you know, the benchmarking discussion may potentially, depending on how we decide to do it, may potentially impact, you know, how those are set there. So I just thought I'd share those comments.

MS. BROOKS: Thank you, thank you, Ed. Palav.

MEMBER BABARIA: just in response to Kristine on the data exchange piece. For those of you who may not be aware, the final requirements for the California Data Exchange Framework were posted and, you know, there is a timeline for when most health plans will have to adhere to them so that will help. On the Medi-Cal side we are requiring MOUs and data exchange between our managed care plans and county behavioral health plans to facilitate that data exchange. As everyone is aware, there are federal regulations around some behavioral health data types, most of those are related to substance use treatment and not mental illness. So while there are some barriers for effective data exchange for the follow-up after emergency department visit for SUD those same barriers do not exist for mental illness in terms of federal regulations. So the biggest lift is really just, you know, local entities, plans, and otherwise creating their own data sharing agreements to pass data back and forth for

clinical use purposes. But it is very doable so there should not be any barriers for plans to report on this measure with appropriate local data sharing agreements, which they will have to do anyway shortly with the Data Exchange Framework.

MS. BROOKS: Thank you, Palav.

MEMBER BABARIA: And I will just flag for number 3, you know, based off of 42 CFR restrictions, getting data about opiate use dispensed treatment in SUD treatment programs is a challenge through CalAIM and a number of initiatives. We are working on streamlining and improving the member consent process to make sure that that data can be more readily transmitted but there are some barriers for number 3 for capturing all of the comprehensive data.

MS. BROOKS: Great. Cheryl.

MEMBER DAMBERG: Yes, thanks. So I think we are kind of in this larger, challenging space of, you know, all of these different measure areas are important for different reasons. And I don't know, I was trying to take a step back and think about that this initiative by the Department of Managed Health Care is only one of many initiatives statewide to measure performance, spotlight disparities and, you know, instigate, you know, various, whether it is incentives or transparency, to try to stimulate change in this space. And I guess my hope would be if we can, you know, get to a parsimonious set, you know, to get out of the gate and test this model and make sure that it is working as intended. And that sort of underlying this effort is this broader collection of what I call patient characteristics, social risk factors that will enable us to measure in other spaces and look to see where there are disparities and where to focus moving forward.

MS. BROOKS: Thank you, Cheryl. Lishaun.

MEMBER FRANCIS: Yes, thanks. I just wanted to kind of clarify my question and point earlier. You know, for me it is not about stratification, not just about stratification. Obviously, that is important. But really understanding and being able to articulate why we are collecting some of the measures that we are collecting in a way that feels intellectually honest, right? So what I mean by that is, you know, if we know that the data says that 90% of Black women are actually getting screened but they still have really high mortality rates from cervical cancer, then we know that screening is not the problem. And if this is to encourage either providers or families or plans to do things differently or to do things better, then I do think that we need to at least flag when measures that are up for discussion might not be what we are looking for in terms of trying to actually close disparity gaps. And that's just an example. I don't actually know if those stats are accurate but I do see it all the time. When we talk about measures for collection there is this disconnect between what the problem is and then what we have decided to collect. And then we do really, really well on what we have decided to collect but the gap hasn't closed at all because we focused our energies in the wrong place.

MS. BROOKS: Very helpful. Thank you for clarifying, Lishaun, I think that was helpful. It looks like Silvia has her hand up. Silvia?

MEMBER YEE: Yes. Hi, this is Silvia from DREDF. I was just going to make a brief comment pointing out that HCAI is working on equity measures for hospital reporting and that that's one of those parallel processes that potentially is a very good place to look at something like emergency department use. That kind of measure may wind up there as well or be dealt

with there in an efficient way. Just these things haven't happened yet, of course. So we are where we are here and other things are happening elsewhere, but I just thought it would be a good thing to keep in mind, thanks.

MS. BROOKS: Thank you, Silvia. Not seeing other hands raised right now from Committee Members. Doreena.

MEMBER WONG: Yes, hi, Doreena, Doreena Wong from ARI. Yes. I just wanted to, I am just a little concerned about trying to determine if we can include some kind of a measure to evaluate plans on how they are doing around language, you know, the language and providing language services. I know, you know, I think that Nathan did a good presentation on the language requirements. And I guess, you know, I guess what I am struggling with is the fact that even though there are language requirements there is no way to kind of measure how well plans are doing. And so I think, I think I was hoping that we could find a measure. And we may or may not, you know, be able to. But find a measure where we could at least -- because we already know that, you know, without providing some kind of language assistance like interpreters or translated materials we know that those limited English speaking patients or clients won't have access to a lot of the services and won't get -- there will be health disparities as a result of that. So I am trying to figure out, I think somebody mentioned that perhaps there was a way to address that through other means that DMHC has and so I guess it would be helpful for me to more clearly understand if there is a way that DMHC is evaluating and comparing and holding clients accountable in a real way for the language services that they are supposed to provide.

MS. BROOKS: Thanks, Doreena. I know we had a presentation

on that from DMHC, I believe at the last meeting, but I don't know, Mary or Nathan, if you wanted to just touch briefly on that at all?

MS. WATANABE: I will just jump in quickly. Doreena, I appreciate, I mean, I think this is a long standing issue that you have raised with the Department. And we do collect some data. We have, I think it is a biannual report that we have on our website. We also monitor the complaints that come into our Help Center, which I mean, as you know, they are low, but we also have a low number of non-English speakers that contact our Help Center. So I would just say, I don't know that we currently have the perfect solution but we are collecting data. We monitor this very closely when we do our surveys too so when we go out and look at the plans' operations this is part of what we look at.

In terms of measurement I think the challenge here is how do you come up with a standard or a benchmark, right? Because I don't think we know necessarily how many people need or asked for interpreter or translation services. And so putting this into kind of a quality metric with a standard, it doesn't fit quite squarely into that. But, you know, we can continue to think about at the Department if there's other ways for us to look and kind of meet that need that you are looking for. Just more transparency around how many consumers asked for or needed interpreter services and were provided those timely. So, Nathan, anything you would add?

MR. NAU: No, nothing, nothing, Mary. I think you covered it well other than if anybody has a suggestion we are always open to listen.

MS. WATANABE: Yes.

MS. BROOKS: Thank you, Doreena, for that question; and Mary and Nathan for that informative information. Alice, your hand is up.

MEMBER ALICE CHEN: I hesitated because so many people have made many of these points. I do want to start by just saying, thank you for such a thoughtful and data driven approach, I think that is really important. And I think it goes without saying but I will say it anyways that every single one of these measures represents a really important clinical condition or set of conditions that is important for population health and disparities. I think that goes without saying.

And I think it probably is frustrating for people who don't live in this world that we are so limited to looking for keys under the lamppost, whether it is because, you know, the data exchange isn't there or, frankly, a lot of it is because clinicians aren't coding it. I mean, when I look at prediabetes, there is a national definition of prediabetes but it is predicated on an A1c and, you know, it depends on the clinician looking at that number, comparing it and clicking that box. The same with obesity and BMI. I am struggling all the time to get my MEA to measure the height so I can actually get the BMI, you know. So there are a lot of things that we know are important but our current data and, you know, delivery system infrastructure doesn't really allow it.

And so I guess what I would step back and say is, you know, this is in many ways, as far as I know, a first in the nation approach of really baking in what I would hope is like a floor, a minimum set of expectations for all health plans across the state of California; that is a really radical step forward. And in doing that I think we need to start with the tried and true, particularly because we know that the regulatory process is not so nimble. There are so many things that we know are tried and true already and actually still have a lot of room for improvement. And I think the other -- and I do think that the measures we

choose have to have a large enough and have to be applicable across different lines of business. So I think that's another element that would be important to consider.

And just the last thing is really underscoring Cheryl's point, and I think Mary made this point earlier also, which is, this is one lever among many in California. The good news is there are many of the same organizations and people in the same discussion so I think we are all rowing in the same direction. And just understanding which lever we have right now in hand as this Committee and what -- I don't know, I might have mixed my metaphors. You know, like, do we have a screwdriver or a hammer? And you know, like, is it a nail or a screw? And so I am really trying to match up what we have at our disposal to what we can actually get done.

MS. BROOKS: Thank you, Alice. All right, so I don't see any other hands up from Committee Members. I am going to ask Shaini, if we have any public comment hands raised at this time?

MS. RODRIGO: There are no hands raised from the public right now.

MS. BROOKS: Okay. So at this time we are going to move to conduct a vote on the recommended measure set. Let's actually wait before you move forward. Go back to Slide 28. Let's leave Slide 28 up just so that people can see all the measures that we are voting on as we call the measures.

So Alex will conduct a roll call for each measure. So when she says your name please state 'yes' if you are in favor of including the measure in the final set or 'no' if not. And then at the end of the roll call Alex will state if the measure will be considered for the final set or if it did not pass. So at this time I

am going to turn it over to Alex.

MS. KANEMARU: Thank you, Sara. And I think most of us know the drill but I am going to start it off with Anna Lee Amarnath for cervical cancer screening.

MEMBER AMARNATH: No.

MS. KANEMARU: Bill Barcellona? I believe he is not present but want to double-check.

(No audible response.)

MS. KANEMARU: Okay. And Dannie Ceseña is also not present.

Alex Chen?

MEMBER ALEX CHEN: Yes.

MS. KANEMARU: Cheryl Damberg?

MEMBER DAMBERG: No.

MS. KANEMARU: Diana Douglas?

MEMBER DOUGLAS: No.

MS. KANEMARU: Lishaun Francis?

MEMBER FRANCIS: Yes.

MS. KANEMARU: Tiffany Huyenh-Cho?

(No audible response.)

MS. KANEMARU: Tiffany Huyenh-Cho, I will come back to you.

Ed Juhn?

MEMBER JUHN: No.

MS. KANEMARU: Jeffrey Reynoso?

MEMBER REYNOSO: Yes.

MS. KANEMARU: Bihu Sandhir?

MEMBER SANDHIR: No.

MS. KANEMARU: Rhonda Smith?

MEMBER SMITH: Yes.

MS. KANEMARU: Kristine Toppe?

MEMBER TOPPE: No.

MS. KANEMARU: Doreena Wong?

MEMBER WONG: Yes.

MS. KANEMARU: And Silvia Yee?

MEMBER YEE: No.

MS. KANEMARU: Okay. I am going to check one more time for Tiffany but that won't alter the vote at all. Tiffany, are you there?

(No audible response.)

MS. KANEMARU: Okay. So with five votes this measure will not, does not pass and will not be included in the recommended final set.

Next measure is going to be follow-up after emergency department visit for mental illness. Anna Lee?

MEMBER AMARNATH: No.

MS. KANEMARU: Alex Chen?

MEMBER ALEX CHEN: No.

MS. KANEMARU: Cheryl Damberg?

MEMBER DAMBERG: No.

MS. KANEMARU: Diana Douglas?

MEMBER DOUGLAS: No.

MS. KANEMARU: Lishaun Francis?

MEMBER FRANCIS: Yes.

MS. KANEMARU: Tiffany Huyenh-Cho?

(No audible response.)

MS. KANEMARU: Ed Juhn?

MEMBER JUHN: No.

MS. KANEMARU: Jeffery Reynoso?

MEMBER REYNOSO: Yes.

MS. KANEMARU: Bihu Sandhir?

MEMBER SANDHIR: No.

MS. KANEMARU: Rhonda Smith?

MEMBER SMITH: Yes.

MS. KANEMARU: Kristine Toppe?

MEMBER TOPPE: No.

MS. KANEMARU: Doreena Wong?

MEMBER WONG: Yes.

MS. KANEMARU: And Silvia Yee?

MEMBER YEE: No.

MS. KANEMARU: Okay, with four votes that measure will not move forward in the final report as a recommendation.

Pharmacotherapy for opioid use disorder. Anna Lee?

MEMBER AMARNATH: No.

MS. KANEMARU: Alex Chen?

MEMBER ALEX CHEN: No.

MS. KANEMARU: Cheryl Damberg?

MEMBER DAMBERG: No.

MS. KANEMARU: Diana Douglas?

MEMBER DOUGLAS: Yes.

MS. KANEMARU: Lishaun Francis?

MEMBER FRANCIS: No.

MS. KANEMARU: Tiffany Huyenh-Cho?

(No audible response.)

MS. KANEMARU: Ed Juhn?

MEMBER JUHN: No.

MS. KANEMARU: Jeffery Reynoso?

MEMBER REYNOSO: Yes.

MS. KANEMARU: Bihu Sandhir?

MEMBER SANDHIR: No.

MS. KANEMARU: Rhonda Smith?

MEMBER SMITH: No.

MS. KANEMARU: Kristine Toppe?

MEMBER TOPPE: Yes.

MS. KANEMARU: Doreena Wong?

MEMBER WONG: Yes.

MS. KANEMARU: And Silvia Yee?

MEMBER YEE: Yes.

MS. KANEMARU: Okay, with 29% of the votes this measure will not move forward for consideration in the final report.

And then we have next up, adult immunization status. Anna Lee Amarnath?

MEMBER AMARNATH: No.

MS. KANEMARU: Alex Chen?

MEMBER ALEX CHEN: No.

MS. KANEMARU: Cheryl Damberg?

MEMBER DAMBERG: No.

MS. KANEMARU: Diana Douglas?

MEMBER DOUGLAS: No.

MS. KANEMARU: Lishaun Francis?

MEMBER FRANCIS: No.

MS. KANEMARU: Tiffany Huyenh-Cho?

(No audible response.)

MS. KANEMARU: Ed Juhn?

MEMBER JUHN: No.

MS. KANEMARU: Jeffery Reynoso?

MEMBER REYNOSO: No.

MS. KANEMARU: Bihu Sandhir?

MEMBER SANDHIR: No.

MS. KANEMARU: Rhonda Smith?

MEMBER SMITH: No.

MS. KANEMARU: Kristine Toppe?

MEMBER TOPPE: Yes.

MS. KANEMARU: Doreena Wong?

MEMBER WONG: No.

MS. KANEMARU: And Silvia Yee?

MEMBER YEE: No.

MS. KANEMARU: With 6% of the votes this measure will not move forward for further consideration.

Next up we have the obesity, prediabetes and diabetes A1c control measure. Anna Lee?

MEMBER AMARNATH: No.

MS. KANEMARU: Alex Chen?

MEMBER ALEX CHEN: No.

MS. KANEMARU: Cheryl Damberg?

MEMBER DAMBERG: No.

MS. KANEMARU: Diana Douglas?

MEMBER DOUGLAS: No.

MS. KANEMARU: Lishaun Francis?

MEMBER FRANCIS: No.

MS. KANEMARU: Tiffany Huyenh-Cho?

(No audible response.)

MS. KANEMARU: Ed Juhn?

MEMBER JUHN: No.

MS. KANEMARU: Jeffery Reynoso?

MEMBER REYNOSO: No.

MS. KANEMARU: Bihu Sandhir?

MEMBER SANDHIR: No.

MS. KANEMARU: Rhonda Smith?

MEMBER SMITH: Yes, but.

MS. KANEMARU: Kristine Toppe?

MEMBER TOPPE: No.

MS. KANEMARU: Doreena Wong?

MEMBER WONG: Whoops. Yes.

MS. KANEMARU: Yes, okay. And Silvia Yee?

MEMBER YEE: Yes.

MS. KANEMARU: With 18% of the votes this measure will not move forward for further consideration in the recommended set.

The next measure is meaningful access to health care services for persons with limited English proficiency. Anna Lee?

MEMBER AMARNATH: No.

MS. KANEMARU: Alex Chen?

MEMBER ALEX CHEN: No.

MS. KANEMARU: Cheryl Damberg?

MEMBER DAMBERG: No.

MS. KANEMARU: Diana Douglas?

MEMBER DOUGLAS: No.

MS. KANEMARU: Lishaun Francis?

MEMBER FRANCIS: Yes.

MS. KANEMARU: Tiffany Huyenh-Cho?

(No audible response.)

MS. KANEMARU: Ed Juhn?

MEMBER JUHN: No.

MS. KANEMARU: Jeffery Reynoso?

MEMBER REYNOSO: Yes.

MS. KANEMARU: Bihu Sandhir?

MEMBER SANDHIR: No.

MS. KANEMARU: Rhonda Smith?

MEMBER SMITH: Yes.

MS. KANEMARU: Kristine Toppe?

MEMBER TOPPE: No.

MS. KANEMARU: Doreena Wong?

MEMBER WONG: Yes.

MS. KANEMARU: And Silvia Yee?

MEMBER YEE: No.

MS. KANEMARU: Okay, so with four votes and 24% of the votes this measure will not move forward for further consideration.

Last measure, patients receiving language services supported by qualified language service providers. Anna Lee?

DR. BASKIN: Alex, can we advance the slide so people can see the name of the measure?

MS. KANEMARU: Sure thing. Thank you.

DR. BASKIN: Thank you.

MS. KANEMARU: Okay, so this is going to be number 7, the last measure. Anna Lee?

MEMBER AMARNATH: No.

MS. KANEMARU: Alex Chen?

MEMBER ALEX CHEN: No.

MS. KANEMARU: Cheryl Damberg?

MEMBER DAMBERG: No.

MS. KANEMARU: Diana Douglas?

MEMBER DOUGLAS: Yes.

MS. KANEMARU: Lishaun Francis?

MEMBER FRANCIS: Yes.

MS. KANEMARU: Tiffany Huyenh-Cho?

(No audible response.)

MS. KANEMARU: Ed Juhn?

MEMBER JUHN: No.

MS. KANEMARU: Jeffery Reynoso?

MEMBER REYNOSO: Yes.

MS. KANEMARU: Bihu Sandhir?

MEMBER SANDHIR: No.

MS. KANEMARU: Rhonda Smith?

MEMBER SMITH: Yes.

MS. KANEMARU: Kristine Toppe?

MEMBER TOPPE: No.

MS. KANEMARU: Doreena Wong?

