STATE OF CALIFORNIA

DEPARTMENT OF MANAGED HEALTH CARE

HEALTH EQUITY AND QUALITY

COMMITTEE MEETING

VIRTUAL ONLINE/TELECONFERENCE MEETING

HOSTED BY THE

DEPARTMENT OF MANAGED HEALTH CARE

SACRAMENTO, CALIFORNIA

MONDAY, SEPTEMBER 12, 2022

12:00 P.M.

Reported by: John Cota

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APPEARANCES

Voting Committee Members

Anna Lee Amarnath

Dannie Ceseña

Alex Chen

Cheryl Damberg

Diana Douglas

Lishaun Francis

Tiffany Huyenh-Cho

Edward Juhn

Richard Riggs

Bihu Sandhir

Kiran Savage-Sangwan

Rhonda Smith (joined after Roll Call)

Kristine Toppe (joined after Roll Call)

Doreena Wong

Silvia Yee

Ex Officio Committee Members

Palav Babaria

Alice Huan-mei Chen

Stesha Hodges (joined after Roll Call)

Julia Logan, represented by Lisa Albers

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

Leslie Thompson, Acting Staff Services Manager I

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

Kristen Golden Testa
Children's Partnership

Mary Reth
San Francisco Health Plan

Leslie Goodyear-Moya
Manifest MedEx

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PROCEEDINGS

12:03 p.m.

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

AB 133, the budget bill from last year, I guess now it is two years ago, charges the 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 have been compiled into a report, which we will be discussing today, for the DMHC and developed by Sellers Dorsey as representative of the Committee's positioning. So as I mentioned, we will be reviewing the recommendations by the Committee during today's meeting.

During last month's meeting we heard from DMHC Director Mary Watanabe regarding the DMHC's regulation and enforcement process. In addition, we finalized the benchmarking and measure stratification recommendations.

So we are very excited about today's meeting as we discuss the report and all of the great recommendations that you all have put forth and so we are going to get into it right now.

I am going to go ahead and hand it off to Janel Myers, my colleague, who will talk a little bit about housekeeping.

MS. MYERS: Thanks, Sarah. All right, everyone, one last time.

For our Committee Members, please remember to unmute yourself when making a comment and mute yourself when not speaking. For our Committee Members and the public, as a reminder, you can join the Zoom meeting on your phone should you experience a connection issue.

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

For the attendees on the phone, If you would like to ask a question or make a comment please dial *9 and state your name and the organization you are representing for the record. For attendees participating online with microphone capabilities, you may use the Raise Hand feature and you will be unmuted to ask your question or leave a comment. To raise your hand click on the icon labeled Participants on the bottom of your screen; then click the button labeled Raise Hand. Once you have asked your question or provided a comment please click Lower Hand. All questions and comments will be taken in the 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 asynchronously. For example, member one emails member two, who emails member three. Accordingly, we ask that all members refrain from emailing or communicating with each other about Committee matters outside the confines of a public Committee meeting.

MS. BROOKS: Great. So thank you, Janel.

So as Janel mentioned, this meeting is subject to Bagley-Keene requirements. And just a friendly reminder not to use the Chat during the meeting; I know we all love it but Bagley-Keene does not allow for it and so we just want to make sure to follow the requirements. All right, next slide.

So slide 6 walks us through today's agenda, which includes remarks from DMHC Director Mary Watanabe and a review of the draft 2022 Health Equity and Quality Committee Report. While we are reviewing the report today, we are looking to the Committee to provide input to ensure our recommendations are reflected accurately. So as you can see here we have the Welcome and Introductions we just went through, the Meeting Summary, the DMHC Remarks that we talked about, the draft report, and then we will go into public comment and closing remarks. All right, next slide, please.

So at this time I would like to do a quick roll call of DMHC representatives, Committee Members and then introduce the Sellers team. So we'll start with Mary Watanabe.

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

MS. BROOKS: Nathan Nau?

MR. NAU: Good afternoon, Sarah.

MS. BROOKS: Chris Jaeger?

MR. JAEGER: Good afternoon.

MS. BROOKS: Sara Durston?

MS. DURSTON: Good afternoon.

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

MEMBER AMARNATH: Hello.

MS. BROOKS: Bill Barcellona?

(No audible response.)

MS. BROOKS: I believe he is not here today.

Dannie Ceseña?

MEMBER CESEÑA: Good afternoon.

MS. BROOKS: Alex Chen?

MEMBER ALEX CHEN: I am here. I apologize; I can only join for about two hours today.

MS. BROOKS: Okay, thanks, Alex.

Cheryl Damberg?

MEMBER DAMBERG: Present.

MS. BROOKS: Diana Douglas?

MEMBER DOUGLAS: Present, thank you.

MS. BROOKS: Lishaun Francis?

MEMBER FRANCIS: I'm here.

MS. BROOKS: Great. Next slide. Tiffany Huyenh-Cho?

MEMBER HUYENH-CHO: Present.

MS. BROOKS: Ed Juhn?

MEMBER JUHN: Good afternoon.

MS. BROOKS: Jeff Reynoso?

(No audible response.)

MS. BROOKS: I believe he is not here today.

Rick Riggs?

MEMBER RIGGS: Hey, good afternoon.

MS. BROOKS: Bihu Sandhir?

MEMBER SANDHIR: Good afternoon.

MS. BROOKS: Kiran Savage-Sangwan?

MEMBER SAVAGE-SANGWAN: Present.

MS. BROOKS: Next slide, please. Rhonda Smith?

(No audible response.)

MS. BROOKS: Kristine Toppe?

(No audible response.)

MS. BROOKS: I believe she is going to be a little bit late today.

Doreena Wong?

MEMBER WONG: Here, thank you.

MS. BROOKS: Great. And Silvia Yee?

MEMBER YEE: Good afternoon, everyone.

MS. BROOKS: All right, next slide. Palav Babaria?

MEMBER BABARIA: Present.

MS. BROOKS: Alice Chen?

MEMBER ALICE CHEN: Present.

MS. BROOKS: Stesha Hodges?

(No audible response.)

MS. BROOKS: Julia Logan or Lisa?

MEMBER ALBERS: Here, Lisa, thanks, Sarah.

MS. BROOKS: Lisa Albers, yes. Thanks, Lisa.

Robyn Strong?

(No audible response.)

MS. BROOKS: I believe she is not able to join today. Next slide.

And then this is the list of the Sellers team that has been supporting the project. All right, next slide, please.

Meeting materials. So Committee Members should have received several documents ahead of this meeting for your review: the agenda, the draft report itself, the meeting summary from the last August 17 meeting and including the transcript, the presentation for today and public comment. Next slide, please.

Okay, so this slide essentially tells us the timeline and what we have left here. So today we have Committee meeting number 9, we are discussing the draft report. And then following this there will be DMHC next steps. Director Mary Watanabe will be talking a little bit more about that today as we have heard in previous meetings as well. Next slide.

So with that I will just see if there are any questions from Committee Members with respect to any of the presentations thus far?

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

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

MS. BROOKS: Oh, Cheryl, your hand is up. Please go ahead.

MEMBER DAMBERG: So I was on vacation last week. And in terms of the draft report, I am just trying to understand the expectation for Committee Members. Are we given some period of time where we can provide either written comment back or is the expectation you are going to get all comments on today's phone call and how are you anticipating that is going to work?

MS. BROOKS: Sure, great question, Cheryl. Let me make sure yes, I am off mute, sorry. Great question, Cheryl. So we are looking for feedback during the meeting today but as well in writing if you are interested in providing written comments. Not necessarily looking for redlines, specifically, but more comments about what conceptually might be missing or if we may have misrepresented something. But that is the intent of how we would like to gather information. I hope that answers your question.

MEMBER DAMBERG: Yes. And what is the time period for providing comment back, recognizing the --

MS. BROOKS: Thank you. Sorry, I should have mentioned that. Yes. So we are looking for within one week we are looking for comments back. Okay, and Rick, your hand is up.

MEMBER RIGGS: Yes, just to follow up a little bit on that. So are we going to go through the report section by section to sort of see if there are comments or what was the sort of thought process around how that might work today for gathering comments?

