MetroPlus Health Plan, Inc.
Board of Directors Meeting
February 2nd, 2021

Minutes

The meeting of the Board of Directors of the MetroPlus Health Plan, Inc. (hereafter "MetroPlus or the Plan") was held in the 12th Floor Executive Conference Room at 160 Water Street, New York, NY 10038, on the 2nd day of February 2021 at 2:00 P.M., pursuant to a notice which was sent to all the Board of Directors of the Corporation and which was provided to the public by the Secretary. The following Directors were present via video conference/ via teleconference:

Ms. Sally Hernandez- Piñero
Dr. Talya Schwartz
Mr. Matt Siegler
Dr. Eric Wei
Mr. Christopher Roker
Ms. Nella Lewis
Mr. Sherif Sakr
Ms. Vallencia Lloyd

Ms. Hernandez-Piñero, Chair of the Board, called the meeting to order at 2:05 P.M.

Ms. Hernandez-Piñero chaired the meeting and Ms. Jessica Bauer, Secretary to the Board, kept the minutes, thereof.

ADOPTION OF THE MINUTES

The minutes of the meeting of the Board of Directors held **December 22nd, 2020** were presented to the Board. On a motion by Ms. Hernandez-Piñero and duly seconded, the Board adopted the minutes.

The minutes of the meeting of the Executive Committee held **January 8th, 2021** were discussed in detail to elaborate on the resolutions that were approved. On a motion by Ms. Hernandez-Piñero and duly seconded, the Board agreed unanimously with the approval of the resolutions.

There being no further questions or comments, Ms. Hernandez-Piñero turned the meeting over to Dr. Schwartz.

CHIEF EXECUTIVE OFFICER'S REPORT

Dr. Schwartz's remarks were in the Board of Directors packet and a copy is attached hereto and incorporated by reference.

Dr. Schwartz noted that she would be presenting in the absence of Ms. Leverich-Castaldo and that the administrative needs of the Board has been transferred from Ms. Kathy Nolan to Ms. Jessica Bauer. This is not an official appointment that requires Board approval.

Dr. Schwartz introduced the three new members of the MetroPlus Executive staff: Ms. Michelle Reay is the new Chief Operating Officer, joining MetroPlus with many years of health plan experience. Ms. Lesleigh Irish-Underwood is the new Chief Brand and External Relations Officer, also joining with many years of health plan experience. Ms. Robin Fisk is the new Head of Legal, joining to provide support to anything legal related.

Dr. Schwartz explained to the Board as this is the first Board meeting in 2021, she wanted to go through the focus for the upcoming year. Dr. Schwartz noted the main focus is to run the Plan efficiently given all the changes coming from the State that include COVID-19 adjustments, rates adjustments, and potential carve-out that create a significant financial impact, despite significant membership growth. Dr. Schwartz stated that it was difficult to predict, in a time of COVID and all the State's actions, how membership growth may impact the Plan. Thus, the Plan needs to operate more diligently on expenses, improving operations and managing risk.

Dr. Schwartz explained that last year there was a new initiative to continue the significant progress the Plan made around customer experience. The Plan created an operational infrastructure around this initiative so that it was not just a concept. An example of the results that the new Customer Experience Operations department was able to achieve is that when open enrollment was approaching for QHP and for members to renew their coverage, the Plan had the highest ever renewal rate for QHP and the highest conversion rate from QHP into Essential Plan (EP) and Medicaid. This was a deliberate collaboration effort between Customer Experience Operations and the Sales team under Mr. Roger Milliner, Chief Growth Officer, to make sure that the Plan retains those members by proactively reaching out to the members as their circumstances change. The retention rate shows what can be achieved when the Plan optimizes its Customer Experience Operations.

Dr. Schwartz stated that moving into the year 2021, the Plan intends to expand this initiative into the provider experience and the value proposition. The Plan started conversations with a few large independent physician associations (IPAs) in 2020 but had to pause due to the COVID-19 pandemic and has since resumed conversations with the intention to finalize the conversations and have a contractual agreement that aligns interests in the benefit of the Plan's members.

Dr. Schwartz described the next area of focus for the Plan in 2021 is target organic expansion around geography and line of business (LOB). The Plan has identified zip codes and communities that will be a natural expansion. Dr. Schwartz explained that the other approach to achieve organic expansion is through leveraging opportunities with specific LOBs.

Dr. Schwartz described the next area of focus for the Plan in 2021 is tightening operations to improve the Plan's retention efforts, help with sales opportunities, and alignment with key provider constituencies. Currently, the Plan operates on multiple platforms with multiple data sources.