MEMBER WONG: Yes.

MS. KANEMARU: And Silvia Yee?

MEMBER YEE: Yes.

MS. KANEMARU: Okay, with 35% of the votes this measure will not move forward for the final report. Back to you, Sarah.

MS. BROOKS: Thank you, Alex. All right. Thanks to everyone for going through the vote process, I think that was really helpful. I know, we have gone through a lot of discussion and just appreciate everyone's dialogue. We have a measure set that you all are moving forward in recommending to the DMHC which includes 13 measures. I am excited about that; I hope you all are excited about that, too.

Now don't get too excited about the next slide. Well, I guess it is

not technically the next slide, it is Slide 51. We are going to keep going for a little bit. I am telling you this because it says 'Break' on it. We are going to keep going for a little bit so that we can take the break more at the middle of the meeting. But we will take a break so no worries there.

MS. RODRIGO: Sarah?

MS. BROOKS: Yes, please go ahead, Shaini.

MS. RODRIGO: I'm sorry. I don't mean to interrupt but we do have one hand raised from the public if you want to take that now or if you prefer to wait?

MS. BROOKS: Yes, we should take the public comment, yes. If you could go ahead and call the person that would be great.

MS. RODRIGO: Sure, give me one moment.

Reverend, you should be able to speak now.

REVEREND SHORTY: Good evening, everyone, or afternoon. Very disappointed to see obesity not included in this measure considering there is still COVID going around in California to this very moment.

You shouldn't have to shame medical professions to the rate and amount of people that has passed in his state.

I am really very disappointed in what I have seen in this vote count today, just along with the absentees of the people selected of this committee. Which none of you looks like the people that you guys are truly supposed to represent and help.

As medical professions you guys took an oath. And every day I came to this meeting, month after month, I looked for you guys to stand up to that oath and vote. Judging by the vote today I am very disappointed because

people are still dying, people are still needing help. And the measures that you guys have all selected, I really do hope you guys understand that it may help some people but it won't help all. And the percentage rate once you get all of this going is going to be very disappointing numbers. But I see this is a measure where we are going to have to just take it to our elected officials. Because I am very, very saddened because people are still dying in our state from COVID because they have all the underlying conditions which none of them are being addressed, especially obesity. And it is just, I am at a loss of words, you know, I mean. So I guess I will just have to keep going to my doctor who keeps telling me to take gummy bears is going to help me lose weight, which I know is not the answer. Thank you.

MS. BROOKS: Thank you so much for your public comment, we very much appreciate it. Jeff, I see your hand is up.

MEMBER REYNOSO: Yes, you know, Jeff Reynoso with Latino Coalition for a Healthy California. I think my comment perhaps speaks to the public comment that we just heard. I think it would be important. And, you know, I am still thinking through Alice's comments around the work that we are doing here is historic in many ways. It is really moving our health care system to think about quality and equity in very new ways. And we have had some pretty difficult conversations as a committee and with the consultants around all of the myriad of factors that we have to consider as we are identifying that final core measure set.

So, you know, I think as a recommendation in the report, providing some contextualization on, you know, the conditions, whether they are access, quality, you know, access to care, utilization of services, that we can integrate

some of that language around. We are going to start, you know, with this initial, you know, core measure set and it is the baseline, you know, and we are going to review it over time. And this work that we do as part of DMHC is, you know, I think one, one initiative among many across state government to create a more equitable health care system. So I think I would put that as a recommendation to include some language around, you know. I think I it is really unfortunate that there isn't a good language access measure that we currently have, you know. I would have loved that, you know, one of those measures were included. But that's just the reality of where we are today, you know, I think in terms of what is available. So just speaking to that and uplifting that in the report. I would, you know, I would put that forward as a recommendation.

MS. BROOKS: Thank you, Jeff. I think that is really helpful and certainly something that we can take back after this meeting as we continue to work on the report so thank you. All right.

So here we are, State Department Benchmarking Process Presentation. So during last month's committee meeting we heard from members that a presentation on what the other purchasers are presently doing and lessons learned would be helpful. So we decided to call on our Committee Members to do a presentation today for you on this issue. So we will go ahead and hear now from Covered California, CalPERS and DHCS. I am going to go ahead and turn it over, I believe it is to Alice, to start, but I will just turn it over to you all and then you all take it away. And then we will have an opportunity for questions afterwards.

MEMBER ALICE CHEN: Great, thank you, guys. So I am going to go ahead and present the slides. And I know my colleagues, I think it is Lisa

sitting in for Julia, and then Palav will jump in with their experience. So thank you for providing an opportunity to share Covered California's experience on the issue of measurement, benchmarks and disparities.

Many of you, or some of you, may know that Covered California has had quality provisions in our contracts since we opened our doors in 2014 and disparities provisions since 2017. So we have a number of cycles under our belt. And despite this focus we haven't seen significant or sustained improvement across our health plan partners and this really has led us over the last couple of years to step back and rethink our strategy. So next slide.

I am not going to go into a lot of details but at a very high level, this is a schematic of how we framed our quality requirements for the 2023-2025 contract.

So the idea is, first, we want to establish a floor or minimum threshold for quality. So in those regions where we would still have at least three insurance companies for consumers to choose from, because, frankly, that's the fundamental, in terms of Maslow's hierarchy, for Covered California, having a choice and competition is kind of first level.

But once we have that, any health plan product that has persistent poor performance, and we define that as four consecutive years of below 25th percentile national performance for the marketplace composite clinical score. So that's a lot of words there nut it is basically a set of clinical measures, many of which we have talked about already, that gets rolled up into a composite score. We have national benchmarks. If it is below 25th percentile, would be removed from the marketplace, so they wouldn't be able to participate until they increased their quality scores. So that's the floor.

At the same time, and this speaks to what we were talking about before, the other levers that purchasers have. And we want to signal that it is not just about avoiding poor performance, we want to shoot high. So we have a financial incentive structure for improving quality up to 66th percentile of national performance for a very small, very -- I mean, if we are talking about parsimony here we are talking about very, very parsimonious for our, what we are calling our quality transformation Initiative. It is four measures that are tied to financial incentives and two behavioral health measures.

And we landed on this hybrid approach after a lot of intense discussion about both how do we signal the importance of high standards while being pragmatic about where plans currently are, and realistic about how much investment and work it actually takes to improve a measure. So next slide.

This gives you a flavor of the type of data that we looked at to drive our decisions. So this is measurement Year 2020 performance for our four QTI, Quality Transformation Initiative measures, that are tied to financial consequences. And you can see, so the rows are the measure and then the columns are health plans. And you can see that we have a really wide range. We have some plans with three out of four measures below 25th percentile; and on the other side of the scale we have one plan that has four measures above 90th percentile national performance. So if I were to translate our quality initiative goals into this color code, our first order of business is we want to get rid of the red, or orange or whatever color it is on your screen. But we want to get rid of that red-orange box and at the same time we want to nudge this entire color scheme over to the green. So it is kind of a two-pronged approach.

And so I know this dovetails with some of the comments before

around the regulatory process, but in the context of this Committee's work given the regulatory role of DMHC and the levers it has in terms of setting minimum standards through penalties and sanctions, I would suggest that, you know, DMHC should focus on establishing a floor or minimum of performance standards, while purchasers like Covered California, DHCS, CalPERS, really take the mantle up of incentivizing high performance. So that would just be my opinion.

And then before I leave this slide, this footnote at the bottom is to remind me to share that national benchmarks are really useful but they are also problematic in that they are relative and shift over time. So for both of these quality initiatives what we decided to do is choose one year's benchmark and hold it static so that our health plans know what they are shooting for, rather than the ball moving year to year. And frankly, retroactively, because again, claims data, which is where much of this data resides or it gets pulled from, is almost a year in arrears. So you don't really know how you did, particularly in comparison with other people or other health plans until a year later. Next slide.

And just another issue which is even more complex to consider in terms of using relative benchmarks is that in the health plan world benchmarks are established within lines of business. And so this is a chart of select HEDIS measures with the corresponding 50th percentile. National performance for the first column is Medicaid. The second column is QRS, which is the marketplace like Covered California, all marketplaces are measured by QRS measures. And then Commercial. With the lowest performance for each measure in red. And you can see while many of them are quite clustered, the absolute performance can vary quite a bit between lines of business. So for example, if you look at

diabetes, which is the first row, in Medicaid the 50th percentile means that 46.8% of your enrollees have an A1c less than 8, while for marketplace plans 50th percentile means 56% are in control under 8%, which is nearly a 10% difference. And then you can see for controlling blood pressure the differences are quite small. It is about 3.2% with Commercial performing the worst.

And so this is, you know, I think the Committee will want to consider whether we use benchmarks tied to lines of business, which is the established approach, but it means that the results of different health plans and effectively different populations will have different targets in terms of absolute performance.

Or do we want to adopt a single target for all the health plans? I would say from a population health perspective it would send a really important signal to have a single target. And at the same time, a number of people have raised this already, the reality is that the ability to achieve high performance on these measures is only partly tied to what a health plan or even a provider can do. And I will just say, as someone who has seen patients at either FQHCs or public hospitals my entire career, I know that if my patient lives in a food desert, has a cell phone that honestly is disconnected half the time, you just keep trying until it gets reconnected, and doesn't have reliable transportation, there's only so much that the health care system, whether you are the provider or the health plan or the purchaser, can do to really move the dial on some of these measures.

So I want to put that out there not to advance a point of view. But to really emphasize that transparency here is going to be critical to really fostering discussions both about disparities across payers and the needed

societal investments. Not just the focus on health plans but just kind of writ large what we need to do together in order to really create a single standard for all Californians.

I think the other important thing, just to remember is that no matter what benchmark we choose, unfortunately, there are really large opportunities for improvements on almost every measure no matter which benchmark you choose. Next slide.

I want to shift now to share experience with disparities. As I mentioned before, we have had contractual requirements since 2017. And our first learning was that despite the fact that there are requirements, that collecting accurate and complete race/ethnicity data is not only foundational but much more complex than we had realized.

We started in 2016 with health plans reporting of race/ethnicity data completeness. In 2020 established an 80% threshold tied to performance guaranteed, which essentially means financial penalties for not meeting it. And you can see that performance in that last column has improved over time but not yet consistently across all our health plans to the level we'd like.

And in 2022 we are going to be shifting away from plans self-report to using our claims database for a more objective measure. And I want to note here, focusing on race and ethnicity, because frankly, this has taken a lot longer than we had anticipated and we are now only turning to SOGI and disability status. So those have been on our radar for a long time but it has taken us quite a lot of work just to get to where we are in terms of race/ethnicity. Next slide.

And that was just around completeness of data. Like once you start actually using the data you get into issues of accuracy and usability. And

so we have really had to spend a lot of time digging into the data systems and working hand in hand with their carriers to troubleshoot and ensure that the data can be cross-matched across systems. For example, for ethnicity we discovered that if an enrollee checked Latino as an ethnicity but didn't choose a race, because frankly, in California, many Latinos are like, that is my race why should I check some other box. There was a snafu in our systems where that data didn't get transferred over the health plans in the 834 file. So, you know, only by starting to use the data did we actually surface this issue, had to track it down, fix the systems. Next slide.

And similarly, for what the Feds at least consider race, we have had to do a lot of detailed work understanding categories and cross-matching data. And so my reflection on this kind of first step is that despite, again, an expectation in California, the truth is, I think it is important for us to just recognize where we actually are. Complete, usable race/ethnicity data is not a given. And if we are serious about addressing disparities in California we have a whole set of work to do around understanding and bolstering our data streams and obviously not just race/ethnicity, but also SOGI and disability. And I would hope that we could figure out a way in our regs to point to some of the things that are happening at a national level so that potentially tying, you know, when things get finalized at the federal level that we then automatically adopt it, or even at the state level in other settings. I see, Rhonda, you have your hand up.

MEMBER SMITH: Yes. I just had a question. I am curious about whether you all have considered when you look at Black and African to actually stratify that by African immigrant? African like, Afro-Caribbean or Afro-Latino?

MEMBER ALICE CHEN: Yeah. No, that is so important, right?

MEMBER SMITH: Yes.

MEMBER ALICE CHEN: And I think I would just say that, I mean, I have a whole beef with, as many of you know, about the whole OMB 15 framework and just how. I mean, frankly, the feds in that framework treat many of the Asian American ethnicities as race and then, you know, have this whole Latino Hispanic thing going on. It is just very confusing. And you are exactly right. Black African American is not monolithic and we actually do need to have more granular categories there. I am just reflecting here what our current systems are. But absolutely we have talked about trying to be more granular. And also hesitating to do it in isolation. Wanting to make sure that we do it, again, in conjunction with these other systems so that we don't find ourselves in a place where we are trying to true things up on the back end.

MEMBER SMITH: Thank you.

MEMBER ALICE CHEN: Next slide.

And so this is my last slide. I know, there's a lot of words on here but let me just say that, you know, even as we knew and we discovered that -- I mean, I will back up and say that we were very, very ambitious in the beginning. In our first contract 2017 to 2020 we had our health plans collecting race/ethnicity, data to a certain completeness, identifying disparities, identifying a target and closing those disparities. All within a three year period, which, of course, is a case where your eyes are bigger than your stomach.

So I think then we stepped back and what we realized was, you know, in 2015 we went through a process that I was, I mean, full disclosure, I wasn't there at the time. But we went through a stakeholder process with our health plans and consumer advocates, identified 14 measures to stratify. I

suspect actually some people on this call were part of that process. And these are all, again, really important measures. However, some of these also are not very frequent events, fortunately, like amputation with diabetes. Luckily that is not a large sample size. And then when you start stratifying by race/ethnicity you end up with a lot of cells that basically have no people in them.

And so because of that we ended up requiring that our health plans report data across lines of business. So they had to report data for Medicaid, Commercial and Covered California stratified by race/ethnicity. And even then, some of these measures had sample sizes that were too small to analyze in any statistically significant way. And we then found ourselves in a position where we really couldn't do health plan to health plan comparisons because some health plans were predominantly Medicaid and then other health plans were predominantly Commercial and you saw already that the National benchmarks are very different across lines of business depending on the measure.

So that led us to really step back and for the 2021-2022 cycle focus on a small set of measures that were kind of a transitional set moving into our current contract, which is the Quality Transformation Initiative, which are the four measures, diabetes, blood pressure, colorectal cancer screening, childhood immunizations. Chosen for many of the reasons we have talked about in this Committee, including the fact that NCQA has identified at least three of them in the first round for stratification. And then we felt like -- and those are the four that are tied to financial incentives.

Depression screening and follow-up and pharmacotherapy for opioid use disorders are, frankly, placeholder measures in some ways because we felt like behavioral health was so important. We didn't like the measures in

QRS and we don't know that there are perfect measures at this point, but we felt it was important enough to really move forward. And these are also part of a separate effort, you know, referencing Jeffrey's comment, the PBGI CQC IHA, I know that was a lot of acronyms, but there's another initiative around advanced primary care measure set and so that was in part why we chose those.

We have a long way to go, frankly, before we -- so we are requiring our health plans to stratify these measures by race/ethnicity. Already we are bumping up against small sample size for some of these measures that we are trying to talk through. But I will say we have a long way to go before we can tie consequences to performance. So we are working with Medi-Cal and CalPERS to create a joint framework and methodology for things like selecting a reference population, selecting the target population for any given measure, determining what appropriate measure collection methods are, do we allow for imputed race/ethnicity data, what is the minimum sample size, what is the statistical significance and improvement targets? And I will say that we are not alone. CMS is in the midst of these same discussions, I suspect, and I know NCQA has been grappling with some of these very basic issues as they stratify, require stratification of HEDIS measures.

So I will wrap up by suggesting as a non-voting member that on the disparities front we really have our work cut out for us already in ensuring California as a whole has complete and usable data for race/ethnicity, SOGI and disability. Would recommend that we focus our initial requirements there and revisit the disparities reduction targets in a couple years when the state of the field is more mature. You know, I think I mentioned in a previous meeting that I have had more experiences than I care to remember of being on not just the

cutting edge but the bleeding edge of something, which in all cases has required going back and revamping systems once there has been a national standard that was developed. So I would just caution us against doing too much of that.

I will pause and turn it over to Palav and Lisa.

MEMBER BABARIA: Thank you so much, Alice. I agree with everything that you have presented here and just a few points to highlight.

One is, you know, we are thinking about this extensively within the Medi-Cal program as well and for some of this it really is about the sticks and the carrots. And so, you know, I think the sticks are really the regulatory framework and accountability and sticks work very effectively to set a floor or a minimum performance level. I think there is a lot of scientific literature and studies and other evidence out there that sticks are not really great for, you know, pushing people to strive for excellence; that is not something you can penalize people into. And really focusing here on what that minimum performance standard looks like makes sense to us and is aligned with what we are trying to do in Medi-Cal as well. And then really looking to purchasers to look at value-based payments, other types of incentives to really drive towards excellence I think makes sense.

And one comment just on the benchmarks. You know, I think that -- I don't know that there is a right or wrong answer here but it is clear that for, you know, many if not most measures there is some type of disparity in what the performance is between different lines of business when you look at Commercial versus Medi-Cal versus other payer types. And as Alice pointed out, it is, you know, likely most of those disparities are not necessarily actionable by health care providers or health care plans, they are really a manifestation of

deep inequities in income and poverty in our state as well as structural racism leading to health care disparities.

That being said, I do think just from a moral and ethical perspective setting different targets for different populations just based off of who their insurer is, is really problematic. And, you know, I think if there is a way that we as a committee can really think collectively about how do we set standards that apply to everyone, independent of what zip code or income level they were born into, it would send a very powerful message around health equity. And we, you know, it would be worthwhile to see if we can come up with a solution that is still logical and reasonable to set that standard, not only for our state but really as a model for our nation.

MEMBER ALBERS: Thanks, Alice. Thanks, Palav.