MS. BROOKS: Sure. So the presentation will include an overview of the report and then open it up for dialogue and discussion. Certainly if there is

something -- I hope to get through the majority of the presentation so that we can have a good discussion about the report overall. But certainly if there is something key that somebody wants to raise at some point as we go through the presentation then I hope that people will feel comfortable to flag that as well. Okay, Kiran.

MEMBER SAVAGE-SANGWAN: Yes, I am just concerned, continuing to follow up on process. Is there a public comment period for this report as well or is it just the next week you are accepting comments from Committee Members?

MS. BROOKS: Do you want -- let me ask, can I ask DMHC to speak to that question, if that's okay?

MS. WATANABE: Yes, maybe I'll start and then I'll let Nathan jump in here on the timeline. So, you know, I think as we have talked about in the past, we had a very aggressive timeline to get through the recommendations from the Committee, which are in this report. Our goal is to have all public comment from both the Committee and members of the public submitted within one week after this meeting. Because I said the last time, you all have left me with some difficult decisions. So the next step really is to get all the public comment, get a final report that will come to the Department for us to make our final decision and we need to do that quickly in order to give the plans guidance on what they are collecting starting in November. So I would really encourage everybody to get any comments in on kind of the Committee discussion, the process, the content of the report and the recommendations within a week of this meeting, which I think will have on the last slide but I believe that is the 19th. Nathan, do you want to add anything in terms of the timeline and process?

MR. NAU: Sure. Mary, you stated it perfectly but just a little bit more context and we have talked about some of this in the Committee meetings already. But the Department's goal is to release a high-level APL this calendar year that would outline the measures, stratification options and the benchmarks. Reason why is this process begins measurement year 2023 and so we want to make sure we notify the plans before that measurement year. In the future there will be more iterations, that All Plan Letter will certainly grow, but those are our immediate next steps. And so like Mary kind of alluded to, they are going to sneak up on us pretty quickly here so we need that feedback and we are eager to see it from everybody.

MS. BROOKS: Thank you, Nathan and Mary. Any other questions or comments from the workgroup members or Committee Members?

Okay. And Shaini, I just wanted to do a double check to make sure there's no other public comment hands raised?

MS. RODRIGO: No, there are no hands raised.

MS. BROOKS: All right. Silvia, please go ahead.

MEMBER YEE: I was just wondering, given this very short timeline, will the report be available in other languages, or if it's requested, in alternative formats?

MS. WATANABE: So, we don't have a plan at this point to post it online in different languages. But of course we can always make that available upon request in alternate formats or other languages.

MEMBER YEE: Thank you.

MS. BROOKS: Thank you, Silvia. All right, so not seeing any other hands raised at this time I am going to go ahead and move on to the next slide.

All right. So the August 17 meeting summary was included in your meeting packets. I just wanted to do a check to see if there are any changes to the meeting summary that should be made from work group or Committee Members that would be recommended? If none, then we will go ahead and finalize the public, excuse me, the meeting summary. Okay. I don't see any hands raised. Shaini, are there any public -- Alex, go ahead, please.

MEMBER ALEX CHEN: Hey, Sarah, I have been giving sort of a mental review of the last meeting in my mind since the meeting.

MS. BROOKS: Okay.

MEMBER ALEX CHEN: And I wonder, should I give maybe like a follow-up feedback now or should I wait until sort of the discussion of the content later to give a quick feedback?

MS. BROOKS: So it has something to do with a discussion that was held during the meeting is what you are saying?

MEMBER ALEX CHEN: Yes, that's right.

MS. BROOKS: I think I would wait until we get to that point in the meeting and then we can have that piece of the discussion, if that makes sense.

MEMBER ALEX CHEN: Okay.

MS. BROOKS: Do you want to kind of put out there that the report itself does reflect kind of the recommendations and the discussions that happened during the Committee meetings and so we will wait to hear what you have to say. Just wanted to kind of make sure that we stay -- the report will stay in that line, I guess, is what I was trying to say.

MEMBER ALEX CHEN: Yes, that makes sense.

MS. BROOKS: Okay.

MEMBER ALEX CHEN: Thank you, Sarah.

MS. BROOKS: Thanks, Alex, for raising that. All right.

Shaini, do we have any public comment hands raised at this time?

MS. RODRIGO: There are no hands raised.

MS. BROOKS: Okay. So we will move to slide 18 and I will now turn it over to Director Mary Watanabe for DMHC remarks, for Mary's remarks.

MS. WATANABE: Thank you, Sarah. And I will make this brief. Just as we are at our last meeting here I just wanted to take an opportunity to thank the Committee Members for their participation on the Committee but also just the time commitment that this has been. I know it has been some very long meetings but I really appreciated the seriousness with which you have taken these discussions and the robust conversations that we have had. I am thankful that I have had the chance sit through I think just about all of the meetings from the beginning to end to hear the discussion. You have left us with some challenging decisions to make but I am impressed and very pleased that the Committee was able to reach some consensus on both the measures and the benchmarks.

And again, I would just encourage you to think not just about the report and the, like Sarah said, not necessarily redlines but the content and the recommendations that you all have made. And for the members of the public too of just, you know, where we have landed in terms of the recommendations. And would welcome your input not just on the report but also what we should do going forward. We have recognized I think throughout this process that we are doing something very innovative and new and there will be a lot of lessons learned as we go through this process and appreciate some of the feedback

about reconvening the Committee and giving the public an opportunity after we have maybe two years of data at least to really revisit what we have, what we have learned. And again, there is a commitment to making changes and adapting as we go forward as well.

So with that I would just reiterate my thanks and appreciation to all of you and look forward to the discussion today. And I will just give Nathan a chance to, Nathan, I don't know if there's anything you want to say or add as well.

MR. NAU: Well, Mary, I wanted to echo thanks to the Committee Members. But I think also it is a Bagley-Keene meeting so those in the public who have been following along and who have verbally given us comments or sent something in, thank you for that support as well.

MS. BROOKS: Great, thank you, Mary and Nathan. Questions for either of them from Committee Members?

Okay. Shaini, do we have any hands raised from the public?

MS. RODRIGO: No, there are no hands raised.

MS. BROOKS: Okay, so we will move on at this time to slide 20.

MS. RODRIGO: Oh, I am so sorry, one hand just got raised.

MS. BROOKS: Okay.

MS. RODRIGO: One moment. Kristin Golden Testa, your hand is raised, you should be able to give your public comment.

MS. GOLDEN TESTA: Hi, can you all hear me? This is Kristen.

MS. BROOKS: Yes, we can hear you, Kristen.

MS. GOLDEN TESTA: I'm sorry if you said this at the top of the hour and I missed it but where can I see the final draft report? I didn't see it on

the website.

MS. BROOKS: It should be posted on the DMHC website. Leslie, do you have any other different information than that?

MS. THOMPSON: No, the draft report was not posted. We can post it though real quick.

MS. BROOKS: Oh, okay. I misspoke then. That was my fault, I apologize. I thought the packet was posted, I apologize.

MS. WATANABE: Yes, let me just pause there. Leslie, we should have that posted on the website. Can we get that up?

MS. THOMPSON: Yes.

MS. WATANABE: Add it. And just for the public that doesn't have it, it's on our homepage, under What's New you will see a link to the Health Equity webpage. We also have it under the hyperlinks on the right under Public Meetings. So give us a little bit of time and we will try to get that posted quickly.

MS. BROOKS: Thank you, Kristen, for asking that question.

Shaini, other public comments?

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

MS. BROOKS: All right, so we will move on then to slide 20, please. So we will now walk through each section of the report and the content in which it contains. Some of these talking points that I am going to go through you all just asked me about, I'll just be upfront with, but I think it is good to repeat things and make sure we are all on the same page.

So this meeting will serve to confirm that Committee Members agree that the summary of committee discussion and recommendations are accurate and reflect the sentiments of the Committee. Committee Members are

asked to identify areas, as we talked about, conceptually in terms of changes or things that we might make that don't particularly reflect what was discussed in the Committee itself during the Committee process.

We will review the report in entirety and then move to Committee discussion as we discussed previously. Feedback received will be considered for inclusion in the final report based on the prior recommendations and direction of the Committee.

As we review the report we ask that you consider the following questions: Does the report summarize the recommendations of the Committee correctly? Are the voted-on and recommended concepts reflected accurately? Is anything missing that was discussed in previous meetings that you would like to see included? So next slide, please.

Slide 21 outlines the general approach that Sellers Dorsey took when compiling the report. So, review and reflection of meetings. So we reviewed and reflected on the meeting summaries, transcripts, public comments and any other relevant information obtained in compliance with the Bagley-Keene Act. So basically we took all of the information that we received as long as it was in compliance with Bagley-Keene and incorporated it into the report.

The draft report reflects Committee discussion and recommendations. To determine specific discussion topics for the draft report, meeting transcripts and summaries were leveraged.

And the draft report has been condensed into a succinct manner for easy consumption for the public and for you all as well. Next slide, please.

So the Executive Summary is an executive summary, it provides a high-level breakdown of the draft report in terms of what its contents are, the

relevant AB 133 requirements, and Committee recommendations. Next slide.

Section II, the Introduction, describes key provisions of AB 133, including the establishment of health equity and quality measures and benchmarks for DMHC-licensed full service and behavioral health plans, as well as language around convening the Health Equity and Quality Committee, key tasks carried out by the Committee and timelines for implementation, and DMHC's enforcement approach. Next slide, please.

Section III, Summary of Health Equity and Quality Committee Meetings, outlines Committee membership and an overview of meetings and presentations. Next slide.

Section IV, Framework for Health Equity and Quality defines the California and national landscape.

In addition, an overview of presentations on health equity, quality and disparities subject matter that were given throughout the duration of Committee convenings is provided. Next slide.

Section V gives an overview of each step of the measure selection process, including guiding principles for measure selection. So you will recall all the different guiding principles that we went through from the beginning.

The process for measure selection. For example, how the Committee narrowed down measures by focus areas, were then presented a consolidated list of measures by focus area, and related measure-specific information and so on.

Committee discussion on measures and benchmarks.

And just noting that to determine specific discussion topics for the draft report, meeting transcripts and summaries, again, were leveraged. All right,

so next slide, please.

I know this is a lot and I appreciate you all sitting through and listening as I go through these different slides.

Section VI. Section VI focuses on the Committee's recommendations that will ultimately reduce variation across health plans and facilitate a better understanding of where disparities exist. Recommendations include the 13 measures proposed by the Committee, benchmarking methodology, including the use of national Medicaid data to set benchmarks for both Medi-Cal and Commercial plans. In addition, there was Committee consensus that a consistent percentile across all measures be applied based on annually adjusted Quality Compass data. The recommendations include a note that the Committee did not reach consensus on determining if the 25th or 50th percentile be applied. This is something that the DMHC will ultimately make the final decision on.

For measure stratification, the Committee expects health plans will report performance data on the nine HEDIS measures required for stratification by race and ethnicity. So I did want to flag that for you. In the report that is drafted right now it says eight measures, it is actually nine measures, my apologies, we will make that additional change to the report itself.

In addition to those nine measures, the Committee recommends the DMHC require health plans report their performance on the four additional measures not presently required for stratification by NCQA, utilizing NCQA’s methodology.

And then during the last Committee meeting some members expressed interest in creating a process measure for measure stratification. As

a result, a recommendation was included that the DMHC require health plans to report what demographic data they have collected, for what percent of their membership, along all demographic characteristics. For example, plans may report the percentage of members who self-report as being Black or African American or self-report gender identity and/or sexual orientation. Okay, next slide.

In addition to the recommendations previously mentioned, there were additional recommendations by the Committee for DMHC to consider in the future, including additional accreditation requirements. There was Committee discussion that the DMHC consider requiring NCQA health equity accreditation and RAND's Health Equity Index should they be approved by CMS.

Additional demographic data: At this time the Committee recognizes there are pending federal and state requirements for health plans to collect additional demographic data, including disaggregated race and ethnicity, language, sexual orientation, gender identity, disability and tribal affiliation data. If and when collection of such data becomes possible the Committee recommends the DMHC require California health plans collect this data.

Measure concepts and issues for future consideration: During Committee discussion on measures there were some concepts or issue areas that were of particular interest to Committee Members but there were no high quality measures for such issue. Such issue areas are outlined in the report and included at a high level, for example, prostate cancer, anxiety, suicide, COVID-19 vaccination status and obesity.

There are additional concepts and measures that were discussed by Committee Members that did not move forward for a variety of reasons.

Okay, slide 29, please.

And then this brings us to the Conclusion of the report which provides a summary of the report and restatement of the Committee's recommendations.

And then slide 30 provides a summary of the different appendices that are included in the report. You will see Appendix A listing Committee Members; B, All Recommended Measures and the Percent of Vote Received; C, the Vote Count by Committee Member; D, the Characteristics of Recommended Measures; and E, a Summary of Plan Performance.

All right, so we have moved through the report and outlined what is included in it.

We will move to slide 31, which includes those questions that I asked at the beginning which really asked about:

Does the report summarize the recommendations, as I mentioned, of the Committee correctly?

Are the voted-on and recommended concepts reflected accurately?

And is anything missing that you would like to see included?

So with that we are going to open it up for discussion, we will move to the next slide. Well actually let's leave the slide up, I apologize, before, which has the questions on it. So we will move to Committee discussion. I see Rick has got his hand up so let's start with you, Rick.

MEMBER RIGGS: Hi, yes, thank you. By the way, I think the Executive Summary is a really great overview and summary of the work that was done so congratulations on being so succinct.

I think number -- on slide 2, number 13 of the report, I think that it

is -- in the report it is summarized as getting need care. And I think in that and the table on page 12 it really is getting needed care.

MS. BROOKS: Okay.

MEMBER RIGGS: Probably just not pulled off appropriately off of those pieces but that made me want to check.

And then I just had a general. I wanted to check with the rest of the Committee and the group around the sort of Committee, we understood the areas that we were going to focus on, the sort of 12 different areas that we agreed at the outset. That's the adult prevention, chronic conditions, et cetera. And I just wanted to check with regard to the areas that we decided on that substance use, as I see it, may or may not have gotten -- one of the areas that we had either good measures or whatever to address. But I wanted to make sure that we perhaps call that out as we move forward.

And then also, I guess, the patient experience piece also may have been another one of the original tenets that we were, thought that we had sort of wanted to consider. And then I think all of this will address population health but I don't know that we have a particular roll-up measure that actually looks at that.

But just I wanted to check my understanding of where we landed with the crosswalk of the others. It looks like we have we hit all the other ones with one or more measures that we identified for inclusion.

MS. BROOKS: Thank you, Rick. And I see your hand up, Nathan. Let me just make a quick response and then I will move to you real quickly. I think you are correct in your understanding of what appeared and showed up based on your reflection that you just made. Patient experience I think could somewhat be reflected in CAHPS and the measure that was selected there. But

understand kind of your statement that you are making and so hear your comments and agree that those different areas were touched on during the Committee meetings. Nathan, did you have a comment?

MR. NAU: Thanks, Sarah. I just wanted to mention for those who needed it, the report is now posted on the website.

And then since I am unmuted right now, we wanted to talk a little bit more about the process measure at the end, just so we understand what to put in the report, because there is not much information in there as of right now. So we wanted to circle back with the Committee on that.

MS. BROOKS: Okay, sounds good.

Alex, I see your hand is up.

MEMBER ALEX CHEN: So Sarah, I think this may be a good place for me to share my thoughts from last time regarding benchmarking, if it's okay. I feel bad that Mary and DMHC has been put sort of in a difficult place in making a decision but I have full confidence that, you know, everyone from DMHC has a strong grasp of the conversation the Committee had. But I thought I may be able to help a little bit. I have been giving some thought since the last meeting and I have done some sort of mental simulations in my mind so I wanted to point out two things.

One, we all agree that health equity measurement and health equity work is intended such that no one racial ethnic group or any disadvantaged group gets left behind, right? So that's the first point.

The second point is that by mathematical and logical definition, a 50 percentile means that there's 50% of the entire population that's above it and there's 50% of the entire population that's below it. So I am just going to ask the

question, which the answer is apparent I am sure to everyone here, is that if we set the benchmark at the 50th percentile, imagine that nobody gets left behind. Who is the 50th percentile that's below the 50th percentile for it to be 50th percentile? It doesn't exist. I think this is the mathematical equivalent of chasing our own tail so I just wanted to share that thought with the Committee.