We completely agree here at CalPERS with everything that Alice presented. As everyone has heard numerous times, CalPERS is engaging in an RFP with its HMO plans and as much as possible we are aligning with Covered California and with DHCS. Establishing that minimum floor for quality performance, which we have had in place for a while; but in addition to that, establishing aspirational goals. And having the regulator really be the one who enforces that minimum floor makes a lot of sense to us as well.

I absolutely agree with Palav that while we acknowledge there are differences like in geography, you know, variations in geography and access in this enormous state of ours, I think setting a standard benchmark that says that everyone is valued equally sends a very powerful message.

And then just finally echoing what Alice said about demographic data collection. Here at CalPERS we are really just at the beginning of that data

collection journey, trying to learn as much as possible from DHCS and Covered California and their experiences. So while we are excited to use our RFP to push that process forward here at CalPERS it is going to take some time. So we would very much agree with Alice's comments about taking it slow with accountability around disparities targets.

MS. BROOKS: Great. Thank you to all three of you for that wonderful presentation. I see hands are up already so there is some interest in this discussion here. I am going to start it off with Lishaun.

MEMBER FRANCIS: Thanks, everyone, for this presentation, really good things to think about.

I want to echo what Palav just talked about in terms of setting standard benchmarks across lines of business. California has a really long history of focusing on, say, like Medi-Cal versus Commercial. But I think as we have all seen, you know, really robust and new research come out that focuses on racial disparities and how income does not necessarily play a role in the disparities and gaps that we are seeing. So we are seeing Black and Brown women and men, even who are of middle class and upper class, have really poor outcomes compared to their poorer White counterparts. So I think it is important to really echo that and to think through a standard benchmark as we think about disparities and what we are measuring across lines of business.

MS. BROOKS: Great, thank you so much Lishaun. Bihu.

MEMBER SANDHIR: Bihu Sandhir from AltaMed. I actually think this was a great presentation so thank you very much, it was very helpful.

The couple, just a couple of comments. I think we, I am relieved we have got the same measures across all lines of business. My concern with

having one benchmark for both Medi-Cal and Commercial is there is sometimes a big difference in where they are already performing. So if you set the benchmark too high for Medi-Cal patients it becomes, I am not sure if it is achievable unless you give them some time. I think from some of the data that Alice showed it takes time to get to where you even show a change in data.

And what I can tell you from, you know, in the field where we actually see this population of patients is that you will actually, you sometimes feel like it is unachievable if you set the benchmark too high if you are trying to catch up with Commercial. And I think we may have to consider -- what I ask is that we make it reasonable. That we feel like we can achieve it. That's more the carrot approach. I agree in the stick but I think that's usually a more effective approach to really bring about change. If we set the benchmark too high for, say, a Medi-Cal population just because we are trying to match it with Commercial I don't think we are really necessarily going to get what we are really looking for here because you sometimes will just say, okay, I can't achieve it and then you move on to something else. And that is what I can tell you I see in the field all the time at this point. So thank you.

MS. BROOKS: Thanks, Bihu. Actually, can we just advance the slide real quick? And I think great comments, Bihu, and we will be getting into that a little bit later. I thought there was a question slide but we can leave that here. Cheryl, you are up next.

MEMBER DAMBERG: Well, I just want to thank Alice for such a great presentation and I think she raised a lot of pertinent points to the ongoing discussion in this Committee.

I want to, you know, call out one of the areas that she had flagged

in terms of setting a sort of a single bench benchmark across different lines of business. That is a very critical point because otherwise if you set sort of within lines of business, say Medicaid versus Commercial, you are essentially adjusting for the delivery system and that's sort of a bad thing to do in quality measurement. So I wholeheartedly support, you know, the direction of a single benchmark in that space.

But I do want to take stock of what I think Alice was signaling more broadly, which is, you know, kind of biting off more than we can chew. And, you know, maybe looking to kind of sequence this work in a way and whether, you know, we need to establish benchmarks at this point when, you know, the reality in front of us is, you know, this first stage of just being able to capture information on patient characteristics, whether they are economic, social risk factors, and on it goes. So I hope and it would be interesting to hear from the perspective of the DMHC whether we have the latitude to sort of progress in more of a stepwise fashion.

MS. WATANABE: Maybe I will respond to that, Sarah. Not really, Cheryl. I think it was very clear that the expectation is that we would set those standards and that we will take enforcement action starting in 2025. I will say that for those first two years the expectation is we will all know what those standards are and so we will be working with health plans in those first two years to really develop robust corrective action plans to start to advance to whatever those benchmarks are. But it was pretty clear in the statute that we will have benchmarks that we will be holding health plans accountable to starting once we have the regulations in place.

MS. BROOKS: Thank you, Mary.

MR. NAU: Sarah, this is Nathan from the DMHC.

MS. BROOKS: Go ahead.

MR. NAU: Probably a good time to also mention what we have mentioned a few times previously is that, you know, in around the five year mark we are going to reconvene the Committee and we will be looking at not only the measures but the benchmarks as well so that would be the way where we can change things over time. We are hopeful in five years that there will be maybe consistency on benchmarking and different measurement options to hopefully address some of the things that people have talked about that they want us to address, but it doesn't appear to be good options currently.

MS. BROOKS: Thank you, Nathan.

Cheryl, did you have additional comments or questions? You are on mute. No, you said no. Okay. Thank you so much, Cheryl.

You see on the screen we have a slide that says Benchmarking. We have a whole presentation on benchmarking and discussion so lots more to come. I think Cheryl and others have already made some really great entryway comments with respect to that.

We will move on to Ed right now.

MEMBER JUHN: Thanks. Ed, Inland Empire Health Plan. First, thanks so much, Alice, Palav and Lisa for the great overview and presentation.

One thing I think to keep in mind in addition to variance between lines of business is also the fact that there are existing regional differences in performance in the overall population for the measures. So within California, you know, even between northern and southern, you know, there are some regional differences to take into. So as we go into the benchmarking discussions it would

be great for this Committee to consider what the best approach might be if we are setting benchmarks that health plans will be held accountable to, recognizing that there might be some regional, I guess you could say variances, at least out of the gate as, we look to improve on these important pieces.

MS. BROOKS: Thank you, Ed. You will see something on that soon in the presentation, actually. Jeff?

MEMBER REYNOSO: Yeah, Jeff with LCHC. I will be brief with my comments because I know this is the start of future conversations around benchmarking. You know, I think I really hear my colleagues and the challenges with benchmarking across lines of business. I think for our population, just given the disparities that we see already with the Medi-Cal program. You know, I believe it serves one in three Californians, about half of the program is Latino/ Latinx. And so the concern for our population is by already building in different benchmarks with different product lines then we are actually introducing into the system an opportunity for more disparities. So I would be under the camp of really thinking through what is, you know, a fair, a fair floor for us to start with and then building, you know, our system from that. I recognize that the challenges are hard. Our Medi-Cal populations are more likely to be on the receiving end of structural racism and economic inequality. But I think we should try at least as a state, you know, as a committee, to advance the opportunity for health equity for all Californians regardless of, you know, what insurance card they are holding.

MS. BROOKS: Thanks, Jeff, for your comments. Not seeing any other hands raised from Committee Members I am just going to check with Shaini to see if we have any comments from the public.

MS. RODRIGO: There are no raised hands from the public right

now.

MS. BROOKS: All right. I think what we will do is before we move into the benchmarking full presentation we will go ahead and take our break. It will be a 15, technically I guess we will go for 17 minutes. What time does that mean? Sorry, you just lost the minute, we will go for 16 minutes. We will come back at 2:35 and we will continue with benchmarking. Looking forward to that discussion; thanks, everyone.

(Off the record at 2:19 p.m.)

(On the record at 2:35 p.m.)

MS. BROOKS: Welcome back. A lot about benchmarking now. I think this will be a dynamic discussion and I am sure DMHC and Committee Members will have lots to weigh in on here.

So we will begin the conversation around setting benchmarking approaches and options. And just as a reminder, there is information in both the candidate measures workbook and the performance epidemiologic handout that may help inform you review the benchmarking options that we will be discussing during this presentation. So those two handouts that were provided to you all as meeting materials today should have some additional information that would be helpful.

So benchmarking is used to determine the standards against which performance is assessed. Such benchmarks can be sourced in a number of ways. A common approach is using NCQA's Quality Compass, which provides the results for up to three trended years on HEDIS and CAHPS performance on national, regional, state and plan levels.

Although Quality Compass data is available for many measures, for

those where data is not available the Committee may need to identify alternative benchmarks through other external sources such as national surveys and measure steward recommendations or develop their own benchmarks through internal sources including electronic health data or annual reports, among others.

But I think just recognizing here that we are looking for something that is enforceable by DMHC and that has clear expectations that can be set by the department. So next slide, please.

All right. So the approaches to benchmarking vary depending on the type of performance improvement desired and data available. The most common methods for benchmarking are included on this slide, absolute relative and improvement based, which we will be discussing later in the presentation.

A little bit of background though now is that the Absolute approach sets the benchmark as a specific value of performance for all entities.

The Relative sets the benchmark based on performance of similar entities or performance within an industry.

And the Improvement Based benchmark sets the benchmark as a specific change in performance to achieve.

So depending on the goals, certain approaches may be more appropriate than others.

During last month's meeting, there was discussion on DMHC enforcement approach rather than an improvement in performance approach and I think we heard a little bit about that from Alice and the other purchasers earlier and there was some discussion afterwards.

It is important to note, to revisit this conversation, to clarify that the objective of this measure set is not to create incentives around improving

performance but rather to bring all health plans to the same level by setting the floor for performance and promoting greater data collection on disparities, to position them for success in advancing higher quality and greater equity. With this in mind, we do encourage the Committee Members to review the measures and other relevant information in the workbook and review the percentiles, specifically the 25th and 33.3 percentiles as those may be helpful to you all.

Similarly, as mentioned previously, performance data may not be available for all measures, which may limit the feasibility of certain approaches. The Committee is encouraged to be mindful of these considerations, among others as we prepare to select benchmarks. Next slide, please.

All right. So in this example of an absolute benchmark a baseline is determined and specific target rates are set for each year. So you can see the baseline is set at 50% and there is the 5% increase each year. All right, next slide, please.

So this approach, we were asked last time about kind of strengths, challenges, pros and cons about the different benchmarking methods so just providing a little detail here on that. So this approach here, the Absolute benchmark is most common for measures that a specific performance value is desired or when performance across participating organizations varies little. It is important that the baseline performance is considered so the benchmark can drive improvement while also being feasible. Because a specific value is set, the benchmark can be the same across payer types. All right, next slide.

So in this example of a Relative benchmark, the NCQA Quality Compass 50th percentile is used each year. Quality Compass, as we talked about, provides benchmarks that are measured as percentiles that show how a

plan ranks compared to a proportion of other plans that reported performance on that particular measure for NCQA. For example, if a plan performs at the 75th percentile that means it performed better than 75% of plans nationwide on that particular measure. I think that is an important point to emphasize and note. This really means that if you set the benchmark at 75% the plan needs to perform better than 75% of all other plans in the nation that have reported or collected data. All right, next slide.

So this approach is most common for measures where performance should be maintained and may vary greatly from year to year. This benchmarking methodology assumes Quality Compass or other benchmarking data is currently available. And that since Quality Compass is updated annually based on the performance data submitted, the benchmarking would change from year to year, so noting that. Also of note, Quality Compass data are released for each product line at different times of the year. So that is kind of important in terms of how DMHC might have to think about their process if they had, if the Committee were to recommend two different benchmarks and not one, how would that work out in terms of when the data becomes available for the DMHC? All right, next slide.

All right. So we will now review a few different recommendations for measures that have -- wait a minute, I am on the wrong slide, I'm sorry. We will now walk through a few benchmarking examples.

So in the first example here the benchmark is based on improvement over the baseline with a specified percent of change each year. So we can see that that's presented on the slide here. Next slide.

So in the second example the benchmark is set at the NCQA

Quality Compass 50th percentile for Year 5 and leading up to that the health plans are required to show improvement toward meeting that goal. Of note, as you get closer to a benchmark there are typically smaller degrees of improvement. So this is an example of the improvement based benchmark. All right, next slide.

This approach necessitates baseline data and is most common for measures that continuous improvement is feasible and desired for. Current performance is significantly below targets or baseline performance among participating entities varies greatly. Both examples allow for improvement to be specific to the health plan's individual performance by setting a benchmark on the degree of change required. The primary difference is that the first example, improvement over baseline, does not specify a final performance rate; whereas the second example, improvement towards benchmark, sets an end goal without specific improvement goals year to year. All right, next slide.

All right. So we will now review a few different recommendations for measures that have available Quality Compass data. For measures that do have Quality Compass data we will discuss in further detail later on in today's discussion. Sorry, that do not have. So we are going to talk about measures that have Quality Compass data now to start.

So as an easy reference, please see your measures and other relevant information workbook. So that was the first attachment that was on the slide earlier. If there is data in columns W through AL this indicates that Quality Compass data is available. If the cells contain N/A, not applicable or not available, this indicates Quality Compass data is not available. Note, that if there is any thought about not utilizing Quality Compass data we welcome

recommendations about other approaches as well. All right, so next slide.

So for benchmarking the following voting methodology will be applied to the recommendations on subsequent slides. So for voting, we will review two recommendations. For the first recommendation we will vote on the performance benchmark that will apply to all measures. Then we will vote on various scenarios and review examples. The scenario for example A or B with the most number of votes will move forward. So we can move to the next slide.

So this is the first question that we are looking for feedback or for a vote on from you all, which is, what Quality Compass percentile does the Committee recommend as a benchmark? And you can see that listed here on the slide are the available percentiles. And as we mentioned, most of this data is included in the workbook that you all have been provided.

So just as a reminder, I think Alice did emphasize, I remember hearing this in her presentation, that DMHC's approach is definitely related to enforcement, we talked a little bit about that earlier. And through the overlap of priorities with Covered California, DHCS, CalPERS, that driving of quality improvement will be achieved through their programs. All right, next slide.

So we will now discuss how the benchmarks should be determined based on differences between Medicaid and Commercial plan available data. For whichever benchmark is applied to the measure with available Quality Compass data there are two scenarios to consider. The lower of the national Commercial and Medicaid performance is one. Or an average of the national Commercial and Medicaid performance based on what is recommended by the Committee in Question 1, which you will recall was tied to what percentile should be used as the benchmark for B here. All right, so next slide.

So for Scenario A, the lower of the national Commercial and Medicaid performance, this example shows where the benchmark would be set if the Committee were to set the benchmark at the 25th percentile. So you can see here in black the boxes here. The National percentile would be at 48.07 and the state percentile would be at 53.24 for the 25th percentile if we were to go for the Medicaid benchmark. Next slide.

For Scenario B, the average of national Commercial and Medicaid performance if the Committee were to set the benchmark at the 25th percentile. So this would be the straight average of the percentile and which was voted on by the Committee. So here we see at the bottom there is some great math that adds 66.57 in the first column here, plus 48.07 in the third column here, which combines the 25th percentile for Commercial and Medicaid, and then divides it by 2 to come up with an average, as you all know.

All right, so we are going to move forward and have some discussion now on just the benchmarking and the options and what we have been, what we have put forward here for consideration before we vote. So I see there are some hands, there is a hand up already, so Cheryl, welcome your comments and questions, please.

MEMBER DAMBERG: Thank you. I just want to make sure I am clear on how the Department of Managed Health Care is imagining this working. So the penalty is the plans would get a corrective action plan. But when we think about setting these benchmarks, so the benchmark you are using here is combined all different subgroups, right?

MS. BROOKS: That is correct.

MEMBER DAMBERG: And is the idea. So just take one of the

priority measures. So take breast cancer screening. Let's say we are going to stratify it by disabled and non-disabled. So are you, is the Department thinking about, okay, measure by measure, subgroup by subgroup, you know, a plan would have to meet, let's say there is some minimum absolute threshold at the bottom. That they would have to perform at that level or higher for all their subgroups, you know, whatever subgroups we could measure, and if they fail on one or more they get a corrective action plan? I think I am just trying to figure out operationally how this, how they are imagining this is working.

MS. BROOKS: Let me just see if Mary and Nathan have any comments with respect to your question.

MS. WATANABE: And I was nodding along to Cheryl. And again, I will reiterate that this to me is the most complex part of our Committee discussion that we have had to date. You know, getting back to Sara's presentation on the enforcement. When we take enforcement action, yes, it is around changing behavior, it is a corrective action plan. But at some point there needs to be a value that we are going to say, if you do not hit that value by the subpopulations, let's just say take race and ethnicity, by each of those racial and ethnic groups for that measure you are going to get referred to our Office of Enforcement. We are probably talking fines and penalties.

And just to be clear, we sometimes go to our Accusation phase with plans and plans challenge us. We end up in court or in litigation and so this needs to be something that we can prove in a court of law that the plan is not meeting that standard that has been codified in regulation and so I think it is really important to think about that.

But I in my head, and again, this is for breast cancer screening,

what number are we looking at as the floor the plans need to get to by these subpopulations in order to not get referred to our Office of Enforcement. Nathan, anything you want to add; Sara? Sara Durston.

MS. BROOKS: Yes, I was going to say, I thought it wasn't me, I think you are asking Sara Durston.

MS. WATANABE: Sara is doing the reg. But Nathan, are you aligned with what I am saying?

MR. NAU: Yes, I am aligned with what Mary is saying. The only other thing I would add is we haven't made any predetermined decisions, we need to hear what the Committee's opinion is. This is a Health Equity Committee so that health equity is a part of it, but like Mary said, we just have to tie the numbers to something. And for more context, I have been on the end of challenges that DHCS and DMHC, both of which we were not successful and are not fun and we don't want to put all this effort with you and internally once this Committee is over with, with having these situations and us not being able to enforce what our goal is. So just keep that in mind as we move forward.

MEMBER DAMBERG: Yes. And I think sort of getting to the heart of the question I am asking is, you know, let's say you take breast cancer screening as just one measure and you have three different categories. So you have disabled, non-disabled and then you have the race/ethnicity categories, and I am trying to think of a third category. And so if the plan failed for any of those subgroups on just that single measure, they would be referred for corrective action plan. Versus an approach that I am going to suggest, which I don't think is necessarily represented here. And I agree this benchmarking thing gets complicated and, you know, how you structure this. One could, in principle,

evaluate performance for each subgroup. And then you could take that information, and let's say you converted scores based on some relative scoring mechanism and turned them into stars. And then you could create an index of how a plan performs across all these measures by all these subgroups. And for plans that fall below some threshold on this index, you know, which is looking comprehensively across the set of measures that you are going to include in this, then you would say, if they fall below, let's say they are a one or two star, you know, plan, then they get a corrective action plan. So I think it has very different implications in terms of like how you score this, you know, and what is going to happen. So I think that this topic may need some additional thought before at least I would be prepared to vote on it.

MS. BROOKS: Thanks, thank you, Cheryl. Mary, just checking to see if there are any additional comments? I don't think so. I am saying no. Yes, okay. Thank you, Cheryl, that was very helpful. Andy, I see your hand is up so I don't know if you have a quick comment.

DR. BASKIN: Yes, no, I do, I want to provide a little clarification here. What we are talking about here and what we are asking is for a benchmark for the total measure, not for any subgroups. If you were to view ahead in the slide deck there is another section where we talk about disparities reduction benchmarking, which would include some of the suggestions that Cheryl made about whether each subgroup has to meet a certain benchmark or whether there is some other way to calculate whether disparities are being reduced or not are adequately being addressed. Right now the specific question is not based on stratification, it is just based on the result of the measure for the entire population what would be the benchmark, and we are going to get into that

other nuance later on. We knew that would be a complicated discussion but I think separating them makes some sense.

MS. BROOKS: Thank you, Andy, for clarifying that, that was very helpful. Ed it looks like your hand is up.

MEMBER JUHN: Thank you so much. I think Andy's comment answered my question. And I guess, you know, the comment that I would have is when we get to the subpopulation discussion and the benchmarks there it would be helpful for me to understand what type of classification. For example, are we going by the OMB classification? Are we considering, you know, other data elements for other, I guess, groups that we have to reduce disparities? Because I do think that the subpopulation discussion may be something that could get complicated based on what data is available today by health plans. And based on the data that is available how that can, you know, influence what gets stratified and the results and the disparities that we close there, so.

MS. BROOKS: Thanks, Ed. I think that definitely connects to Andy and Cheryl's comments and then our upcoming kind of discussion and the distinction between what we are kind of talking about and would be voting on here as compared to kind of the stratification piece that will come later. Bihu.

MEMBER SANDHIR: Bihu Sandhir from AltaMed. Just a couple of questions and maybe some, I am not sure if I am understanding completely here. Andy, thank you for clarifying because I, my concern was if we are going to talk about the different subgroups do we have data on that for each one of these measures before you can even set a benchmark? Because I think that's part of what we -- in some of these we may have to collect data and it might take us a few years to get some of that before we can even benchmark, so that's one

of the concerns I have.

The second thing is looking at this example here. If I understand this correctly, we are saying that if we set one benchmark we are actually cutting down the standard for Commercial and bringing up the standard for Medicaid. Is that really equitable? Is that appropriate that way? So that is what I, maybe I am not understanding that or maybe I need some understanding of that, maybe Andy can explain that.

And then the last question I have is, you showed us the three different ways that we can set benchmarks. Can we mix them? Does it always have to be one or the other? Can it be a Relative and Improvement benchmark strategy instead of just having one that we have to just go with one? Could we set a benchmark and then have improvement parameters in there so that way, maybe -- to me that may make more sense. It just, does it have to be just one of those absolute ones that we have? Those are my questions. Thank you.

MS. BROOKS: Thanks, Bihu. I am going to let Andy start and then I will jump in also as well. You are on mute, Andy.

DR. BASKIN: Sorry. let me address the first part of that question, Bihu. You know, you know, what is the standard of care? I mean, we are looking for a floor here that says that plans are providing at least the standard of care. Now the standard of care is not the 50th percentile because by definition half the plans don't perform that well. The standard of care could be anything from the 10th to 90th percentile, the 25th to the 75th. I mean, it is how you, how you want to define it. So the fact that you pick something that is the lower of Medicare -- I mean, of Commercial, Medicaid, or the average of Medicaid and Commercial, meaning by definition it is going to be below one of

them, at least, well certainly below one of them, doesn't mean you have lowered the standard of care, it just means you are defining for the purposes of this group and the DMHC is what we are considering the standard of care. So we are actually defining it by that number but we are not actually lowering anybody's standard of care.

MEMBER SANDHIR: Thank you.

MS. BROOKS: Thank you, Andy. Now Bihu, I will be honest, I didn't get through all your questions but could you repeat them, I'm sorry.

MEMBER SANDHIR: The last question I had was, and that's just a question to put out there. You know, you gave, we have three strategies of how we can benchmark.

MS. BROOKS: Ah, yes.

MEMBER SANDHIR: So is it possible to mix and match them? Does it have to be one or the other? Because I think there's value to some of them, to each. They all have value; especially I thought the second and third. But it is just, does it have to really be just one or the other? Could we consider mixing them and having some improvement options with a Relative benchmark? So you set a Relative benchmark and then, you know, you look and see whether we had some improvement to it. Or maybe I am just not stating that right but that was my one question I have, is that even an option?

MS. BROOKS: So I think what we are looking for is things that are kind of -- not what we are looking for. What we are looking for is discussion from the Committee here on kind of what should be put forward. I think, you know, it will be important to recognize that not simplicity but that creating something that is too complex to recommend that may not be doable because of all the great

things that, all the things that you all have talked about already and raised in terms of data availability, sources, all those different things you know. I don't know that we want to get too complex, I guess, is what I am trying to say here. But definitely, you know, we are here for discussion.

MEMBER SANDHIR: Thank you.

MS. BROOKS: Thank you, Bihu. Alice.

MEMBER ALICE CHEN: Actually, I was going to say I would really strongly encourage simplicity. I mean, honestly, combining absolute and improvement just gets super complicated. I do think that the two principles that I think would serve us well are having a single standard and simplicity. I think even the averaging of two benchmarks is going to start to get complicated. I also think it is really hard just to decide. And I apologize if all this data was in the background material and I didn't see it. In the absence of actually looking at the absolute performance for every given measure, to just unilaterally decide, oh, we are going to do Commercial or Medicaid or 10% or 25%, because I do think it may even vary between the different measures depending on how clustered or how much room there is for improvement.

So again, I would encourage us if we are going to do the single threshold, which I do think has a lot of signaling importance in terms of population health, particularly as we get to disparities. And I will just signal ahead that I was getting really -- I may still get really concerned by the time we get to disparities about the idea that we are going to set methodology now. I would love to explore if there is any opportunity to really select the measures, set benchmarks for total population and then potentially defer some of the absolute decisions on the disparities. Just because I think we will be making decisions in

a vacuum. And I do think that we should look to NCQA and Kristine in particular to see where they are thinking about it, just because they are another national stream that is going. But again, would encourage us to do a single standard, simply pick one benchmark, but potentially look at it measure by measure.

MS. BROOKS: Thank you, Alice. Jeff.

MEMBER REYNOSO: Yeah, Jeff, with LCHC. I guess, yeah, I am just trying to kind of map out in my brain all the various possibilities. And maybe some of the other Committee Members feel this way. I feel like we need to have more discussion. A couple of -- I feel like it would be helpful. I don't even know what questions to ask at this point, you know. And, you know, I think one that just comes to mind would be, with the other payers with the state, so CalPERS, DHCS, Medi-Cal, Covered California, what type of framework have you all used with performance improvement measures? I think that might be helpful. And if other questions come up I may pose those. But I think I am, I am. You know, I know we are starting the conversation, I don't feel ready to vote yet. You know, I think just more context would be helpful.

MS. BROOKS: I don't know if any of the other purchasers have any comments. Lisa, your hand is up if you want to go ahead with that or with respect with something else.

MEMBER ALBERS: It is really both.

MS. BROOKS: Okay.

MEMBER ALBERS: It is to respond to Jeff and just to echo what Alice always says so much better than I ever will. But really want to emphasize that simplicity and streamlining as much as possible would be our plea as well.

And Jeff, just to provide an example, you know. Similar I think to

the other purchasers, CalPERS traditionally has used NCQA benchmarks for our plans, of course the Commercial benchmark. You know, we choose, settle on a percentile. Historically, it has been the 50th but we are looking to align with Covered California as we move forward. So we have settled on that one benchmark, that one benchmark from NCQA. It is updated annually in their Quality Compass and that is what we have adhered to.

And I think when it comes to making this process as doable as possible, for our plans and our providers not only is important to have a parsimonious list, but it is also important to make the process as simple as we can. And so to have them be able to focus on a benchmark would be much easier to have than trying to focus on several different benchmarks.

And then finally with regards to different populations and disparities also I agree completely with Alice. I just don't think we are in a position yet to be setting those targets. We don't have all the data. And so as much as we can put that off for a bit until we have data that we can actually work with and rely on I think that would probably be wise, especially because all of this has to be codified into regulation so I think we want to keep that in mind.

MS. BROOKS: Thank you, Lisa.

Ignatius, your hand is up.

MR. BAU: So I just wanted to clarify, Lisa, that when you said 50% was what you were working on contractually with the claims at CalPERS. That is your improvement goal, that is not your floor, in the same way that Alice talked about 66% being the improvement goal that you are trying to get people to and it actually potentially puts the incentives behind.

MEMBER ALBERS: That is correct. Thank you, Ignatius, for

clarifying.

MS. BROOKS: Thank you both. Silvia.

MEMBER YEE: Hi, Silvia from DREDF. I just want to, I have some clarifying questions too. And thank you, Jeffrey, for articulating what I suspect a number of us sort of are feeling this kind of, but there are many balls in the air here. When you are saying benchmark you are referring to a single benchmark that covers all of the, all the, all the factors that have been chosen, like the EHB benchmark, the Essential Health Benefit benchmark? That's what you are referring to? So that there would be one approach or the three options that apply to all the different measures or are you talking about that each measure would have a benchmark?

MS. BROOKS: Each measure would have its own benchmark. We will have further discussion about stratification and such later in the presentation. But for this purpose we are talking about just setting a benchmark for each measure individually. And so the questions that we are asking here are really what percentile should be selected based on when NCQA Compass data is available for a measure what percentile should be selected as the floor to recommend to DMHC?

And then separately, how should we, how should we set the benchmark? Should it be set as the higher of Commercial or Medicaid or should it be an average based on the Scenario B here? So we are asking kind of two different questions.

MEMBER YEE: Okay.

MS. BROOKS: So I appreciate your questions and everyone's comments so far. Definitely want to hear and I think this is good discussion. As

you all are talking, if there is additional information that you all would want or that would be helpful, because I know you have said you are not ready, I have heard a couple people say you are not ready to vote yet. What is that information so that we know what that is? Because I think we need to know that so that we can perhaps have that discussion today so just asking that people share that as we move forward in the discussion.

MEMBER ALICE CHEN: Sarah, do you mind if I just jump in briefly?

MS. BROOKS: Sure, go ahead, Alice.

MEMBER ALICE CHEN: Just because I thought Silvia's question was actually a really good one, which was are we, in the absence of kind of knowing what the actual performance is and the benchmarks, it is a little challenging to say, for every measure of the 13 that we have we are going to pick a single approach.

MEMBER YEE: Thank you.

MEMBER ALICE CHEN: So we are going to pick 10% versus 25% and we are going to pick Medicaid lower or higher, you know, average. It is hard to make a single decision without actually seeing like that grid I showed of the different lines of business and the actual spread of performance.

MEMBER YEE: That's what I was trying to get because I can't, I didn't quite, it doesn't, it is not quite clear to me. And actually I had one specific question for Alice which is, in the -- I think you did use the opioid, you had placeholders you said for opioid addiction and emergency follow-up of mental health, I think. And for those, I mean, how did you choose a benchmark as they are placeholders?

MEMBER ALICE CHEN: Well, we didn't choose emergency follow-up. We didn't choose the opioid use disorder. Primarily, frankly, to be in line with Medi-Cal, even though the numbers are likely to be small. And the reason we haven't tied any consequences to it is because we don't have benchmarks. So it is reporting only. We are going to see, you know, how the distribution falls out and then we are going to figure out do we keep it, do we move to something else? And if we keep it then we would start establishing targets and benchmarks.

MEMBER YEE: Thank you. I appreciate that. I mean, those are the things, some of the votes I made earlier were because I think they are important enough to be included, though I know they don't have benchmarks. And that's part of it. I know we are on the benchmark discussion, we are past the measure-choosing, but I just think it is important to keep that in mind too as we are thinking about what are the things that we think are important for equity; because that is the overarching goal here, even though we are mired in the actual execution of it. Thank you.

MEMBER ALICE CHEN: And my last comment, sorry, Sarah, is that and that is why we specifically don't tie it to consequences. And I think that is the difference here is that the DMHC frame and, you know, set play is that whatever we do adopt ends up having consequences.

MS. BROOKS: All right. Thank you, Alice and Silvia. And I think just a reminder that some of the data, or not some, there is benchmarking data available in the workbooks that we sent to you all, it is an aggregate but it is available to you all so there is data that we have provided to you, just as a friendly reminder. All right, we will keep going with the conversation here. I see

Kristine's got her hand up.

MEMBER TOPPE: Sorry, slow on the unmute. A couple of thoughts. Definitely agree, super complicated discussion. Agree with the recommendations around simplicity. This gets incredibly complicated, especially for plans serving multiple populations. And you want them ideally kind of focused and addressing their populations in equitable ways so I think that that's an important point to restate.

There was a question, I think, Sarah, that you raised around or a point around the timing of the release of Quality Compass data. I have a question. So those data, Medicaid data benchmarks are released nationally later in the year because of the timing, there are some operational issues. But basically the Commercial data is released earlier than the Medicaid data. But my question back to the Department is, is there a way for, is there a timing issue that would limit the ability of the Department to kind of look at those data sets or wait until it is all out, I guess, for enforcement purposes. If that was going to be part of the decision process that, you know, if we were going to use different benchmarks for Medicaid versus Commercial. So that's one point.

And then Alice raised the point around like kind of where NCQA is going, what we have coming out. And, you know, to the point she made and others made, you know, we are in this process with them. And Covered California has been doing this work, as she described, for some time and they have some great experience. And this is our first foray really substantively at a national level into having these data reported. And we won't get that data until, you know, spring of next year, June of next year. That's the first data we will be really seeing reported at a national level with respect to these measures that

have been stratified. The five initial measures that will be reported in stratified results.

I have heard Mary also say that there is not, you know, a lot of flexibility in terms of what the bill expected the Department to do with disparities reduction so I don't know how you get to that kind of compromise or that future state. But, you know, we are in this discovery process, as well and so I think that the degree to which there can be some flexibility and maybe like a timeline put in place to revisit that, I would, I would second that recommendation.

MS. WATANABE: Maybe I will just jump in really quickly, Kristine. I want to be careful. We have some flexibility, I think in the regulation process. I think we can say things like for a measurement year we would tie the benchmark to the Quality Compass for that measurement year for, you know, whether it is Medicaid or Commercial. I think there is a way to craft the language or to say, the most recent version of the Compass. So I do think there is a way to do that.

I also think there may be some options, and Sara Durston, jump in if I get this wrong, but I think we could potentially say for a period of time we, for example, would have a separate Commercial or a Medicaid benchmark; and then at some point we would have a single benchmark. So I think there's ways that we can craft regulation language potentially that would allow some sort of a phased-in but we would have to be very clear about the years and the timeframes that we would do that.

The other thing, I will just, I want to make sure this does not get lost. Because when we were writing this, the language for this initiative, I kept having to move the language around so that equity came first. This is not a quality initiative. The purchasers are doing tons of stuff in the quality space.

This was not about necessarily raising the quality overall. It was making sure we are not leaving people behind and so this really is about equity. And it may be that we start with race and ethnicity because that is what we have but the goal is hopefully at some point to get to other data elements like SOGI data, disability status, age, or what have you. And we may just need to think about when that comes into play and I know that is part of the other discussion. But I don't want to lose sight of the fact that this, this whole thing is about equity so we are going to have to figure out how to kind of structure that. Sara, Nathan, anything you want to add?

MS. DURSTON: This is Sara Durston from the DMHC. I would just agree with Mary that we have had regulations in the past where we have said, you know, for the first two years, and we will list what those years are, we will do X and then after this we will do Y. An example of that is the reasonable and customary regulation that we had. And oftentimes also in regulations where it is complicated like this, we will include an example, similar to the type that you see on the screen. So we will have the regulatory text and then we might do an example. Like for example, you know, this is what the benchmark would be, so it is a little bit easier to understand.

And in regulations when there is confusion, we also have the ability to issue All-Plan Letters after the fact of a regulation that just kind of clarifies some questions. We have to be very careful that we don't kind of go around the regulatory process and give additional requirements in those All-Plan Letters but they are really just to clarify. So there is some ability if we get a lot of questions about something after a regulation has been enacted. Maybe if something was missed, if somebody didn't comment on something they had a question about

during the regulatory, during the notice and comment period, we can respond to questions afterwards, both informally and kind of a little bit more formally through an All-Plan Letter.

MS. BROOKS: Thank you. Ignatius, I think you have a comment, it looks like.

MR. BAU: Yeah. So to Mary's point about, you know, the importance of this being an equity-focused initiative and effort. Again, A, having the enforcement of DMHC behind it is unprecedented, and really, really important back to sort of what the overall effort is. And then secondly, I do think that then reinforces, at least in my mind, the need for a single statewide standard and not starting to parse by population or geography or payer. Because not only does that make it complicated but it really then says that different outcomes are acceptable, which really contradicts the principle of equity. And so again, whether that's a phase, whether that happens in stages, but ultimately the goal should be all Californians should enjoy this baseline floor of quality when it comes to health care and that would be equity.