I hope that was clear. If not I am happy to answer questions. And Cheryl, please help me out here. I think it makes sense, right? If it is 50th percentile that means there are some people that's going to be below it. And if nobody gets left behind then there is no 50th percentile, the target doesn't exist.

MEMBER DAMBERG: Right. Yes, well, 50th percentile means half the people are below it, so yes.

MEMBER ALEX CHEN: So Mary, I hope that helps you. And you can blame it on me if you end up, you know, being criticized.

MS. WATANABE: No, I appreciate that, Alex, and I am sure Andy will want to add. I mean, I think this has always been the challenge in the discussion we have had about a floor. And I think we had information too that is in the back of the report about the number of plans that currently fall below for the measures too. But no, I appreciate that point. Andy, I don't know if you want to jump in and add because I know this is something we have talked about as well.

DR. BASKIN: Yes, thank you, Mary. Hi, just a quickie. So understanding the 50th percentile means that half the plans are above and half the plans are below. But remember, we are picking a 50th percentile that is a national percentile, not the state's percentile. So it is not mathematically impossible that the state performs above the 50th national percentile across all

of our plans. I have to say it is an extremely high bar. But the mathematical possibility would only be if it was within -- if we were comparing ourselves against the state's average, not against the national average. So it is technically possible. I won't, well, I won't use a metaphor about how unlikely that is to happen, I will leave it at that.

MS. BROOKS: Thank you, Andy. And thank you, Alex, for raising that issue. Diana.

MEMBER DOUGLAS: Thank you. Diana Douglas with Health Access California. First just want to express appreciation through this whole process and I know operating on a quick timeline. Really appreciate the report that was pulled together here and all of the work from the Department and everyone else to get this together, concluding our time.

I think as far as just kind of going through the questions here in terms of summarizing the recommendations of the Committee and then I think also whether the concepts voted on are reflected accurately. I think the one part where I might want to see a little bit more nuance in the report is in the benchmarking discussion. And I think, you know, as was just discussed, I think some of the conversation on benchmarking and the sort of -- I see that in the report it says there was a consensus on Medicaid versus Commercial and obviously the vote was split on the 25th versus 50th percentiles. I do feel like there was maybe some more nuance there in our previous August discussion that wasn't necessarily captured in the report on the merits and drawbacks of each. And I know, I know I and others had talked about having an approach where it was more of a phased-in or increasing benchmarks to hit and I am wondering if that -- and maybe I just missed it in the quick reading of the report.

But I think seeing a little bit more discussion of possible approaches and the merits of each it would be helpful to fully capture what was discussed.

And I understand it seems that the use of the national Medicaid benchmark is -- the direction it seems like we are going I think it might be overstating a little to say it was a consensus. It still seems like there was a lot to discuss. Which I know obviously with the timeline we are in those discussions might not come to fruition. But I think the report could reflect that and be helpful for future iterations of this Committee as we come back to the report also.

And then I think additionally in terms of what is missing, so much of our earlier discussion when we were looking at measures focused on data that was missing, particularly with regards to language, and SOGI data. I know that that's mentioned and there is a kind of brief section here on missing demographic data. But I would really love to see this report be a little bit more forceful in not just highlighting what was missing but maybe serving a little bit more as a call to, you know, the state and stakeholders to push for this kind of data because it's really integral to the work here. And in a lot of ways I think if this entire process is falling short in any way it is because of the lack of, of data in those areas. So I would like to see that called out a little bit more directly in the final report.

And then I think also would like to see highlighted a little bit more the areas where we were not able to settle on measures, particularly with regards to mental health and substance use disorder. And I think there were others as well just that would have been seen as kind of no-brainers to include and weren't able to because of the lack of data. And I think as, you know, we or others come back to this process in a few years to revisit, that those sections on

what's missing and next steps will in some ways be, you know, some of the most important parts of this report so I think emphasizing those would be good to see.

I think that's all. I think the only other -- the other part too is I know in the beginning of the report it discusses just kind of the general approach as -- with this being part of an enforcement process, again, that these measures are not part of contracting, they will be wrapped into an enforcement process. Eventually we know that will take a few years to ramp up. But I think maybe having a little bit more detail on just exactly how that functions and what that means and what that process will look like. And I am looking at like page 4 here towards the end of the introduction. I think that might be helpful also is this is a little different maybe than the sort of contract requirements and other methods that we are used to. I think that wraps up most of my comments but I might be back later.

MS. BROOKS: Thank you, Diana. You clearly read it very closely and have provided us with a lot of great feedback here that we can look at incorporating. I think you made some great points as to things that were discussed earlier in the Committee so thank you. Earlier and later, throughout the whole process, thank you. All right, Silvia.

MEMBER YEE: Hi, thank you. This is Silvia from DREDF. I think the concept after reading through, I believe that there was some discussion throughout, and especially from the advocates, about intersectional characteristics and discrimination and thinking through what that might mean and I would love to see that reflected here in some way. This is recognition that whether it is going to be in future concepts or future considerations or a little bit more throughout, that we are looking closely at race and ethnicity here and there

is some collection of that information. But there is also, there are also many multiple characteristics. People have race, ethnicity, have disabilities, speak different languages have sexual orientation and gender identity characteristics and that very likely has an impact on their experience of health care. So we have an incomplete picture of race and ethnicity-related disparities when we don't have a picture of some of these other characteristics as well and how it intersects for these populations.

I think that I do recall that being brought up by different people and would like to see that reflected in the report. As Diana said, a stronger, a stronger -- I think this group really pushed for demographic data, emphasizing the importance of it. Not just sort of let's collect it when we can but to encourage plans in any way to be looking ahead. To also be recognizing that this is not just for health -- I mean for health quality but for health equity; and health equity requires a real examination of all the kinds of barriers that people face because of who they are and that is the emphasis that I would really like to include in here. Now I, of course, am speaking from a disability viewpoint, but also recognizing that people with disabilities are -- have different races, different ethnicities and speak different languages. It is again, it is just a concept I would like to see infused a little more throughout the report. Thank you.

MS. BROOKS: Thank you, Silvia. Ed.

MEMBER JUHN: Yes, thanks so much. First I would probably like to start off by saying just thank the Sellers Dorsey team, DMHC and all the Committee Members on this call for kind of groundbreaking conversations and just thankful to be part of the conversation and appreciate everyone's input and feedback.

Maybe adding to Alex's point. You know, it is interesting, because regardless of the percentile that we use, whether it is the 25th or 50th national percentile, you know, the fact that we are requiring all the subpopulations to be above this threshold, I think it is important to consider what the, you know, statistically standards, you know, would mean, you know, for all health plans involved in this and just something for consideration as the final recommendation is made. As well as that as improvement occurs, again, I think we are breaking new ground and we all recognize that health equity and equality is the ultimate goal. That the overall performance of California would actually increase the bar, you know, in the percentages associated with the national percentile. So I think that is just something, you know, I would like to consider and support Alex's comment earlier.

The second thing that I think might be beneficial to more explicitly call out in the report is regarding reassessing the benchmarks and the measures. I know that there is a statute that allows the standards and the measures to be placed for a fixed amount of time. But as we had, I think, collectively discussed in the course of our conversations, as we collect data, evaluate that data, stratify that data and see what that means for us across the state of California, there potentially might be an opportunity to readdress or reassess the measures and standards at maybe another point in time. I know that was briefly touched upon. But given that we are breaking new ground, and that we want to do this right and get this right, I think even though the statute fixes the actual standards in place for I think five years, but potentially language in there to reassess, reevaluate at some point, you know, in between may be beneficial. If it is already there I apologize.

MS. BROOKS: Thank you, Ed. Doreena.

MEMBER WONG: Yes, thank you. Yes, Doreena Wong from ARI. I just, I do have just one. Well, I have many comments and so I don't know if you want me to go through all of them. I thought we were going to actually go through the report section by section because I had different comments for different sections. Do you want me to just go through? I don't know the best way to go through it because I had questions and comments for, you know, all the different sections. Would you like me just go through all of them so you could just take them all then. And some of them are reiterating some of the other comments that people made that I can highlight as well.

MS. BROOKS: Yes, I think if you have comments that are conceptual that you want to make, Doreena, about the report and the different sections that you think should be considered please go ahead and make them.