MS. BROOKS: Thank you, Ignatius. Doreena.

MEMBER WONG: Yes, thank you. Yes, Doreena Wong from ARI. Wow, this is very, this has been really a pretty fruitful discussion, you know, talking about equity. It is funny to think that we talk about equity without considering some of the characteristics of race or ethnicity, or some of the socioeconomic conditions since there are structural, it contributes to structural barriers and structural racism and other, you know, biases. But it seems like it is kind of like talking about not looking and trying to be colorblind or something.

But what I really was trying to, what I really wanted to ask about, I

think Sarah you asked, what would be helpful for us to kind of make this decision. Because I am struggling similar to, you know, what Jeff and, Jeffery and Silvia are about how to pick, you know, some percentage, right, because it seems somewhat arbitrary or random. Do we pick 25% versus 50% versus 33%? And it would be helpful for it to be tied to something. And obviously the percentage would have to be related to whether or not it is kind of an absolute. You know, we choose to have an Absolute benchmark versus a Relative benchmark, which I guess could be, you know, the one that you use for, to show improvement.

So I guess I am struggling to try to figure out, you know, is that the discussion we should have first. Because obviously like Covered California has a 66%, you know, benchmark but that's for, you know, for one purpose, and NCQA uses 50%. So, is there some way somebody could kind of explain how you chose these different percentages and, you know. It would help me to understand it a little better. Because otherwise it seems like we are just kind of picking some percentages out of the air.

MS. BROOKS: Sure. No, that's a great question and actually something I think we probably should have spoken to before, Doreena. So those percentiles that are selected are what is available from NCQA with respect to benchmarks. So if we can go to a slide that has the percentiles on it. I apologize, I don't remember them all off the top of my head, but I remember that like 66.67 I think is a percent. Yeah, there we go, that slide that we were just on. But in any case, the point being that's the benchmarking data that is available from NCQA Quality Compass. And Kristine may want to correct me or jump in here. But that is why those percentiles are chosen is because they are available,

they have data that is available.

MR. NAU: Hey, Sarah?

MS. BROOKS: Oh, I am sorry, go ahead.

MR. NAU: Sarah, Nathan from DMHC.

MS. BROOKS: Yes, go ahead, Nathan.

MR. NAU: I don't want to volunteer anybody but perhaps someone can explain what the percentage actually means, that may be helpful.

MS. BROOKS: Okay. I think, yeah, that would be great and I am going to – Kristine is smiling; I don't know if that's good or bad. Can I call on you?

MEMBER TOPPE: Sure. Sure. I was just going to say, so we publish these data based on all these plans across the country that submit Medicaid, Commercial, Medicare data. And we, you know, aggregate that and create national benchmarks; to the degree there is enough data in areas we create regional and state benchmarks. And so those are used by a variety of stakeholders, private payers, public purchasers, regulators, and so forth for all these different uses. And so it is intended to give flexibility depending on what the goals of those various users are.

So, you know, what we are talking about today is what are the priorities for California for, you know, improving health care for the populations that are regulated by DMHC, DMHC-licensed plans. And so the 50th is, you know, as was described, I think this was your question, Doreena. You know, 50% of the plans are above the 50th percentile and 50% are below. But that actual number is dependent on the measure. So when you look at individual measures it is less about, it is less about what that number is then it is like, are

you really looking to, you know, hold the bottom half of plans to an expectation that they should improve.

And then, you know, with the rising tide you would expect that actual number of performance, say, if you look at the spreadsheet. And I am just looking at the first measure on the spreadsheet, which is colorectal cancer screening. And that data is only available for Commercial at this point because it was just specified for Medicaid so that's kind of another complexity to this. But if you look at that, the 50th percentile nationally is 63.6%. So 50% of the plans nationally are scoring 63.6% on colorectal cancer screening. And so the question is, you know, is that kind of good enough or do you want, do you want to be higher? Because then the 75th percentile, so 75% of plans, or excuse me, plans that are top performers are performing at 68%, so roughly 5% higher. Is that the, is that the, you know, the standard that you want to set?

But I think that's kind of a, I think what I have heard so far is creating some simplicity in choosing kind of a percentile. And Alice and others jump in if I am misrepresenting what you have said. But I think the idea of giving folks kind of one line upon which to kind of gauge how they want to look at or how they can approach the performance of their providers in their network and improve the health and experience of the members they are serving is a more straightforward approach to actually getting to improvement. So that's my two cents about it.

MS. BROOKS: Thank you, Kristine. And I think, you know, you made a, or you used the word improve, which I think is kind of key also here in this discussion in that oftentimes those are improvement goals that are being set, for example, by-Alice has her hand up-by Covered Cal or by DHCS. But we

are really looking to set a standard here so yeah. Alice.

MEMBER ALICE CHEN: And just to answer Kristine's question. I don't, I don't know if it is more straightforward because, frankly, health plans think line of business so I think in some ways it will cause some consternation for health plans. And I think, if we are willing to kind of embrace the complexity and/or like really embrace the fact that we are trying to set a minimum level of performance and floor so we don't overreach. Having a single standard I think really puts us on a path in California to do real population health improvement. Because you can't do population health based on line of business and you certainly can't reduce disparities by line of business. I mean, it really just has to be a community-wide thing. So I think it would be a huge signal with a lot of complexity.

And so I do want to say, you know, I really, Mary, appreciate this calling out that the primacy is equity and it is not kind of quality improvement with the veneer of equity and I think that's really important.

And what I would say is the state of race/ethnicity, SOGI disability data, the state of methodology is such that it is a little bit like some of the quality measures we were talking about. Like we would love to choose. I mean, obesity is a public health scourge. I mean, I have given talks on it. If you look at the rates it is crazy. And the data is not there. So it is really hard to choose that as a measure if you actually put all this effort into it and you are not going to actually see population health improvement. So I worry that we are doing this on the disparities. And I wonder, if we do land on a single measure across lines of business, in some ways that is our equity frame. That is radical. I mean, I look to Kristine to confirm this but I think that is pretty radical in the health plan world

to say, we don't care if your Medicaid or Medicare or you know, Commercial, but we are going to actually hold you to the same, you know, minimum performance threshold.

And in some ways that in itself is an equity measure while we figure out how we approach this stuff because I do worry. And many of you know I have been working in this space for two decades-plus. I do worry that there are opportunity costs and it also rolls down. When we make a requirement on health plans it lands on providers. I can speak to that, you know, in great detail with Prime and QIP and things like that. And so I think if there is any way to figure out some, some flexibility and figure out how to both push as hard as we can without getting ahead of the curve, I would really encourage us to, to do that.

MS. BROOKS: Thank you, Alice. Alex.

MEMBER ALEX CHEN: Hi, everyone. I do want to, just to kind of echo what Alice has said and what Mary has said earlier. And I think this is for everyone on the Committee just so that we have sort of straight clarity, right. So first of all, we are looking for floor, right? We are not looking for seating. So that is important to just remember.

And the second thing is that I think what Alice said about simplicity, it is obviously correct. But I do want to say that the reason health plans think line of business isn't because health plans like to divide membership by line of business, it is because historically benchmarks by line of business differs. So we have to disaggregate out how we manage each line of business differently because the benchmark and the target is different. So I will be more than ecstatic if we have one target for all lines of business for all members, right.

So this really kind of echoes for Ignatius is saying is that the whole

point about the equity exercise is that we need to be consistent. We don't want anyone to be worse off than anyone else based on their natural characteristics. So by definition, there shouldn't be any distinction by line of business, by the way they are financed or by the way they are paid, right.

And then this brings me back really, just really strongly to Mary's point that this is an equity exercise. This is about nobody being left behind. We are not trying to do quality improvement by setting a particular target to raise the tide, we just want to make sure that nobody gets left behind. So from that perspective, if we are going to be philosophically consistent I think the way we will be choosing measures isn't a blended benchmark or blended target that, you know, the quality (indiscernible) can put together. We may want to consider something like the following. And I don't have a solution, this is just a philosophical question and suggestion.

That if we have data by racial/ethnic status let's say, and we have national data where White members are at 60% for colorectal cancer at 50 percentile, then we should expect the floor to be any other race be at 50 percentile nationally of the same benchmark as the White members are, regardless of whether they are Commercial, or Medicaid. And that is the consistent sort of approach where nobody gets left behind by race or ethnicity.

So I just want to make that clear. I don't know if that's possible but we should be setting benchmarks like that. But again I wanted to really call out, I am not suggesting 50%. I think it may be 33.3% or 25% because remember, we are setting floors, we are not setting ceilings. And we need to have a reachable and practical goal to begin with because otherwise you are going to turn everybody off and they are just going to give up.

MS. BROOKS: Thank you, Alex; very helpful, very helpful. Diana.

MEMBER DOUGLAS: Thank you. Can somebody help me understand just how the NCQA stratification by race/ethnicity comes into play? Because that was such a part of our discussion as we were selecting measures and I am struggling to understand. If the measure is stratified by race/ethnicity but the benchmark is overall then at what point does that come into play? And maybe this is basic and I missed it. I am trying to put the pieces together of how the measure being stratified then results in a benchmark or down the line being able to look at that stratification. Is there any way that it is weighted in some way or how does that come into play at the other end?

MS. BROOKS: So I think that is a great question and something we were intending to discuss later in the presentation. But let me just see, Ignatius, maybe you have a couple of comments here, that we can talk about?

MR. BAU: So I think when we, and Kristine should jump in here. I think the plan is, the hope is that once we get sufficient national data that we will be able to, at a national level, unfortunately, confirm that disparities exist. That we suspect that those disparities are there so it will be hard for an individual plan to say, I don't see any evidence nationally that those disparities are there. And then ask each plan in a quality improvement approach to look at its own data and say, does our data for our plan match what we are seeing at the national level, and that should motivate us to then do something to develop interventions, work with those communities to try to reduce those disparities.

I don't think NCQA is at the point yet of then setting additional sub-benchmarks for how those disparities reductions are going to occur. And I think that's, again, going to be the next conversation, I think. What the collection of

data by NCQA for these HEDIS measures will do will create the evidence that is undeniable and will create the motivation for people to actually act. To the extent that the evidence isn't already there and the motivation shouldn't already be there, but again, it will be now much, much more transparent and accessible to everybody.

MEMBER TOPPE: I can jump in if you, if it is appropriate.

MS. BROOKS: Yes, go ahead.

MEMBER TOPPE: So thank you, Ignatius, because you are always so very eloquent. But I think the -- where we are now as we kind of described before is that we are just starting this data reporting. You know, the measures have been identified, the first five for this year, another eight for next year. And those data will come in for the first time, you know, next year and then the following year. So we don't know what that's going to look like. We have ideas based on testing. Obviously, we don't go out -- we don't put these kinds of requirements in place without a heavy amount of testing and stakeholder input to make sure that we are putting things out that are realistic.

But as has been stated, the kind of state of race and ethnicity data collection at a minimum is still evolving. And we are trying to assert, you know, that getting data directly from the member is the gold standard. So that is another facet of this, which is really critical in terms of understanding, you know, how a person self-identifies. And so that is --

I think in the last meeting or a previous meeting somebody raised the idea of the health equity accreditation, which is the kind of the structure and process requirements that many of the plans in California will be going through to kind of get at a lot of this infrastructure building and then the subsequent

reporting that goes along with that, which some of these measures are, you know, a part of. So I think we don't know what that --

In terms of your question about the benchmarks. We are going to, when the data come in, we are going to see what they look like, we are going to see how robust the direct data is, the indirect data. And as we, as we analyze that we are going to have to, you know, we ideally would get to something that we can put out, you know, as soon as possible for folks to like start looking at this data to the point that Ignatius made. But we are in this, we are in this kind of discovery, initial launch all together.

MEMBER DOUGLAS: Thank you, Ignatius and Kristine. I guess I would, I would say then as we look ahead to what will be in the report, I hope that there will be very sort of clear sort of outlines of future steps of what we can expect into -- since the stratification in that data coming along is a little bit on a kind of a separate track from the benchmarking, in a way, I hope that the report will also kind of guide the path, even though we are not there, of where that information when it is available should take us and how it should be used.

MS. BROOKS: Thank you, Diana. And definitely we are taking that into account hearing that; we have heard that and hear that today So thank you. Wanted to flag because Cheryl cannot raise her hand right now. She just wanted to say that she is a plus-one for you, Alice, in terms of your comments; so just flagging that. Palav, your hand is up next.

MEMBER BABARIA: I just wanted to sort of underscore and lend support for Alice and Alex's comments on having a unified benchmark. I will also say, when we look at sort of the racial and ethnic distribution of numbers, Medi-Cal serves a disproportionate number of communities of color and so

benchmarking by service line inherently will also potentially exacerbate some of those racial and ethnic disparities because the population is not evenly divided across payers.

MS. BROOKS: Thank you, Palav. I am not seeing other hands raised right now. I think, you know, I want to ask the Committee if you have any recommendations as to kind of the direction that you might want to go if we weren't going to go with the approach that we have proposed here in the slides, if there are other thoughts about that? Ed.

MEMBER JUHN: Can I just maybe ask a clarifying question because I do think Alice brought up a great point. And Alice, I apologize if I may not have interpreted this correctly. But I think you had mentioned a point that just creating a single, I guess, benchmark, for example, for a measure in itself would be, I guess, not only groundbreaking but by definition, equitable in itself. Was that, did I hear that correctly as sort of the approach to take as opposed to potentially looking at all the subpopulations and then setting separate benchmarks or is it a combination of the both? Just wanted to get, make sure that I was tracking.

MEMBER ALICE CHEN: You know, I was, I was saying that as a way to essentially repeat without repeating my request that because a lot of the more granular disparities methodology is still in play in terms of when you stratify by any given demographic factor, assuming you even have that demographic factor in hand, there are so many questions about, do you use only self-reported versus imputed data? Do you use? Who is your reference population? Is it the best performing group or the average group? Who is your target population? Does it, you know, change? And then what actually constitutes a disparity in

terms of percentage difference? You know, what is a statistically significant improvement? There are so many questions on that front that it feels to me like we would be premature if we tried to set benchmarks by, you know, different groups, and so I was thinking just on a general population level, you know.

And when I presented I said, you know, I am not advancing any particular point of view, I think there are pros and cons. I do think, from this, just hearing everyone talk from an equity frame, having one, one single standard, the benefits does outweigh the limitations as long as you, you know, are cognizant of what the unanticipated consequences might be.

And then the question becomes, as a placeholder, depending on where we choose it, could we then say, whatever stratification we are ready to go out with, everyone has to meet that floor. At which case it needs to be a fairly low floor, I have to say, if we are going to say everyone. And there will still be room for improvement by doing that we maybe inch it up over time. Or not even inch it but we like start really pushing on it over time as we get more learnings from NCQA and the national data.

MEMBER JUHN: Great, thank you.

MS. WATANABE: Alice, can I just maybe ask a very pointed question? If we picked the national Commercial 25th percentile across the board, and let's just say that applies to Medi-Cal, Commercial, all measures regardless. And what gets reported is overall quality score for each measure but also the percentage for each, let's just say racial and ethnic group to the extent we have the data. Like, is that, is that what you were talking about?

MEMBER ALICE CHEN: Yes. And I would say, I would hesitate to land on both the number of 25th and Commercial without actually having that

spreadsheet in front to really look at, here are the final measure set and how does the distribution work. But I think for simplicity it would be great to say, we are going to choose this benchmark across the board. I just, I do think there could be unanticipated consequences.

MS. WATANABE: I just want to make sure just from an enforcement perspective and from a regulation perspective that is very easy and simple. And I think being able to apply that across the various demographic factors as the data becomes available also helps. But I just wanted to make sure if that's like the example that would get to what you are saying. And I am seeing a lot of nodding heads so I think it is. Thank you.

MEMBER ALICE CHEN: And can I just say two quick things? Which is one is, again, not to have a poverty of ambition. But if we were going to do that, depending on what the data shows I might start pretty low at 10%. And I would absolutely want to frame it in the way where people recognize that it is not just the health plan that is moving it. Anyway. Because we know that a lot of the things, for example, that CalAIM is trying to do are squarely recognizing that it is not just within the traditional health care system.

MS. BROOKS: Okay, thank you, Alice; thank you, Mary. Kristine, your hand is up.

MEMBER TOPPE: Yeah, I was just thinking, if we are not going to vote on this today, to provide an example of that. Maybe it is -- because your spreadsheet I think gets to some of that and maybe it is a matter of like literally just kind of teeing them up. And I don't know if you can do that in slides. Because there are some, there are some measures that are like all green in Commercial and, you know. You know, there's the combination at the 25th so

there may be a way to make that clearer. Kind of the implications, at our next meeting, if we are, if we are tabling this.

MS. WATANABE: I will just note about what we can and can't present at the meetings, just to give you all some context. Our slides have to be at a minimum of a 24 point font and so that is why many times you see data presented across slides, you don't see a lot of graphs. I will just highlight that we are starting to send you more materials in advance and post materials in advance because of our limitations with the slides and so I just would encourage you to look at those materials we are sending out in advance because we are trying to share some of that more technical information that we can't squeeze into slides.

MS. BROOKS: So I have heard some different -- I see some hands up. Bihu, go ahead.

MEMBER SANDHIR: Bihu Sandhir from AltaMed. I think, Mary, actually, you really kind of hit the nail on the head right there with what you said. What I think would help us all because this is a lot, it is very confusing, is just to map it out. If we -- I think Alice showed us all the different. I am not saying we need all of those, like all the way to the 90th percentile. But if we could see at least what this looks like. What is 33.3rd percentile? What is 25th percentile for Commercial and for Medi-Cal? And if we look at that, you know, I think that will give us some direction for the measure and it might help us then make this decision. Because I think the decision is going to be one thing in the end but the question is, I think what is missing here is there is no data for us to understand it, to see it visually. I think that would really be helpful.

MS. BROOKS: Just a follow-up question, Bihu. Are you looking for

the data in a different way?

MEMBER SANDHIR: Yes.

MS. BROOKS: Because we have provided all the data to you guys.

MEMBER SANDHIR: Yes.

MS. BROOKS: And so I just wanted to understand how you are looking for it.

MEMBER SANDHIR: Yes. So like this. So sorry, Sarah. The example like this example that you showed with breast cancer screening. If we just, I am not sure if we can get back to that slide. But if we could show what is the 25th percentile, what is the 33.3rd percentile for Commercial and Medi-Cal. So right now when I look at it, to me the concern here is there's such a difference, you know, between Commercial and Medi-Cal. I understand, you know, us being equitable, but it is like we are bringing down to me the benchmark for Commercial where we already performing so high on that. So what is something that kind of meets us in the middle there? Yeah, you could have gone back to even this one, okay. So what we don't have is the 25th percentile, we don't have a 33.3. Those are things that we didn't maybe think about, I didn't think about 33.3 percentile. But maybe see what it is and look at the, see what that is and see how it relates. Maybe it will help us actually maybe pick what we need to pick here.

MS. BROOKS: Janel, is that information in the workbook right now? I am just not remembering.

MS. MYERS: Yes.

MEMBER SANDHIR: Okay, it is, okay.

MS. MYERS: It is. I would just encourage everyone, please look at the workbook. You will find the state and national 25th, 33.3, 50th and 75th percentiles. And, you know, you know, 66.7 isn't in there but you can kind of guesstimate that it is going to be between the 50th and the 75th percentile. So that's available for both the Commercial and Medicaid 2021 performance rates in your workbooks. Thanks.

MEMBER SANDHIR: Okay. So maybe we can look at that and then make the make the decision. Okay, thank you.

MS. BROOKS: Thanks, Janel and Bihu. All right, Diana.

MEMBER DOUGLAS: Thanks. I think, you know, I see in the workbooks those percentiles. I think prior to this conversation, you know, I think this conversation has helped give context and maybe like others it would be helpful to sit with some of this and be able to dig in, you know, in the meantime and then come back and vote on this is what I would personally recommend.

And I think also just in terms of the discussion on what percentile we would land on. You know, the conversation is maybe leaning towards or focusing on, I think, some fairly lower standards and lower percentiles than I would like. I know we also need to be realistic and hit, you know, reachable goals. I would also encourage us to look into the possibility of having a sort of increasing or stepwise approach, or it could maybe start out at one level but increase. Because when we are talking about percentiles as low as, you know, 25% or so forth, I think we would like to see those standards increase over time. And I think we don't, I don't want to focus too much on setting a floor that is lower than maybe we should be aiming, especially as we consider that these will be in place for a number of years going forward. So I think whatever we can do to

have the conversation of what it would look like increasing those over time would be helpful.

MS. BROOKS: Thank you, Diana. Janel, your hand is still up, is that from before?

MS. MYERS: Yes, I apologize.

MS. BROOKS: Okay, no worries. Go ahead, Silvia.

MEMBER YEE: Hi, Silvia from DREDF. Yeah, I certainly understand the approach, the simplicity and the desire for that, especially in a regulatory environment. But I guess I am just going to make a brief sort of plea the other way too and maybe. So the improvement approach of the three is not the simplest, clearly. But it is one that would provide some carrots, some incentive to every plan to actually improve. I am always a little -- and also to, you know, eventually to get that stratified information on race and ethnicity.

I know the numbers can be, can be low, it can be 10, 25%, whatever that percent is. And then I am always fearful, you know. Eventually we will get to the stage where we get the demographic information and it is like, oh, I guess the people who weren't getting served were the people who are of color and the people who are -- that's sort of in my head and I don't want to discover that in four years, or five years. I would like plans to be incentivized to be doing that, to be finding that out as soon as they can. So that's, I am not speaking against simplicity, I am just saying there has to be a balance here of being aspirational and then our understanding that you are in a regulatory environment and you have to attach consequences of being realistic as well.

And I apologize, I have to run and get a child who will be raging at me for being late so I will see you in a while.

MS. BROOKS: Thank you for your comments; we appreciate your participation. All right. So Kristine, why don't you go ahead.

MEMBER TOPPE: Sorry, I just had one last kind of question for the group as we are going back and looking at this. My question is related to what DHCS, Covered California and CalPERS have as their benchmark. Are they using the national or the state for their various initiatives?

MEMBER ALICE CHEN: Covered California is using national QRS benchmarks.

MEMBER ALBERS: Same with CalPERS, the National Quality Compass.

MEMBER TOPPE: Okay.

MEMBER BABARIA: Yeah, the same with DHCS for Medi-Cal. I will say we recently increased our minimum performance level right before the pandemic to the 50th percentile nationally. And so obviously if we did at a state level it is like a losing proposition because half of your plans would not meet your minimum performance level, which defies the purpose of having a minimum performance level, but we do think that's achievable using national benchmarks.

MEMBER TOPPE: Okay, thank you. That's helpful because I think in looking at those data then if you can line up the columns, you know, and look at the national benchmarks at the 25th and that will just, I would think that that would help folks just kind of understand what the potential implications are. Thank you.

MS. BROOKS: Andy, it looks like your hands up,

DR. BASKIN: Yeah, I just want to make a brief comment about percentiles and maybe put it in a little different light for people to think about. So,

you know, without actually running the numbers, but I am pretty confident that if every plan, if we were successful and every plan was able to make it to the 25th percentile, meaning they are at the 25th or higher in terms of how well they are performing on any given measure. If we were successful doing that then probably California would be the best performing state in the United States out of 50 states. I mean, that's, that's what that percentile would mean. To think that every plan could get to the 33.3% or 50% for sure is just, I would say virtually impossible that every plan could do that. Because remember, there's plans across the country that are all trying to improve as well in other states.

So, you know, this benchmark of percentile number will change from year to year as all the plans in the country improve and there's other efforts out there to do that. So I just want people to understand what that percentile really means in a very practical basis. I mean, it is actually even possible that if every plan in California got to the 10th percentile or higher we could be one of the highest performing in the country. But certainly at the 25th percentile I would without doing the math be assured that you would be in the top one to five states in the country. I mean, that's how percentiles work and I think people have to realize that as they think of the aspirational goals or the kind of conversation we are having. Thank you.

MS. BROOKS: Thanks, Andy. So I see a couple more hands up. I think let's go and hear Jeff and Alice and then I have a couple thoughts just based on what I have been hearing and I want to circle back with you on just to get some feedback. Jeff, go ahead.

MEMBER REYNOSO: Yes, just in terms of -- Jeff with LCHC. Just in terms of what would be helpful, and consulting team, let me know if this is not

feasible. Could we in the data workbook add kind of on the lower end just to complete the distribution of the data? So I believe that's the 10th and the 5th. Not to say that I am leaning that way but it would be helpful to have the complete data. And I am wondering, and this may not be possible, but it would be helpful if we were to choose like 25 versus 10, you know, how much of a gap there is between Commercial and Medicaid plans? So are we closing more of a gap at that 10% versus 25%? I am not sure if I am like, asking the question correctly. But I think, you know, I think having a sense of what that gap looks like. I know we can go back and forth but just having that column and that data there for us to be able to look at the differences I think would be helpful in our discussions.

MS. BROOKS: Sure. So I think great comments, Jeff. And Alice, I am not forgetting about you. I think that kind of connects to what I was going to say, which is, you know, I think what I am hearing from the group is that -- so please correct me if I am wrong. Is that, you know, we are focused more on setting a floor as opposed to, because we recognize this isn't an incentive program. And so likely the -- and I just heard you ask, Jeff, for the data on the 5th and 10th percentiles. We would be looking to select from the 5th, 10th, 25th, 33.3rd percentile likely is what I am hearing from the group. And so if we could put data together for you all that reflects the 13 measures, like I said it would be 12, the 12 measures, with CAHPS it makes it 13. That have been selected for recommendation to move forward. We have provided this data to you also. We would need to, you know, we would show it to you again, you know. Would hope that you all would look at it before the next meeting if we weren't going to move, well, yeah. If we weren't going to vote today and then, you know, be able to take a vote pretty quickly at the next meeting based on your review of that

information. And so I just wanted to get feedback from the Committee in terms of if I am hearing you correctly, and what your request is. And I am taking silence is probably that I am on, I am on track.

MEMBER SANDHIR: That's okay.

MS. BROOKS: Okay, okay. And I have another question for you but let's go with Alice and let's go ahead with your comment first before I go on to my next question, I just wanted to tie in to what Jeff was saying.

MEMBER ALICE CHEN: As a non-voting member my reflection would be it would be really helpful to have the 12 measures and focus on the national for exactly the reasons that Palav raised. And then start with, I don't know about 5, but I mean, it is good to have if it is there, 5,10, 25, 33, 50, and I would probably stop there if we are talking about a floor and see what the -- and then see Commercial and Medi-Cal, that would be great.

The other seed I wanted to plant and I had mentioned this in Covered California's approaches and I think it would also be consistent with regulatory simplicity is we choose a benchmark by percentile performance because that is how we think about what is possible. But it tracks to an absolute number and we stick with that absolute number for the whatever, three to five years of the regs. Because that way, again, everyone knows what they are working towards rather than having a shifting target over time. If there's a place already, where we are going to be revisiting and resetting I think that makes sense for the, for the health plans.

MS. BROOKS: Thank you, Alice. I am just taking some notes. Andy, you have your hand up.

DR. BASKIN: Yeah, just to the point about the shifting over time.

So if let's say you pick the 25th percentile. Yes, there is no doubt that the 25th percentile absolute, the actual number of how well the 25th percentile plan performs will change from year to year. But think about that. It takes into consideration the fact that there are many external factors that occur. So what if we had had a static number and COVID came along? Well, that would have thrown that out the door. So having that shift in numbers, it is actually maybe not a bad thing. It has some other benefits to it. And it is, it is not necessarily new to plans because any plan that has a Medicare Advantage plan that is in the Stars program knows that that's exactly how the Stars program works. Your target shifts from year to year and in fact you don't even know what it has shifted to until after the year has already been completed. So it is not exactly something that plans don't have some experience with. I wouldn't necessarily say you have to have a static number that lasts for five years as opposed to a percentile, which stays for five years, but the value that percentile represents actually fluctuates from year to year.

MEMBER ALICE CHEN: Sarah, can I just mention one, so two quick things. That approach hasn't really resulted in significant improvement over time and I think that's -- I mean, part of it is what are these measures being used for. And I think, again, when you actually then drill down into the delivery system, which is where the care actually happens, people need a target to shoot for and that's how most QI programs get situated. So it is a -- and I think your point about the pandemic is really well taken. And hopefully, you know, if there's something that catastrophic then oftentimes we put a hold on all sorts of things, right. CMS is right now not even publishing hospital quality or safety measures two years out because of some of these concerns. So I think that would be a

bridge we would have to cross when we get to it.

MS. BROOKS: Thank you, Alice, I think that's helpful. And I see Bihu, you have your hand up.

MEMBER SANDHIR: Bihu Sandhir from AltaMed. So I actually kind of agree with Andy because I think we are looking at 25th percentile of a national benchmark, which will fluctuate, is how I understand what we are looking for. So if we are going to go with NCQA as being our, is what we are going to use, then I do envision it is going to change every year. Now when we do QI even, you know, we, the part that I think is hard for us is it comes out so late sometimes, that's the problem. It is not coming out exactly before when you actually need it, which is the beginning of the next year where you, you know, when we are setting up our goals. But I do think some fluctuation I think is going to be, is understandable. I actually agree with Andy's point that if there's things that come up and they change in that way we can we can work with that in some ways. So although there is a delay that's the part that we have to take into account is the delay in when we get those benchmarks, which is really out of our control at this point. So I think we have to, we have to think about that.

MS. BROOKS: Thank you, Bihu.

MS. WATANABE: Sarah, can I just make sure I understand. Alice when you say an absolute number, for example, do you mean we would say the measurement year 2023 25th percentile and that would be the benchmark in place until we revise it?

MEMBER ALICE CHEN: (Nodded.)

MS. WATANABE: Okay. I just want to make sure when we talk absolute versus one that is tied to the Quality Compass that would change year

over year that that's what we are talking about. Thank you.

MS. BROOKS: Okay, Kristine.

MEMBER TOPPE: Sorry, now I am confused. So, Alice, what I thought you meant was, you pick the actual rate in a given year that is tied to a measure's performance. So in the example I think I pulled out of the spreadsheet it was performance, it was like 63%. Well, anyway. So were you suggesting that we use, like keep that number, that 63% stable?

MEMBER ALICE CHEN: (Nodded.)

MR. BAU: (Nodded.)

MEMBER TOPPE: Just as a yes? I am seeing people nod.

MEMBER ALICE CHEN: Yes. I was suggesting that basically you, you start with the relative because that is kind of what's possible and then you anchor on it for the improvement period.

MEMBER TOPPE: Right.

MEMBER ALICE CHEN: Here is your target. And you don't then say, well, 63% became 58% so now the target is reduced. You know, you just know where you are shooting for the next five years on these 12 measures.

MEMBER TOPPE: Yes. And that's the approach that you all have used with locking in the rate, right?

MEMBER ALICE CHEN: (Nodded.)

MEMBER TOPPE: Okay, just thank you. Lots of heads nodding and so I just want to make sure I am clear, thank you.

MR. BAU: And I just wanted to jump in and just get clarification, both from Alice for Covered California and Palav for Medi-Cal that that's the methodology when you said, minimum performance, Palav, was at 25 percentile

and now is that 50 percentile, that that was a lock for that contract period?

MEMBER BABARIA: For Medi-Cal, we do not lock it, we update the benchmarks every single year. So we do it differently; I think that's how we have always done it. The major downside is obviously the benchmarks, the date at which we get those and they are locked in, there is a time lag, which I do acknowledge is frustrating to everyone.

MEMBER ALICE CHEN: And just to share our thinking. So we, for example, in our performance guarantees still retain some penalties connected to consumer experience QRS measure set. That gets, that's just a 25th percentile, or actually it is two stars, but it is relative year over a year. And the star system is even more relative than the 25th percentile actually, it is a little bit more, less transparent. The reason we decided to go with the fixed benchmark on 20, on our floor as well as the QTI is because there is so much riding on it. It is your participation in the marketplace. Or in the QTI I didn't mention but we start off at 1% premium at risk going up to 4% premium. Our entire budget is funded on 3.25% premium. So the idea was it is such high stakes that we wanted to give people clarity. And that was actually the feedback that we got from our health plans. So it may not, I don't know how. I mean, I am hearing from health plan colleagues that they prefer relative, which kind of blows my mind, frankly, because you don't know where you are headed. But on the other hand, if everybody does worse then you get a lower benchmark.

MEMBER ALBERS: Yeah, I would just say that CalPERS currently does what DHCS does as well. We use Quality Compass and it is updated every year for our 50th percentile. And part of that too I think is because we have five year contracts and so we were uncomfortable keeping that benchmark

static for five years.

MEMBER BABARIA: Yeah. And I would just say I think from the DHCS perspective, I think we did it similarly because our contracts lasted a really long time so we updated annually. And prior to the pandemic I wouldn't have seen, you know, a lot of problems locking in. I think, obviously, what we have seen with the pandemic is just vast fluctuations year to year and I have stopped trying to predict what's going to happen with this pandemic, or any future ones that come our way. So that may be one, something that we want to consider.

MS. BROOKS: Great. Thank you to everyone for your very insightful comments and thoughts and feedback during this discussion. I think what we heard is that we need to come back and provide the information to you in a little bit, and it will look differently. It will be focused on those lower benchmarks or percentiles as we talked about earlier. Looking at how we can demonstrate difference between Commercial and Medicaid but I think, you know, being clear that it is going to be different for every benchmark and so, you know, it will vary. But we will prepare that in information for you all.

I think what we should do is move on and talk just in the remaining time that we have, talk a little bit about benchmarking for measures that don't have Quality Compass data, just so we can talk a little bit about that. And then we will close out and continue our discussion next time if that works for everybody. So with that, we are going to move on to Slide 78.

Oh boy, okay, there we are, here we are, okay. So benchmarking for Measures Without Quality Compass data. So for measures without Quality Compass data the Committee will discuss today or start discussing today an alternative recommendation since there currently is no comparative state or

national data for Medicaid and Commercial plans to use for benchmarking purposes. So these are measures where Quality Compass NCQA benchmarking data does not exist. These recommendations will be not be voted on but rather included in the report for consideration by the DMHC, just recognizing that there isn't an action that can be taken in response to them given that there isn't data quite yet available. Next slide, please.

So let's see. All right. So looking at some discussion questions here. We are wondering if does the Committee have any recommended approaches to set benchmarks for measures without Quality Compass data? So I mentioned there isn't benchmarking data available, wondering if the Committee has recommendations.

We have an example here. Year 1 or more years may be used for collecting baseline data and in subsequent years benchmarks may be set.

So the recommendation: Measures without Quality Compass data will be report-only for X number of years prior to a benchmark being set. Next slide, please.

So that's pretty much it. I know that was pretty short in terms of the presentation but there isn't a lot to say outside of the fact that there isn't data available. If there are recommendations as to how we might benchmark this data or data that are available we certainly welcome that. But wanted to open it up for discussion here today and then likely lead to a recommendation for the report based off of that discussion. So let me see. I don't see hands up yet but let me just see who may have some comments, questions, feedback. Bihu.

MEMBER SANDHIR: Bihu Sandhir, AltaMed. So we don't have benchmark data so is it possible since this is a five year program to maybe think

about maybe saying for the first couple of years to collect the data so that way we could actually consider benchmarking it, is that an option? That might be one way of doing it. I don't know. I don't know of any other options but I am just throwing it out there.