MEMBER WONG: Okay. Well just in the beginning I just wanted to just clarify that I think like in the beginning the report says that, you know, our Committee met, I guess, over nine months, I think it is only seven months. I wish we could have met more because we tried to push so much information in in such a little amount of time. But I think we began meeting in February and it is September so that is really seven months, not nine months.

And then, and then I think, with the other comments that I think both Diana and Sylvia made by being more specific about the addition of demographic factors, in particular. And I know that I always harped on the disaggregated race and ethnicity, you know, that we needed. That didn't even identify -- that we needed to identify the health disparities. I would think that that should be highlighted a little more because we spent a bit of time talking about

that.

Also, I guess related to reconvening or having this Committee reconvene. In the timeline on page 4 I realized that DMHC may not be promulgating the proposed regulations before 2026 when they get the, you know, final quality compliance report in 2025. So I thought, you know, rather than waiting five years, I think other people have suggested that we reconvene this Committee to see how, what the results of those reports are. And by that time maybe there will be more data that we could include, and we could have some kind of recommendations around that that I think might be helpful. Because I agree that a lot of -- we were very limited by the number of measures that we could adopt because we didn't have either the right data or the, or the measurements weren't stratified by race and ethnicity and other demographic data, and that the measures maybe weren't nationally accepted.

You know, I am thinking specifically about the, you know, the issue around the language data that was raised. And I know that we were trying to, you know, trying to integrate some of those access issues, you know, and have a question around. And this is in particular, I think it was mentioned before in the future concepts, but we really do need to be able to tie in the language access requirements to -- to have a measurement around language access.

And another, I think, conceptual issue that some of us raised was around cultural competency and cultural humility or however you want to name it. But, you know, to actually have a measurement around that. I know, we couldn't, you know, when it came to the voting we couldn't, there were some Committee Members that felt strongly that we should have some kind of measurement around that. It's just that some of the measurements, you know, weren't around

long enough or were new enough and suggested by states that we didn't have enough -- that there wasn't enough time for Covered California to actually develop a measurement around that. So I guess that's another kind of missing concept that I would think -- I would like it to be included in the general conceptual, you know, conceptual measure for the future.

And also I do agree about stressing with regard to disaggregated data. I know there was reference in the section around the OMB, adopting the OMB standards. But I think there was discussion about other possible standards that we could adopt like the census, the American Community Survey categories, and the Section 4302 from the ACA that also recommended additional categories for the Asian and Pacific Islander communities and for the ethnic ethnicities as well. So I just -- I guess I would like to include those kinds of suggestions in the report as well.

And I guess those -- I am sorry, I am kind of trying to go through my whole list of recommendations for that.

MS. BROOKS: We have time, Doreena, go ahead.

MEMBER WONG: Oh, okay. You know, and then with regard to the sexual orientation and gender identity and the data collection around those. I know that we had suggested different entities that have suggestions for that, I think like the Women's Institute at UCLA, on guidance on how these might, how this type of data could be collected on these various categories. And I think we just need to have a little more discussion on those other Silvia identified, you know, especially because of the intersectionality of the different populations that might make them even more vulnerable. That we should put in suggestions that some of us, some of the Committee Members came up with in our discussions.

And then, and then finally, in some of the measure concepts and future considerations I think there's a reference to, you know, having access to translated materials. But I think the whole idea is much broader than just translated materials. But the whole issue of language access more broadly, including access to interpretive services, notices about the free language assistance, I think, you know, could be highlighted. I think we kind of raised, some of us raised those issues as well.

And I think let's see, I think that -- and finally, I guess there was somebody, some other Committee Member raised this issue. It would be nice to have some discussion about how we -- the process that we undertook to narrow the measures, I think there isn't really any discussion about that. I know that we just said, you know, that there were some proposed measurements and then we had to narrow it down. But I know there was just a lot of valuable discussion about, you know, how we thought that a lot of let's say the access issues were incorporated or the patient satisfaction, the patient satisfaction would be incorporated, that I don't think actually got properly incorporated. So I agree that that was one of the concepts that I think is missing in the future considerations.

Even though getting needed care is in there from the CAHPS survey, I think, I think some of us wanted much more, much more, I guess, a direct measurement towards like the barriers to the care. Maybe lack of communication, you know, lack of being able to communicate with your provider, that type of, that type of measure.

Well, I think that those are most of my comments. Oh, and then finally, I guess, I think when we were talking about the obesity measure, since there was so much public comment on that. And I do think that the Committee

Members also, we not only raised it I think but also supported strategies to address it in the future. But of course, we couldn't come up with an adequate measure for that. But I guess I would like to include that the Committee also supported those strategies as well. So thank you for letting me go through all of those.

MS. BROOKS: Thank you for providing us with all of that feedback, that is very helpful. And I think just one thing to kind of mention is that, you know, I know I talked earlier about the fact that we looked at the meeting summaries and that's one thing that we are really hoping can carry a lot of the specific details when people are looking for the background information. Just not wanting to make the report, you know, a 1,000 page report, but wanting to make sure it represents the Committee discussion. And so it is important to hear these things that you are highlighting in terms of areas that we should take a look at again, so thank you. Lishaun, I believe your hand is up.

MEMBER FRANCIS: Yes, thanks, Sarah. And thank you to Sellers Dorsey for pulling this report together, I think it is really comprehensive.

And Doreena actually did say my main comment which was, I really was hoping to see the discussion around BMI and obesity reflected a little bit more heavily in here even though that measure did not pass. So I think the common theme that I am hearing from folks is not just the things that we agreed on but the things that we talked about, you know, at length. The things that we debated and really went back and forth on should also be reflected here because that is also a measure of how the Committee has been thinking through some of these topics.

The other thing that I will flag briefly, as I remember there was

some discussion very early on about age. And not just Adults versus Under 18 but subgrouping of age for say 0-5 population versus 5-12 versus Transition age Youth, that I would like to be reflected here a little bit more under the demographic section. That's all I have right now, thank you.

MS. BROOKS: Great comments, thank you Lishaun. All right, Kiran.

MEMBER SAVAGE-SANGWAN: Thanks. And actually Lishaun said one of the things I was going to say; but just a couple.

One, just a fairly basic thing is I always think it's good to have a definition of equity so that we are all on the same page on what we are talking about, so somewhere in the report to have a call out around what we mean by health equity.

I think there were a couple of things that are in the report that I feel like should be highlighted more in terms of discussions that happened that were important and nuanced and maybe didn't result in a consensus but did result in sort of a majority will. And one is that all health plans would be treated the same. We wouldn't set different benchmarks for our Medi-Cal plans versus our Commercial plans but they would all be held to the same standard and why. I think it would be important just to say a little bit more about that because I do think that was a very important discussion to the group.

And then in the same vein, the idea that the benchmarks will be the same for subgroups, right. So we won't set lower benchmarks for subgroups or that wasn't the recommendation I think is really important to highlight a little bit better in the report. So those two.

And then I also, you know, there is the section at the end that talks

about issues for future consideration and that includes the health equity accreditation, and the demographic data. And it was not my impression that those were, that the Committee was suggesting that the DMHC doesn't deal with those issues right now. So I just feel like calling them future consideration is a little misleading because I think we actually said some of those are fairly foundational.

And for the health equity accreditation, my recollection is the context was looking at some of the measures that were available to us in terms of evaluating health equity, some of which were more process measures, there were a lot of them, some of them didn't quite fit. And so we said, well, instead of trying to pick through and add, you know, one or two of these to our 13 measures, why don't we encourage the Department to require the health equity accreditation, which has many similar components and is something that, to my understanding, Covered California and DHCS are doing so there would be alignment there with all health plans. So I think more context about where that recommendation came from and that it really was tied to the measure set from my recollection and an alternative way of looking at some things; and that, again, I didn't think of it as for like a phase two, I thought of it as something that would potentially go in the regulations that the Department is working on.

And I think similarly for the demographic data as other folks have said, like that really I think people stressed over and over that that really is foundational. It is not really a future consideration, it is a now consideration. And I think it would be beneficial to have more detail about what is going to be required of health plans by the Data Exchange Framework because it really does address a lot of the issues that have come up in here. And talking about what

are those ONC standards and what are the data categories that will be included because it does address SOGI and if we get to Version Three disability, right. I think it is helpful for folks to know that and for the Department to consider that as you think about benchmarks, like what will already be required of the health plans.