MS. BROOKS: And I think definitely would like to hear from the DMHC. I don't know if Sara has comments on that with respect to --

MEMBER SANDHIR: I just want to give you an example. Like we have like CMS is coming out with the Health Equity Index, you know, for next year. They don't have, I doubt that they have a lot of benchmark data. But that's kind of how the approach most likely I would think would be that you, you know, you give it, it is over a few years. You figure out, picking up, getting data. And then from there you can benchmark. We have done. That's what I have seen them traditionally do with other measures. And then eventually you start having standards and then you keep on improving in them over the years. So that's, that was just the thought process. Thank you.

MS. WATANABE: I am just going to take a stab at this. But I think potentially we could use the first two years' worth of data and say it is the 20th, 25th or 50th, whatever the percentile is, of the baseline data based on the first two years of reporting. I think we could maybe put that in regs; Sara? It is not a number.

MEMBER SANDHIR: Yes.

MS. WATANABE: Can you get creative with that?

MS. DURSTON: I think that's fine.

MS. WATANABE: Yeah.

MS. DURSTON: I think that's fine.

MS. WATANABE: Okay.

MS. DURSTON: Yeah. I mean, if the question is whether the Office of Administrative Law will think that's fine, but based on other things that we have done I think that would be, that would meet their requirements.

MS. WATANABE: I think so too.

MEMBER DAMBERG: Mary, this is Cheryl Damberg. So the first few years you would say that at the 25th percentile, relative performance within the state. And then using those data, say in subsequent years, you would move to setting say an absolute number per our earlier discussion?

MS. WATANABE: I think the challenge will be the timing. If we have to put an absolute number we would have to probably amend the regulations because we would need we need to collect the two years' worth of data to know what that absolute number would be and by that time we would have to have the regulations in place. But I think as long as we can tie it to something and be descriptive enough I think it will work. Similar to tying it to the national 25th percentile or something in the latest version of the Quality Compass, like there has to be something tangible we can tie it to. Sara, are you feeling okay? Sara is nodding, kind of.

MS. BROOKS: Will you ask for the transcript?

MS. DURSTON: Yeah, I think that's fine. I think, you know, saying for the first two years it will be the 25th percentile and then I think it would be easy to say, you know, after the first two years it should be the 30th percentile. But I think, yeah, I think what Mary said, I think it should be fine. We will just get a little bit creative with our, we'll just make sure we justify it.

MS. WATANABE: I think what would happen, and someone can

correct me, but I think for the first two years there would not be a benchmark because we wouldn't have data. So we would have to collect two years' worth of data and starting in year three the benchmark would be whatever percentile we say, based on the first two years. I am guessing. Someone can say that's wrong but I think (overlapping).

MEMBER SANDHIR: No, Mary, that's exactly what I was trying, I mean, you said it much better than I did. But that's exactly what I was kind of, that's the thought process I had at least on this. Unless there is some data, but it sounds like that's what we are missing. So you get your data and then from that you can benchmark to 25th percentile, which will then be consistent with whatever. Well, if it is 25th percentile is what we choose, but it could be similar to what we choose with others.

MS. WATANABE: Yeah.

MEMBER SANDHIR: But I guess Andy says no. So what is it? We need help here.

MS. DURSTON: I --

DR. BASKIN: Go ahead, Sara, I'm sorry.

MS. DURSTON: Oh, sorry. This is Sara Durston from the DMHC. I do want to say one piece we might have a problem with is that the underlying statute enacted by AB 133 references that starting in Measurement Year 2025 we will take enforcement action for plan deficiencies for failures to meet the standards set forth in the regulations. So that suggests that we maybe should have some sort of a number in place by 2025 rather than just having it be data collecting still at that point, but that's something we can look into.

MS. WATANABE: I think we will be okay because I think by 2025

we will have collected Measurement Year 2023 and Measurement Year 2024 data so we will have it to be able to determine what that percentile is. The tricky part is if someone asks us what that is while we are in rulemaking we wouldn't have it, but we would have a description of what it would be. We could try, Bihu. OAL may say no but we can try.

MEMBER SANDHIR: Innovation here.

MS. WATANABE: Yes.

MS. BROOKS: I see a couple of hands up.

MEMBER DAMBERG: Do you have to have two years' worth of data?

MS. BROOKS: Sorry, go ahead, Cheryl, what did you say?

MEMBER DAMBERG: Yeah, I guess I am trying to understand the rationale for two years of data versus one year of data.

MEMBER SANDHIR: It is just -- with some of the work I have seen with Medicare in the past, the innovation part is usually about a couple of years of data. But there is no, there is no scientific, any basis to that. I mean, we are open to anything at this point. That's why I think I would like, you know, I think Kristine and Andy, I mean, they have got some subject matter experts to see how they do it, that would be helpful to us.

MS. BROOKS: Yeah. I think one thing is, if you -- one thought. And I am certainly not an expert. But in terms of using two years data is if the denominator is too small then you will have a better data set to work with, right?

MEMBER SANDHIR: Yes.

MS. BROOKS: So I see a couple of hands up. I am going to ask those and then I have -- I kind of hear what you guys are saying I think already

so I will repeat back what I am hearing. But, Andy, I think you have a comment real quick.

DR. BASKIN: Yeah, a real comment real quick. I just want to point out, and no offense, Mary, but it is not actually the same if you set 25th percentile for the other measures, to set it for this measure. There is a fundamental difference in that the 25th percentile for these measures would have been set on only California plans so they would be competing against themselves. And the ability for them all to hit the 25th percentile in future years when they're not getting better than the rest of the country, they are going against themselves, there's always going to be plans that are, that are, you know, at the lower end. I would caution that if you set a percentile only based on California that you use a lower percentile than whatever you pick for the ones that are competing against the national. And then basically after one year find out let's say what the 10th percentile is and then that result would be the static number that would remain forever. In other words, you wouldn't fluctuate that one from year to year because that would be very hard to do, and especially hard to do in your statute. But you could do it in your statute by saying after one year we figure out what the 10th percentile is. And by the way, you have the option of doing the 15th percentile or 20th because you are calculating it yourself so you are not limited to 10 or 25. And then setting that as the floor for the rest of the program. That would be from a practical point of view easier to write into regulation and to implement.

MS. BROOKS: Thank you, Andy. All right, it looks like Kristine's got her hand up and then I think I am going to circle back. Go ahead, Kristine.

MEMBER TOPPE: Yeah, just real quick. All the measures that

were selected, they will all have benchmarks by, they all are HEDIS measures. So there's only two that don't have benchmarks, colorectal cancer screening for Medicaid, which has now been specified for Medicaid so there will be benchmarks. And then the second measure, which is the depression screening and follow-up, which I think was modified, which is why there were not current benchmarks. And so those will have data available within the next couple of years so just -- I realize that the Department is not bound by this list so the exercise is still necessary but I just wanted to level set in terms of what was being recommended.

MS. BROOKS: Thank you, Kristine. So I think what I am hearing from the group is that there is a recommendation that for measures where there isn't Quality Compass or other benchmarking data available that DMHC would utilize the first two years of data for reporting-only, those would be reporting-only years, and then a benchmark would be set based off of the first two years of reporting for Year 3. Did I hear that wrong?

MS. MYERS: Sarah, I just want to reiterate what Kristine just said that, you know, we prepared this part of the slide deck, anticipating if those measures that we reviewed today might get voted on, then we would have non-HEDIS measures to talk through. As Kristine just pointed out, we now have a set that's finalized and is largely made up of measures that are HEDIS and have the Quality Compass data available and it sounds like relatively soon. So I would ask Sara D, are we able to craft language that says once that data becomes available that it would use the same methodology that we are proposing for the other measures where that Quality Compass is already known?

MS. DURSTON: And the short answer is yes, I think we would

be able to do that.

MS. MYERS: Okay, so I don't think that -- and Sarah Brooks, correct me if I am wrong if you are hearing something different. I don't think that we need to dive into this. It sounds like we are going to be able to craft language and just use the same methodology so I think we can wrap this topic up.

MS. BROOKS: Yeah, I think you are right, Janel.

MR. NAU: Well, Sarah, this is --

MS. BROOKS: Go ahead, Nathan.

MR. NAU: Sarah, this is Nathan, I am not, I am not sure. Maybe it is better to have a little bit of a conversation on it if we could, if we are close to having a recommendation, because it is not a guarantee that we would auto-select all the, all the recommendations by the Committee, although that's probably, you know, something that we are looking to do. But there could be a case where the measure set that is recommended isn't the final set, if that makes sense?

MS. BROOKS: No, it definitely makes sense and my apologies. Because I thought I heard from the Committee that there was kind of consensus but maybe I misread so if I did, I apologize.

MR. NAU: Yeah, yeah. I just want to make sure there is and if there is we can get it put in the report in case we get to a situation like that.

MS. BROOKS: Perfect. That's a great comment. Thank you, Nathan. Are there other comments?

So with respect to what I said before about using the first two years As reporting years or baseline reporting years and then moving to setting a baseline for Year 3 and accountability by DMHC, is there anyone who has other

thoughts or recommendations different than that that we should talk about?

Okay, all right. Well, I think that means that we can move on to discussing disparities reduction and measure stratification. So we will start into that and then we will see how far we get before we finish today. And just appreciate you all hanging in here. I know that it is a long meeting but we are having good discussion so thank you so much. All right. So we are going to transition to discussing measure stratification and disparities reduction. All right, so next slide, please. All right.

So stratifying measures allows for the analytical and comprehensive identification of health inequities to inform targeted quality improvement initiatives, interventions and strategies. The ability to stratify measures is crucial to systematically measure and report on health care disparities in a standardized way. Next slide, please.

As mentioned in previous meetings, for several HEDIS measures NCQA requires reporting race and ethnicity as defined by the Office of Management and Budget or OMB standards for maintaining, collecting and presenting federal data on race and ethnicity. For each product line plans are asked to report members in one of the nine race stratifications listed on the slide here, which then roll up into the OMB categories. Next slide, please.

All right. Likewise for NCQA, plans are asked to report members in one of the four ethnicity stratifications listed on this slide, which will then roll up again into the OMB categories.

All right, so let's see. We are going to -- I am just moving along here because we are not going to vote today. I am moving along. You will see some things in the slides that maybe don't make sense. I apologize. Thank you

so much. All right.

So why don't we move into just some discussion on -- let me see. Let's move to Slide 90, I'm sorry. Thank you.

All right, disparity reductions, all right. So another possible approach or add-on to benchmarking is setting disparity reduction goals for subpopulations where disparities exist. So next slide, please.

So this slide shows a few examples of disparity reduction benchmarking. For example, an Absolute benchmark may set the difference in performance between Black Californians and White Californians to be no larger than 2 percentage points. An Improvement Based benchmark may require the performance of Asian Californians to decrease by 5 percentage points compared to the prior year performance. All right, next slide please.

It is important to keep in mind the varying degrees of data collection currently available and as a result the lack of completeness on where disparities exist and where efforts should be focused, which limits the ability to apply to set disparity reduction goals. Likewise, disparities may look different across payer types and the unique member makeup among providers that may create challenges for entities with lower baseline performance to meet benchmarks. So just saying these things to, not to discourage disparity reduction, obviously, but rather to ensure the appropriate factors are considered. Next slide, please.

So based on the Committee commentary and feedback the following recommendations have been made at this time:

DMHC should consider requiring minimum reductions in race and ethnicity disparities.

And DMHC should consider whether regional rather than statewide race and ethnicity disparities reduction requirements are feasible and appropriate.

I did want to pause now and ask if the Committee Members have comments or questions; comments, concerns or questions with these recommendations? Alex, your hand is up.

MEMBER ALEX CHEN: Hi, Sarah. I don't have any concern or question about the two recommendations that's on the slide right now but I do have a quick comment about the slide before that.

MS. BROOKS: Great. Can we go back one slide? Go ahead, Alex.

MEMBER ALEX CHEN: That wasn't --

MS. BROOKS: Maybe not this slide. Go ahead, though, sorry.

MEMBER ALEX CHEN: Yes, sorry about that. So there were, there were two approaches, right. One is a minimum gap approach between the different racial ethnic groups and one is the improvement approach. That's the slide I was talking about. I think there is an inherent flaw in the improvement approach because if you are requiring, for example, Asians to improve by 5% but the environment is such that no improvement is possible during that year, like a pandemic year or something like that, then if you build that into regulation then you would have to suspend that in an unusual situation where no improvement is possible, regardless of race, right. So making those kinds of improvement requirements for a particular race I think is problematic because there's an intrinsic flaw in that

And then I also wanted to call out one particular thing that I don't

think we have considered or discussed and I would certainly really love, you know, my friend Cheryl's opinion on that. But on our Health Net data in the Medicaid space our biggest struggle are auto-assigned members. So there is almost a 10 percentage difference depending on the measure for our members in Medicaid who chose Health Net versus members in Medicaid that were assigned, auto-assigned to Health Net because of our quality performance. And I think, Sarah, you have seen this before. And we just have a very difficult time improving members that were auto-assigned to us because maybe they are not as motivated and maybe there are some barriers that's consistent or associated with the fact they are being auto-assigned. And so if for some reason those members that are auto-assigned tend to be members of color, then there are some other confounding factors there that's other than racial/ethnic disparity. So I just wanted to call that out.

MS. BROOKS: Those are great points, thank you, Alex.

MEMBER ALEX CHEN: Thank you.

MS. BROOKS: Lishaun.

MEMBER FRANCIS: On the following slide I think I just needed a little bit of clarity on Option 2, what that means, if you could talk a little bit about that. So not this slide, the next slide. Not that one. There we go, yes. So DMHC should consider whether regional rather than statewide. I just wanted to hear a little bit more about that.

MS. BROOKS: Sure. And, you know what, is Ed still on? I don't mean to call him out but.

MEMBER JUHN: I am.

MS. BROOKS: Ed, this came from you so I don't know if you want

to speak to this at all. I am happy to explain it but I can turn it over to you as well.

MEMBER JUHN: Why don't you go ahead, Sarah, and then I could add.

MS. BROOKS: Sure, sure. So I think that, you know, Ed, and I think you made this comment earlier in the day today, Ed, which is just that, you know, there can be different performance in different areas of the state. This is my interpretation by the way. That there can be different performance in different areas of the state and so perhaps the DMHC could consider setting a different benchmark based on a region as opposed to having a statewide benchmark that would be applicable across the board. Is that correct, Ed?

MEMBER JUHN: Right. It was something to consider and I think it was a statement made before some of the conversations we were having as sort of the absolute benchmark that would sort of span across Commercial and, you know, Medi-Cal. But I do think that, you know, given that there are some geographic variances. Again, this is initially. Ideally we don't want any. But initially out of the gate when we are trying to minimize some of the disparities that we see regionally, that we just want to make sure that we hold everyone to the same standard so that we, you know, arrive ultimately at where we would like to be. So just a point to consider as we think through this.

MS. BROOKS: Yeah, thank you, Ed. Okay, Cheryl, your hand is up.

MEMBER DAMBERG: Thanks. So once again, I think I am sort of struggling with how this is going to work operationally. And maybe I am putting the cart ahead of the horse. A couple of things related to trying to close gaps

between different subgroups. So one thing to note is that the system can be gamed because a plan could choose to reduce performance on the higher performing group to close that gap so I think you will have to be mindful of plans not reducing performance. So let's say performance is higher for non-disabled than disabled, you know, by 10 points. They could choose to reduce that gap if what you are holding them accountable for is, you know, reducing the gap by some percentage point or to reduce it to, you know, no more than 2 percentage points by lowering performance for the non-disabled population. So you may want to try to think about what sort of safeguards you put in place for that.

And then I think the question for me is, you can have data by race/ethnicity, you know, by disabled, non-disabled, and they will not show a gap. But yet they provide suboptimal care for all of their enrollees, you know, versus higher performing plans where, you know, maybe there is a 5 percentage point gap between different groups within that very high performing plan, and yet an enrollee would be better off in that higher performing plan even if there is that 5 percentage point gap. So again, just trying to think about, you know, other than stratifying for kind of public information, you know, how is the DMHC thinking about taking this gap measure and putting it to use?

MS. BROOKS: Cheryl, do you have any recommendations there?

MEMBER DAMBERG: So, I think that, you know, as the DMHC considers moving into looking at performance on subgroups I think I might borrow maybe from what we just discussed looking at overall performance and think about ways to hold plans accountable for achieving some minimum standard within each subgroup.

MS. BROOKS: I'm just taking notes, sorry. Are there thoughts on

that? Bihu.

MEMBER SANDHIR: Bihu Sandhir, AltaMed. I guess the question is, do we actually even have the data right now, though? You know, with the subgroups. Wouldn't we first have to collect the subgroup data to build that into this and then eventually have improvement measures on that? Or is that? So that is my concern. We don't have data on most of this right now, the subgroup part of it. So maybe, again, having a similar process of requiring it to be reported for the first one or two years, you know, we can choose whichever number, and then having standards on those of how to improve those. Am I, am I missing this completely, Cheryl? I don't know. I am just --

MEMBER DAMBERG: No, I mean --

MEMBER SANDHIR: This is a lot for us.

MEMBER DAMBERG: Yeah, no, no, no, I completely agree. And I think this is what Alice was trying to spotlight for all of us is, you know, again, you know, the cart is ahead of the horse. You know, we need to collect information on these patient characteristics to be able to stratify and then try to look for opportunities to improve performance across, you know, within the subgroup but across all subgroups, right. And I think a better strategy may be to measure performance within the subgroup, and then, you know, hold plans accountable for achieving better performance within the subgroup. And so again you could look at the distribution of performance, say, among Black enrollees, and, you know, you could set that at, you know, some threshold or you could try to set it at maybe your national standard that, you know. I think that again it is going to be something where it would be helpful to have some data. Now, maybe one place to go looking for that data is what the Office of Minority Health has done in terms

of stratified performance on the Medicare Advantage measures. So maybe that would provide some insights to help us think a little bit harder about this.

MEMBER SANDHIR: Can I just say one more thing, though. Because I remember when we first started this Committee we had somebody from HEDIS who had come to give us a very good presentation. And I remember what she said was CMS is thinking of next year, because we worried about cherry picking, I think they are worried about that, you know. How they said that they would be setting up some kind of, I don't remember if it is the health equity standard or something like that, where they would actually incentivize you to actually see patients with more, you know, from the minority. That if you actually saw more of them than you actually got more of a, per measure, you got more of an incentive. Now, that is a very complex way of thinking, I am not trying to make this more complex, but I thought that was interesting that that's what they were actually, that's what Medicare is thinking of doing in the future, if I understood it, right. So that way they incentivize you to actually see patients with more, you know, with disabilities, with the concerns. I mean, all of these health equity, you know, concerns that we have, they were actually encouraging you to do it and not let -- so that way you could report. And that you actually got more for doing that, from a measure.

MEMBER DAMBERG: So I think it is more along the lines of as follows.

MEMBER SANDHIR: Okay.

MEMBER DAMBERG: So I think what Medicare is trying to do, so they are taking a multi-pronged approach to this. So one is they are risk adjusting for social risk factors to try to remove within-plan disparities while

preserving between-plan disparities. You know, where there's systematic issue across all plans in terms of achieving high performance that suggest maybe some things outside the provider's control. And, again, that is one way of incentivizing plans to be willing to take those patient populations because they are not disadvantaged, I guess, in the scoring algorithm.

But the other thing that they are doing is they are implementing the Health Equity Index, which is comprised of something I was describing a bit earlier where you measure the plan's performance by each subgroup and you create an index across all those measures and then they would receive a back-end reward factor if they do well for those subgroups. So again, it is trying to think through kind of what the DMHC is trying to do here and kind of what's an appropriate path.

MEMBER SANDHIR: Thank you for clarifying that. It is just, it was very interesting. But yes, thank you, I appreciate that.

MS. BROOKS: Thank you, Cheryl and Bihu. Diana, your hand is raised.

MEMBER DOUGLAS: Thank you. Just saying that I also support some of what Cheryl was just mentioning on having specific, specific targets for subgroups. I do think there was some concern within the benchmarking that there could be improvement overall but even at the expense of certain subgroups if that's what the sort of, you know, if plans are working to just to hit that benchmark or get closer overall, but then at the expense of some who might be even left further behind. So I think just this component on disparities is really important IN making sure that there are some kind of standards within subgroups as well.

I also think when we are looking at improvements over time versus having a set sort of tie between how much between quality between groups, I think, a combination of those might be best. I think that we would, of course, want to make sure that there is improvement over time but also that tying it to a certain number of percentage points might be sort of the ultimate goal. But I wouldn't want to see that that percentage be set at too high of a level because right now disparities are so great. In other words, maybe we can set at the beginning more of a process of closing the gap and then once that gap is closed making sure that it stays within a certain percentage.

MS. BROOKS: Thanks, Diana. Doreena.

MEMBER WONG: Thank you. Yeah, Doreena Wong with ARI. So I apologize. You know, I guess this is the end of the day, perhaps I missed something. But can you explain if this particular recommendation or this, the recommendation around to compare, you know, reductions in disparities, is that applying for each of the different measures? I am trying to figure out how it applies to the measure sets, you know. And so does each measure have another aspect to it that where you are going to be comparing if it is, you know, in addition to meeting those absolute or those benchmarks, right, the performance benchmarks? And then in addition you are going to have a kind of a disparities reduction goal as well?

MS. BROOKS: So I think, great comment and I want to make sure I respond to it fully. If I don't let me know because I just want to make sure. So these recommendations on this slide are really just recommendations that we would be including in the report that the Committee is making to the DMHC. So we know off the top that these are things that the Committee, we have heard

from the Committee during the previous meetings. Separately we will be having a discussion and a vote with respect to disparities reduction and how that, what that should look like. And that's also part of the discussion that we are having today, also. So if that wasn't clear, and I agree with you, it is the end of the day and I know we have all been here a long time. I may not have been clear so I apologize if that was me. Oh, you are on mute, Doreena.

MEMBER WONG: Oh, can I just have one just follow-up? This is another comment.

MS. BROOKS: Of course.

MEMBER WONG: Thank you for explaining that. So we will probably be voting on it probably next time. But I am also wondering when people are talking about subgroups are they talking about the OMB classifications, just those overall racial categories? Because I think, you know, I really want us to try to move towards a more granular approach and I think Alice had referred to it, you know, in the very beginning that we do need to disaggregate even those OMB categories, those racial and ethnic categories, if we really want to get to disparities. Because, you know, when you aggregate it into these larger groups you really miss a lot, especially for certain racial categories, as you know, as I have been trying to point out. So I hope there might be some kind of point or recommendation in the report or reference to that, that that's a goal that we should be working towards.

MS. BROOKS: Great comment, thank you. I am just taking notes on what you are saying. Okay.

So we have like 20 minutes left. We have a couple of slides I am going to run through with you all just so you see them kind of today. We are

going to take public comments and then we will come back in August with some additional information provided to you all and continue with our discussion and close it down. And then in September, we will have a meeting for the report. Let's move on to, let's see. Sorry, I am looking through all my notes and I have different. Let's see. So slide 94 just real quick to touch base on CAHPS.

So with respect to CAHPS and disparities reduction, I just wanted to make sure you all knew that for the CAHPS measure Getting Needed Care, that's the measure that you all voted on, stratification would need to be reported to the health plan from the CAHPS survey vendor based on the member's self-identified race and ethnicity. And that this information may or may not align with racial/ethnicity data collected directly by the health plan. So that's just something that we wanted to inform you of to let you know in terms of the consideration as we move forward and think through the stratification complexities. Is that the data for CAHPS is not immediately available to health plans and so they need to get that from the vendor and it may not align with their actual data that they collect. Ignatius, I know, I think I covered that but let me just see if you have any other comments on that real quick.

MR. BAU: And as we also talked about, the other issue is that given the current sampling size, that most health plans use for CAHPS, the likelihood of having sufficient numbers of respondents in all the racial/ethnic categories for stratification are going to be highly unlikely.

MS. BROOKS: Thank you, Ignatius. And Cheryl, your hand is up.

MEMBER DAMBERG: Yes, two points. I agree with Ignatius that you may run into some challenges unless you pool data over multiple years so that is something DMHC should be aware of. But usually you can do it with a

couple years' worth of data.

And then I guess the question I have about what's on this slide is, is there any reason why the plans cannot provide their race ethnicity data to the vendor when the survey is done such that when the data file comes back to them with results they could use the plan variables? I mean, if those are the preferred variables, versus self-report?

MS. BROOKS: You are asking a very good question. I would assume that comes down to like privacy or the business, the agreement, the BAA. But I don't know if any health plans on the line have. There's hands that went up. Yes, Alex, do you have any, have any thoughts on that?

MEMBER ALEX CHEN: Yeah, no, Sarah, you are right. And Cheryl, there is no a priori reason why that couldn't be done. It is really more of an administrative and logistic reason for the data file connection and/or data file transfer. But there is some privacy and/or HIPAA issues. But that's usually resolved with a, you know, a significant service level agreement with the vendor.

MEMBER DAMBERG: Sarah, and I guess I would say this. Generally on the CAHPS surveys, people that complete the survey tend to complete these items, it is not typically missing, and so it may be that the self-reported data on the survey is the preferred -- this case.

MEMBER ALEX CHEN: It will certainly be easier and it will be sort of less an issue in terms of if there are data errors within the data transfer or the data files. So.

MS. BROOKS: Kristine.

MEMBER TOPPE: Sorry. Yeah. The question comes to mind and I don't -- and Cheryl, you are you are steeped in this more than I am. So plans to

be able to administer the Spanish version of the survey or the Chinese version of the survey would have to know that, right? So maybe this is a question for, for. They would have to know that in order to know which survey to administer.

MS. BROOKS: The preferred language?

MEMBER TOPPE: Yeah. Does that happen after the initial survey is sent out?

MEMBER DAMBERG: Well, I think -- I am not going to speak on behalf of the plans on this call but I think some plans are starting to capture that information and they use it, particularly in this context. I definitely know that, you know, like at RAND we have constructed an algorithm that can designate somebody as having a probability of being Spanish preferring and when it hits above a particular threshold a survey vendor could send a double stuff of both English and Spanish.

MEMBER TOPPE: Got it.

MEMBER DAMBERG: So I think there's different mechanisms. But I think it would be interesting to hear from the health plans the extent to which they are collecting preferred language from their members.

MEMBER TOPPE: Yeah. And I can follow-up with the NCQA CAHPS team to see what we know about that kind of process as well.

MEMBER ALEX CHEN: Yeah, Kristine, we do collect preferred language so we could provide that to the vendor if that is needed. But like Cheryl said, usually just the easier one would be to provide both language Spanish and English and they can, you know, have their pick. We don't do Chinese language CAHPS. I don't know if anyone else does that but we certainly don't and none of our vendors are able to do that.

MS. BROOKS: Thank you all. Ed.

MEMBER JUHN: Yeah, just adding to what everyone else said here. One of the things we are doing here is trying to capture that information, language not only spoken but language in terms of what they can read, as that might impact the surveys as well. So a couple elements of actually the language pieces is what we are trying to collect and then make sure that we send that information so that the surveys are administered appropriately. So I can't speak on behalf of every plan but I know that's what we are doing internally. And again, to add to Alex's point. I think in terms of de-identifying some of the information stored in a CAHPS survey, that is something we would have to probably talk with, you know, the vendor and ensure that there's agreements in place for that from a privacy perspective.

MS. BROOKS: Thank you, Ed. All right. So real quick before we move to public comment and conclude I want to show you a couple of slides So let's move to Slide 86, I think.

Yes. So I wanted to just show you these slides that -- these slides. The questions that are posed on these slides that we will be revisiting during the next meeting. And so these are with respect to measure stratification and recommendations that the Committee might be making. And so the questions that are posed here, and certainly you can read them too, but the first one:

Does the Committee recommend that measures identified by NCQA for stratification by race and ethnicity should also be stratified in the final DMHC measure set?

The second question: For NCQA HEDIS measures not yet identified for stratification through 2023 does the Committee recommend waiting

to align with NCQA?

And then I believe there's a third question; am I correct? Yes. If the measure is not currently stratified by NCQA, or is not an -- oh, I'm sorry. We went through this one already, apologize. Go back to slide 86. And I don't mean to be confusing I do apologize.

So these two questions here I just wanted to make sure to get them in front of you all, and advance at the next meeting. See if there's any questions about them or comments initially right now just right off the bat. I don't see any hands coming up at this time. Cheryl, go ahead.

MEMBER DAMBERG: I guess I would not wait. I think as long as you have the data to do stratification, whether it is by race, ethnicity or any other characteristic, I would, you know, move ahead with stratifying performance.

MS. BROOKS: Great. All right. So we have got an initial comment there. Ignatius, your hand is up, go ahead.

MR. BAU: And just for the Committee's awareness, so out of the 13 measures that you are now considering, 9 of them are going to be stratified either for this year or starting next year and so it is really only 4 additional measures in which there isn't a pathway to stratification at this current time. So if Cheryl's recommendation is adopted by the Committee then it would be encouraging those measures to be also stratified by race and ethnicity sooner rather than later.

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

MEMBER AMARNATH: I think I was going to largely second what Cheryl said around, if it is possible, there can be, I might think there's benefit to stratifying regardless of what NCQA is currently doing for 2023. But I also

wanted to potentially suggest if there Is value in discussing sort of a different third question in this bucket which might be related to what we talked about earlier in this meeting when it comes to thinking about what do we mean when we talk about benchmarks from this perspective, when we are thinking about stratification, and going back to some of the conversation of relative reductions, et cetera, where we might consider applying that or not. And so a third question might be, if we were to suggest as a Committee that stratifications of all measures was worth considering. Does that, do we think that benchmarking should be handled in the same way for measures that NCQA is currently stratifying versus those that they are not?

MS. BROOKS: Okay, that's helpful. And we are taking note of that So thank you, Anna Lee. Kristine.

MEMBER TOPPE: Yes, thank you. My only additional comment is that if the stratification for measures that we haven't slated yet is decided as a yes, that we would recommend, NCQA would recommend following the same methodology that is used for all the other measures so you have consistency across the board. Recognizing that, you know, we are following the OMB categories; there may be a desire for more granularity. But that the roll-up be consistent so that you have got consistency across measures. So that's just some food for thought.

MS. BROOKS: Thank you, Kristine. All right. All right. So we are going to move to Slide 89 now. Perfect.

All right. So we are going to talk a little bit about -- well, we are going to show you the question and I am going to give you some feedback, and then we are going to move to public comment. But this is really just to get you

thinking and get your mind percolating in advance of our next meeting. So currently, I think as we know, there are data limitations and challenges with respect to collecting language, sexual orientation, gender identity, disability, tribal affiliation, health-related social needs data and the ability to disaggregate data by race and ethnicity. So lots of issues with the data; that is not a surprise, I think, to anybody here.

Thinking ahead, we would like for the Committee to consider recommendations for the DMHC on how to proceed with this type of data as it becomes more readily available. So this follows, Doreena, what you were bringing up earlier, actually. So would ask you all to consider the following:

As language, sexual orientation and gender identity, disability, tribal affiliation, health-related social needs data and ability to disaggregate data by race and ethnicity become more readily available due to evolving state or federal requirements, including the California Data Exchange Framework, how and when should DMHC include requirements for stratification by these additional demographic data?

So this is something we talked a little bit about earlier so we have already started this conversation. Doreena, you asked I think almost this exact question earlier and we heard it from others. So we want to, if there's any, if there are any initial kind of comments welcome them right now before we move to public comment but just wanted to get this on your radar in advance of the next meeting as well. So I don't see any hands raised. So with that, we are going to -- Doreena, your hand is raised, please go ahead.

MEMBER WONG: Yes, thank you. I guess my only comment on this particular recommendation is I don't think that we, well I would hope that

DMHC wouldn't wait until like it is required, like there's state and federal requirements. I guess I would like to try to -- I know there's different efforts by different agencies to kind of collect like SOGI data or collect disaggregated race and ethnicity data. And it may or may not be like required, correct. But I guess it would be good if there was like a recommendation on how a methodology developed by maybe another agency that is doing it, that maybe DMHC could explore it before, you know, and not require that it is -- they do it just as a result that it is now required. I hope I am making myself clear.

MS. BROOKS: Sorry, I was on mute. Yes, I think you were making yourself clear. Certainly, we can take that back for discussion as we move towards the next meeting. Kristine, did you have a quick comment?

MEMBER TOPPE: Yes, I just didn't know if this was something different than what the plans would be doing as part of like the measure reporting process that goes along with the actual data collection and stratified reporting they would be doing? Because that process is essentially like spelled out in the measure specifications so I just, I did not understand kind of what the intent was.

MS. BROOKS: Sure. Let me call a lifeline and just see with my fading brain if Andy has any response to Kristine. Sorry, Andy, to put you on the spot.

MR. BAU: I can jump in and answer that.

MS. BROOKS: Ignatius, thank you.

MR. BAU: So, Kristine, we are recognizing that language and eventually sexual orientation and gender identity are going to be required as part of health equity accreditation. But it is addressing these additional factors,

disability, tribal affiliation, social needs, and then the disaggregated race and ethnicity data beyond the OMB categories that again, Alice at least for Covered California and Medi-Cal showed that we are collecting more granular data for Asians and for Native Hawaiians and Pacific Islanders. There is a need to collect that granular data for the other racial categories as well. And so while all that is up in the air it is sort of what would the recommendation to DMHC be from this Committee?

MS. BROOKS: Thank you, Ignatius.

MEMBER TOPPE: Super helpful. Long day, tired. My only immediate thought would be to align with what is happening with the Data Exchange. I mean, it is in here in the Data Exchange Framework. And so the things that are happening with Gravity Project and others around standardizing data collection so that's my two cents.

MS. BROOKS: All right. Cheryl we will take. Maybe you will be the last comment then I think we need to move to public comment. Thank you so much.

MEMBER DAMBERG: All right, I will make this quick. Regarding these other categories or subgroups, is your team able to bring back to the next meeting, are there standards already for collecting these subgroup categories and is that something you can share with us in advance of that meeting?

MS. BROOKS: There are standards. Let me ask my lifeline group here. Are we allowed to share that information? I am not sure what the -- so we will share what we are able to, how about that, Cheryl?

MEMBER DAMBERG: That would be helpful, thank you.

MS. BROOKS: Yeah, okay. All right. Well thank you all for your

comments.

Let's move to public comment. Shaini, are there any hands raised from the public?

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

MS. BROOKS: Okay, all right. Public comment may be submitted to publiccomments@dmhc.ca.gov until 5 p.m. on July 20, Slide 97, there we are. It is up on the slide here, the email address. And then just a reminder that members of the public should refrain from reaching out to Committee Members for discussion purposes and just email the public inbox directly should you have a comment. Let's see. And there is the information there.

And with that, the August 17 Committee meeting will also be held virtually so we will be online. Both of our next meetings -- our meetings will be virtually moving forward. And we will continue the discussion next meeting and just want to thank everyone for the dialogue today and hanging in there. So thank you so much.

(The Committee meeting concluded at 4:58 p.m.)

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I, JOHN COTA, an Electronic Reporter, 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 that it was thereafter transcribed.

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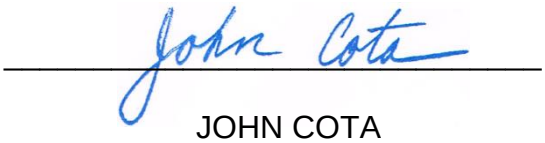

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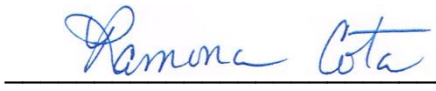

July 26, 2022

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