And then two more things, one that is a little bit more minor. I didn't totally understand the charts in the back with the votes or like what those were supposed to be telling me. I think they are fine. But if we are listing out votes I would say the one other thing I remember us taking a vote on was the benchmarks and it so might be helpful to list out, okay, which Committee Members voted 25th versus 50th, et cetera, just so you have all the votes recorded in the report.

And then finally as more of a question because this had come up at earlier meetings about how this would apply to the COHS plans in Medi-Cal and I appreciate the clarification about that early in the report. But I think it would be helpful to further clarify because my understand -- well, one is because it talks about DHCS will sort of align with DMHC in terms of how this applies to COHS plans. I think a little bit more detail about what that looks like would be helpful. Because one, I don't know if that means DHCS will be taking more enforcement action, in addition to sort of different payment incentives for these benchmarks. And then also if DHCS wants to set a higher standard for the plans depending on what DMHC chooses. My understanding is that that would be fine but I feel like the report lacks a little bit of clarity around that. So I will stop there. Thanks.

MS. BROOKS: Thank you, Kiran, great comments. And I have taken lots of notes, thank you. All right, Kristine. Welcome and go ahead.

MEMBER TOPPE: Thank you. And I'm sorry I couldn't join on time and so I may have missed some points but Kiran's comments were timely for me in terms of the health equity accreditation component of the report, which my memory was similar to what she described in terms of the recommendation being that the accreditation, which is being required by DHCS for Medi-Cal and Covered California for its plans, and I believe being considered for CalPERS, would create a kind of, a plan, a kind of cross-payer regulator expectation for plans to achieve, to work on that same set of standards across the populations they serve.

But to another point she made, I think the intent of that program is to support the -- all of the tasks that the plans have to do to collect data about members' race and ethnicity and then be able to translate that into action through stratified reporting and be able to then address the disparities or like figure out where the where the -- why the disparities exist and then take action. So that's the context and it becomes kind of a structural support for the execution of the work that has to be done to produce the measures and take action on them. So I just wanted to reinforce what, what I heard and what I believe to be the value of that program in the context of the DMHC choosing health equity measures and measures for stratified reporting. So thank you. And I agree the report is very helpful. I am still culling through it and will provide written comments since I can't be on the call for the full time today but appreciate the opportunity to speak now.

MS. BROOKS: Thank you, Kristine. Stesha.

MEMBER HODGES: Hi, Stesha Hodges at California Department of Insurance. I just wanted to say I was present and I will also be submitting

written comments after I have a chance to review, thanks.

MS. BROOKS: Thank you, Stesha. All right. Other comments or questions from Committee Members? Okay.

I know, we want to have a little bit of discussion around the process measure. Nathan, you flagged that for us earlier. I think we can move to that now. I talked a little bit about this on slide 27 if we want to just flip to -- well, I don't know if we need to go there actually. Well, you're doing it so we'll go there. So under the process measure for measure stratification bullet here, in the report you will see that there is a little bit of language about a process measure. And you know, what it says is that a recommendation was included in the report that the DMHC require health plans to report what demographic data they have collected, for what percent of their membership, along all demographic characteristics. So in alignment with what NCQA is doing and what the Committee recommended otherwise.

An example of this is that plans may report the percentage of members who self-report as being Black or African American. Or they may -- another example would be they might self-report gender identity and/or sexual orientation. So just wanted, this was some language that was included in the report based on discussions that happened during the Committee meetings and wanted to kind of just get feedback as to if this is along the lines of what the Committee was thinking or if there were other thoughts or comments with respect to it? And Mary and Nathan may have comments as well.

MR. NAU: Sarah, I don't have any comments but we wanted to make sure that's what the Committee was thinking with the process measure and whether or not we have to add more detail to the report.

MS. BROOKS: Literally, what's in the report at this time is what I did reflect to you so that gives you some background. And I can look real quick to see which page on the report it's in for you guys. Yes, sorry, I should have had that on. It is on page 13. At the very bottom of page 13 is where it starts. So it is within the Measure Stratification Recommendations section. I see people are looking at it so I am just going to wait. Silvia has got her hand up already, though, so go ahead, Silvia.

MEMBER YEE: No, it's just because I did have, I had a comment about it because I didn't quite understand it. It seems to indicate that -- let me just pull it up for myself and my comment on it. I mean, it seems to be that, yes, we are looking at race and ethnicity and in the future there may be more collection of demographic characteristics. But when it talks about the percentage of members who self-report as being Black or African American, is that not part of the race and ethnicity data that will be, that plans are supposed to be collecting on now? Or am I --

MS. BROOKS: That is correct, it is part of what should be collected now, yes. I think what this is intended to do, Silvia, is look at what is really actually being collected by the health plans and what is not. So for -- I think a better example is looking at the gender identity and/or sexual orientation differentiation actually and considering it in that concept, which is, you know, are the health plans collecting it at all? A health plan is going to report to what level they are actually collecting that data, so that the DMHC can have an understanding of that information.

MEMBER YEE: Okay. Maybe that is the question here for me because I had thought this was more about demographic characteristics that will

not be required but that plans are starting to collect on or have been collecting on, right, such as sexual orientation, or gender identity, or disability or language, the things that won't necessarily be a mandatory requirement yet.

MS. BROOKS: That's right. And I don't know, Nathan, if you had a comment. Sorry, I saw you come off mute.

MR. NAU: No, that that's right. And it would help us inform when enough data is available to make it a requirement so it would help future discussions of this Committee.

MEMBER YEE: Right, and so -- yes, I mean, I --

MS. BROOKS: Did she freeze for you all or is it just me?

MEMBER TOPPE: Yes, she froze.

MS. BROOKS: Okay. We'll wait for a second. Let's move on to Kiran and then when Silvia pops on we'll go back to her if that's okay. So Kiran?

MEMBER SAVAGE-SANGWAN: Yes, just to add. I thought this was also because there is a difference between just having the data and having self-reported data and self-report being sort of the gold standard, right, for demographic data. And I thought this was to mirror what I believe Covered California does, which is have some sort of a benchmark for the amount of demographic data that is self-reported. So I do think that is an important distinction. I still think it is an important measure. I don't know if Covered California can just say a little bit more to explain what they are doing because I do believe it was supposed to be sort of copying what they are doing.

MS. BROOKS: Alice, are you on?

MEMBER ALICE CHEN: Yes, I am. Our requirements are to have a minimum threshold of race, ethnicity completeness and the gold standard,

obviously, is self-reported data. We don't have a way of digging into how the data was collected so it is definitely a process, an engagement with the health plans. But the actual standard for which performance guarantees are tied is 80% completeness.

MS. BROOKS: Thank you, Alice, and thank you, Kiran. Kristine, you look deep in thought but you have your hand up, go ahead.

MEMBER TOPPE: Yes. And I know that others have their hand up but this -- I just wanted to respond back to this piece because we, I think, talked about it in this Committee and I have talked about it -- anyway. Our intent at NCQA is to get to, to have plans report the how they got it, so the direct versus indirect. So that was my recollection of what the hope was for getting to that as a process measure, with the idea that the gold standard is direct data collection. So the -- we are not setting our kind of wish as an 80% but at this point we are not putting any -- NCQA is not putting any kind of penalties or expectations in place. But we are measuring the direct versus indirect as part of the reporting that plans will be doing with the stratification. So I just wanted to provide that clarity and thank you for letting me jump the queue to offer that.

MS. BROOKS: I appreciate it, thank you. Ed.

MEMBER JUHN: Yes, just a quick question that maybe this is something that Palav have can maybe weigh in on. But I know for health plans, especially Medi-Cal health plans, we are reliant on state and county eligibility systems to capture some of that race and ethnicity information. And I know the completeness of medical demographic data is something that I think we understand is part of the CalAIM DHCS strategy and working to improve some of that, you know, piece because I think approximately 20% of Medi-Cal enrollees

have unknown race or ethnicity. I was just wondering what the timing of that sort of looks like in relation to what the DMHC might be, you know, sanctioning with this requirement and if those pieces at the DHS level will be accompanying some of the timing that will impact the plans with this enforcement?

MS. BROOKS: Palav, are you with us?

MEMBER BABARIA: Yes, I am here.

MS. BROOKS: Great.

MEMBER BABARIA: Great question, Ed. I would say globally we absolutely are working at DHCS to see how we can improve the completion of all of our demographic and beneficiary contact information data. Right now our source of truth is what we collect via the Medi-Cal application. But as we launch the Population Health Management Service we are looking at what are other ways in which we can collect that data directly from our beneficiaries as well as other partners who may have that information. I do think, you know, that process is going to be a journey and will probably take us at least a year or two to really start effectuating. Obviously, if DMHC comes up with standards where other source data is allowed beyond DHCS data for identification of SOGI or race and ethnicity that is one option here and we would certainly try to coordinate across departments to try to make some of those standards consistent where we can.

MS. BROOKS: Thank you, Palav, and great question, Ed. Alice, your hand is up.

MEMBER ALICE CHEN: I just wanted to add that I think, I hope but I am fairly confident that everyone on this call is in agreement, we need complete race, ethnicity data. The issue is where we are starting from. I just reviewed comments that our team put together to CMS. We have for a long time

collected race, ethnicity data. But we can't collect everything we want, including SOGI data and disability data, in a streamlined way that is not both complex, clunky and confusing for consumers. And so we are trying to get permission from CMS to be able to collect that data in the same format and file. And I know this impacts Medi-Cal as well because we share the same application portal. So there are a lot of different hoops that we collectively need to jump through in order to get robust, complete, self-reported data.

I will say part of the issue is making sure it is a balance between everyone needs to be in on this because part of our discussion with our health plan partners has been, oh, well, you guys collect data. And we do usually have about an 80% completion rate for race, ethnicity and language. We send it over via the 834 and then expect health plans to both increase the completeness level and ideally make sure that it is patient self-report. Again, given the lack of seamless data exchange and the fact that we don't have a lot of clear standards across the board, all of this is a work in progress.

So I just want to acknowledge that I think as long as all of us have the same goal in mind, we will get there. But it is not going to be super clean in terms of being able to say oh, all of this is self-reported, all of this is administrative, where is it coming from. But I think we are putting all the right pieces in play including the work that NCQA is doing.

MS. BROOKS: Thank you, Alice. Other comments or questions on the process measure discussion?

MR. NAU: Sarah, can I make a comment out of turn?

MS. BROOKS: I don't know (laughter). Yes, of course.

MR. NAU: Just maybe a request. I think you guys spoke clearly on

what you were thinking but if you can include that in written feedback that would be helpful.

MS. BROOKS: So any other feedback comments with respect to the report before we move to public comment? I am just going to wait for a minute.

MEMBER ALICE CHEN: At risk of, I don't want to repeat what a lot of other people have said, I think there are a lot of thoughtful things. That I think this is, in my mind, an incredible first step. Hoping that it will be iterative, hoping it will continue to move the bar up. I do want to say that for me, having lived in multiple realms in terms of on the delivery system level as well as kind of on the policy level and then on the purchaser level, trying to figure out which lever we are using is really important. And I think this idea of having a goal. When I look at the data if we landed on 25th percentile it would be not such a challenge for Commercial plans for the most part, but more challenging for some of the Medi-Cal plans. I think there is real value in having one standard; and having one standard where in short order we can push people so it is not too far above. If it is too high a bar I do worry that people get -- feel like they will never get there. If we can set it into place and we can get everyone up to the same floor.

And importantly, two other things. As we stratify by race, ethnicity I am 100% certain that the Commercial plans will have work to do on different racial and ethnic groups. And again, having that same bar for all Californians I think is a very powerful statement. And the other piece being working hand in hand with purchasers who are playing that other role, right? In my mind DMHC has a regulatory minimum viable performance standard, whereas the purchasers are pushing for aspirational improvement. I think both of those going hand in

hand may get us to where we need to be more quickly. Thanks.

MS. BROOKS: Thank you, Alice, excellent points. Any other comments or questions for today before we move to public comment?

MR. NAU: Sarah, this is Nathan again, do you mind if I?

MS. BROOKS: Go ahead, please.

MR. NAU: Okay. So I was thinking about a comment that was made earlier about requiring the health equity accreditation, which is a good suggestion. And so I wanted to -- I know Sara Durston is online so I wanted to see if we can think out loud. But, Sara, I was thinking that we may need a statutory change to have the authority to require that. Do you have any thoughts offhand? We can take it back and research and get back to the Committee; I don't want to put you on the spot.

MS. DURSTON: Yes, thank you, Nathan. I agree that we can do a little bit more looking but I am most certain that we would need a statutory requirement to require plans to receive health equity accreditation. The purpose of a regulation is to make a statute more specific to kind of clear up any confusion, so the regulation that we will be implementing after this Committee concludes will be making more specific the requirements in AB 133, the budget trailer bill that gave rise to this Committee. There is really no ambiguity about the health equity accreditation requirement in that bill so we would not be able to require plans receive the health -- we wouldn't be able to require plans receive the health equity accreditation without some further statutory support.

MR. NAU: Okay, thanks, Sara. So I think, obviously, this is an important point. So the information will remain in the report, it is just something that the Department is going to have to take back and take a look at. But we will

still, we will still circle back internally and verify just to make sure.

MS. BROOKS: Cheryl.

MEMBER DAMBERG: Thanks. I just want to start by saying, you know, this is challenging work that we have all been discussing over the past several months and, you know, I have certainly learned a lot listening to all the different perspectives on this, you know, set of virtual meetings. And I have to confess, as I said at the outset of the meeting, I haven't had a chance to take a look at the report but will be doing some over the next couple of days so I can't comment specifically on what the content is at this point. But I do want to, I guess, underscore what Alice just offered which is, I would agree that I think it is important to have a common standard out there. And I think, you know, as we advance this work, trying to reduce some of the noise in the marketplace would be extraordinarily helpful. And I also appreciate that there is language in this report that is forward looking and recognizing this as an evolving landscape and that, you know, there may be future opportunities to, whether it is reconvened his Committee or to make some modifications to what we are doing based on what we are learning and what is learned more broadly in this space by other states and the federal government that could inform strengthening this effort moving forward.

MS. BROOKS: Thank you, Cheryl, and we look forward to receiving your other feedback as well. Appreciate all of your comments throughout the Committee, they have been very helpful. All right, any other comments? Okay.

I will check with Shaini to see if we have any hands raised from the public.

MS. RODRIGO: There Is one that just came up.

MS. BROOKS: All right.

MS. RODRIGO: Give me one moment. Mary Reth, you have been unmuted. Please state your name and affiliation.

MS. RETH: Hi, my name is Mary Reth and I am from the San Francisco Health Plan. I just have a couple quick questions on this measure set. So just to clarify, it sounds like this is a new measure set that health plans will now need to report starting measurement year 2023. So we do currently report two different measures sets for NCQA accreditation and the MCAS so this will be a third, it sounds like it will be a third measure set that we would need to start reporting as well. So how will this measure be reported to DMHC and will it need to be audited like our other two measure sets?

MS. BROOKS: Nathan, do you want to speak to that?

MR. NAU: Sure. Thank you for the questions. And so we plan on releasing a few All Plan Letters regarding this effort. One of them will be hopefully before the calendar year and it will just have high level information. But as we move into 2023 we would amend the APL and have more specific information that would include how it is going to be reported to us and whether or not there will be auditing requirements.

MS. BROOKS: Mary, did you have any other comments or questions?

MS. RETH: Okay, no thank you, that was helpful. So it sounds like we will be getting more detailed information on how this measure set will be audited and submitted.

MR. NAU: Correct.

MS. RETH: Thank you.

MS. BROOKS: Shaini, other hands up from the public?

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

MS. BROOKS: I think then we will move to slide 33, which is the public comment slide. Public comment may be submitted to publiccomments@dmhc.ca.gov until 5:00 p.m.--I see hands up. I am just going to read this real quick, I'm sorry--on September 19. So we are looking for feedback from the public and also from Committee Members through that time, 5:00 p.m. on September 19. Members of the public obviously should refrain from contacting Committee Members directly regarding this and submit comments to the DMHC directly.

Silvia, I see that your hand is up.

MEMBER YEE: I believe Andy actually had his hand up before me, so.

MS. BROOKS: Okay, okay, sorry. Go ahead, Andy.

DR. BASKIN: Yes, just a point of information, a very brief one. It just so happens that all of our measures are measures used in the HEDIS measure set except the CAHPS measure, but that is also part of NCQA accreditation. So all the health plans already report these measures to some entity, meaning to NCQA, and NCQA does have a process that will assure the quality of the data. And in some instances there's auditing of the data or some other processes to assure the quality of the data. So just as a point of fact, whether DMHC has some other audit above and beyond that, of course as Nathan said, is a decision that is yet to be made and that's fine. But there is already some process in place for the data integrity here.

MS. BROOKS: Thank you, Andy. All right, Silvia, your turn, you are up.

MEMBER YEE: Thanks. Silvia from DREDF. I guess I was just thinking about that, the comment that the Department would also be looking to what other data collection is happening. The proposed Section 1557 rule, which is not finalized yet of course, does have some proposals around data collection, entities that are covered by the 1557 rule. I mean, it is sort of an interesting proposal using its existing -- what the Office of Civil Rights, the Office for Civil Rights at HHS calls its existing regulatory authority to require reporting. And if that's the kind of thing -- the rules aren't finalized but it's something that could happen over the next five years and it does seem to me to speak again to having something. Even though it has been emphasized to us that the regulations that DMHC puts out can't be revisited, let's say, for five years, it does speak to me to having something in there now about potentially incorporating or requiring plans to be keeping up. To be -- if something else requires them to be collecting data, demographic data, that they will be sharing that data with DMHC or, yes, along those lines. Just that DMHC will be watching what happens and incorporates the data developments that will be happening over the next five years. Thank you.

MS. BROOKS: Thank you, Silvia. Kristine.

MEMBER TOPPE: Hi. I was just going to follow up on Andy's point about the audit and I will put this in written comments as well. But to answer or to further address the person who posed the question from San Francisco Health Plan, the existing reporting, in order for health plan data to be included in any kind of national benchmarks it has to go through a HEDIS compliance audit. So while there are scenarios where plans can report

measures for specific uses that may not require a HEDIS audit, those data would never be included in the national benchmarks for measures because they are not considered comparable because they haven't been reviewed. So there's kind of policy steps that we require states to go through if they are going to have plans report data and so there's some just detail that kind of can further be fleshed out that describes kind of when that's applicable and when it is not. But I think in general I just wanted to reinforce Andy's points about, you know, data that is reported for Medicaid or Commercial purposes, for example, go through the HEDIS audit compliance process in order to be considered valid and reliable and used for payment reporting, all of the potential use cases; so just wanted to follow up on that.

And appreciated Silvia's point about OCR. I have not reviewed that, that rule yet but it sounds like I probably need to put that in the, in the queue.

MS. BROOKS: Great, thanks, Kristine. Kiran.

MEMBER SAVAGE-SANGWAN: Yes, thanks, Sarah. Just one issue that wasn't really touched on that I recall in our discussions that I wanted clarification on is the Introduction. I think the statute says that these measures and benchmarks will apply to full service plans and behavioral health plans. I am just wondering if you could talk a little bit about how the Department intends to apply what is in the report to the behavioral health plans in particular.

MS. BROOKS: So I am going to defer to DMHC on that question, if that's okay?

MR. NAU: Yes, thank you, Sarah. So, I mean, the short answer is that anything that is applicable to a behavioral health plan we would apply to

them. So that would mean that only some of the quality measures such as, I believe, probably depression screening would apply but others would not. And so we would have to look at what we think apply. What our final policy is, what we think applies, and then we would have to outline clearly what the expectations are for behavioral health plans.

MS. WATANABE: And Kiran, I will just note that it was important for us not to exclude them. I think there is a tremendous amount of interest in understanding what is happening in the behavioral health area. I think there is a collective acknowledgement that we probably don't have the right measures yet. I think we are very hopeful that over the next few years the measurement around behavioral health will improve; and so to the extent that there were more measures included we would apply those to the behavioral health plans.

MS. BROOKS: Thank you. All right, any other questions or comments on the report?

MS. RODRIGO: Sarah, we do have one hand raised from the public.

MS. BROOKS: All right, let me just check real quick, Shaini.

Anything else from the Committee Members themselves?

All right, Shaini, why don't we go ahead and move to that person publicly, thank you.

MS. RODRIGO: Okay. Leslie Goodyear-Moya, you have been unmuted, please state your name and affiliation.

MS. GOODYEAR-MOYA: Hi, Leslie Goodyear-Moya from Manifest MedEx and I have a past life in a C&L department. So I just wanted to make a comment about the race, ethnicity, language, and SOGI process field that you all

have been discussing. And I just want to, I guess, make the comment that, one, of course it is amazing that we are going to be increasing the data collection there, but to be mindful that probably a large proportion of those responses will be, decline to state. And that we all kind of need to be thinking about how to handle decline to state in terms of overwrite rules and in terms of, you know, is that going to be considered reported or not reported? And then kind of the, you know, kind of the subsequent comment would be that it is tough as a health plan to get past the decline to state and there needs to be a bigger move to educate the public on the importance of the data collection. And yes, just looking forward to seeing what happens in the future. Thank you.

MS. BROOKS: Thank you, Leslie.

Shaini, any other public comment hands?

MS. RODRIGO: At this time there are no other raised hands.

MS. BROOKS: Okay. So what this does is brings us to the conclusion of this meeting series. I am smiling because we have done a lot of -- we have gone through a lot of discussion and hard work, and just want to thank everybody for that. I think it has been a great Committee and just appreciate everyone's input.

As we talked about, you will have until 5:00 p.m. on September 19 to provide us with any comments on the report itself. We ask that you provide kind of conceptual comments if you have them as opposed to redline specifically.

The final report will be posted online in the near future with a date yet to be determined; but that will be provided as an update to the Committee, I'm sure, once it is available.

And additional information about the activities of the Committee

can be found on the DMHC website, as you know.

And with that unless, Mary, do you have any final closing remarks that you would like to make? I know you made some earlier.

MS. WATANABE: No, I mean, I will just say, Sarah, appreciate you and the Sellers Dorsey team for all of your work that has gone into getting ready for these meetings and to the DMHC team as well. We have weekly meetings to prepare so it has been a tremendous amount of work for all of those involved in the logistics.

Nathan, I don't know if you want to add anything.

And I know, Kiran, you had your hand up so I don't want us to close without getting to your question, if you had one.

MS. BROOKS: Sorry about that.

MEMBER SAVAGE SANGWAN: Sorry. I just thought of a question but then I didn't --

(Several people speaking at once.)

MS. BROOKS: Sorry, Kiran, I missed that, I'm sorry.

MEMBER SAVAGE-SANGWAN: No, no, no, I put my hand up late. Just a process question. Since this is public comment now would we still be in violation of Bagley-Keene if we worked with others on the Committee to provide joint comments to you?

MS. BROOKS: Sara Durston?

MEMBER SAVAGE-SANGWAN: Sorry.

MS. DURSTON: You see me thinking. That's a great question; because the formal meeting series has ended. I am not sure. Mary, do you have any gut instinct on this?

MS. WATANABE: I don't. But I will just say, let's say yes, you all should work together and get us good feedback. I will just stress the importance of giving us feedback on the report in particular as soon as possible. And then, you know, additional feedback on what the Department should consider as well is very important, but the priority would be the report feedback. But I am going to make the call that will allow you all to work together since we are formally ending the public meeting.

MS. DURSTON: Okay. Mary, I'll respond. I am receiving messages from Sarah Ream who is also agreeing that since we are not taking any more action as a Committee we will allow it.

MS. WATANABE: Thank you, I feel much better, yes. When the general counsel says it is okay then I feel validated. Thank you.

MS. DURSTON: Thank you.

MS. BROOKS: Great question. Any other questions, though?

All right. Well, with that we are going to go. Thank you to everyone again. It has been a wonderful ride and we appreciate it, thank you so much.

(The Committee meeting concluded at 1:37 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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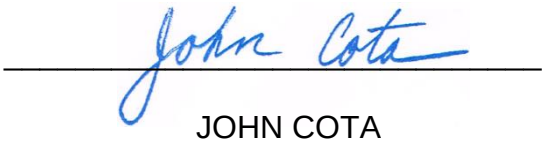

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September 23, 2022

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