Dr. Schwartz described the last listed area of focus for the Plan in 2021 is the Behavioral Health in-house transition and noted that Dr. Sanjiv Shah, Chief Medical Officer, would be giving a more in-depth update on that later in the meeting.

Ms. Raven Ryan-Solon, Chief Legal & Compliance Officer, presented the regulatory updates to the Board. As part of the federal bill to assist with the COVID-19 pandemic, there was an increase in the Medicare Physician Fee Schedule which will be reflected in the financial report later in the presentation. This has a significant financial impact to the Plan. This was passed as part of the emergency bill on December 27th, 2020 and went into effect in January 2021.

Ms. Ryan-Solon stated that the State Department of Health (SDoH) is looking into what actions can be taken to alleviate the burden for Plans and the cost relating to rates changes. All New York State related Executive Orders were extended to at least February 22nd, 2021. Cost sharing waivers extended to various dates in March 2021, depending on the service. Families First Coronavirus Response Act (FFCRA) benefits for the Plan's employees expired on December 31st, 2020. Disenrollment moratorium for Medicaid, Child Health Plus (CHP) and Essential Plan (EP) has been extended through June 2021. If the federal declaration of a State of Emergency is extended through to the end of 2021, that would impact these disenrollment moratoria, recertification and grace period populations for the ACA associated Plans that are in effect. Effective February 28th, 2021, the State is resuming Medicaid disenrollment for members with Third Party Health Insurance (TPHI). Open enrollment in New York State (NYS) was extended through March 31st, 2021. The federal exchange extended its open enrollment to May 31st, 2021, but NYS is not mandated to extend and may decide to extend to align with the federal open enrollment.

Ms. Ryan-Solon went through the NYS budget proposals released by Governor Cuomo for State Fiscal Year (FY) 2022, which starts on April 1st of each year. The budget is in the legislative hearing phase. Legislative hearings run through the end of February 2021. Some of the proposals that were mentioned by Governor Cuomo and released in his State of the State guidance but were not reflected in any of the budget bills being presented to the legislature include tying quality incentives to a reduction in health disparities, mandating coverage for virtual emergency rooms, and creating telehealth reimbursement requirements. Indirect health plan operation impacts include updating State privacy protections, extension of State procurement policies to July 2023, modification to no-fault insurance use by health care providers, and the legalization of cannabis use and the "millionaire tax". Which will help to close the budget gap that NYS is facing and impacts the Plan through its rates.

Ms. Ryan-Solon described the NYS budget proposals that have direct Plan impacts, as outlined in the included slides, some of which will be discussed again in the financial performance section of the presentation. Ms. Ryan-Solon added that the Medicaid and Managed Long Term Care (MLTC) quality pool funding had been reduced by 50% last year, with the proposal aiming to eliminate it entirely in FY 2022. Effective June 1st, 2021, elimination of the EP $20 premium for up to 200% of the federal poverty level (FPL), would expand the population of individuals that EP is available to. This would also have potential Plan impacts on the QHP LOB as members who would have previously only qualified for QHP could also now qualify for EP. EP has a trust fund from the federal government, so while the NYS government does not have funds to support a Medicaid or MLTC quality pool, the NYS government may be able to use these federal funds to create an EP quality pool. The remaining budget proposal items listed on the slide have less of a financial impact on the Plan.

Board Members asked if these direct Plan impact proposals are currently going through the legislative process. Ms. Ryan-Solon replied that yes, they are going through the legislative process and that February 3rd, 2021 is the first hearing on the healthcare related bills. For the most part H+H and MetroPlus are represented by the Mayor in presentations, and the NY Health Plan Association testifies at the legislative hearings.

Ms. Ryan-Solon presented the budget proposals that are related to telehealth, as they are outlined in the attached slides. Ms. Ryan-Solon added that the government is looking to extend the telehealth expansion that they made as part of the pandemic and the COVID-19 Executive Orders into permanent law and make them a standard for telehealth and telemedicine in NY State.

Ms. Ryan-Solon stated the budget proposals on general healthcare as they are outlined in the attached slides. Ms. Ryan-Solon added that a lot of these proposals would impact H+H. The Pharmacy carve-out is scheduled to occur on April 1st, 2021, to date the State has not changed that deadline but there are conversations taking place at the State level to potentially push the deadline back. The Pharmacy carve-out is extremely impactful both for Plans and members. The concern is that potentially making it more confusing or complicated for members to access their prescriptions in the middle of a pandemic could be a large problem and the State is still determining where in the budget the savings from the Pharmacy carve-out would materialize.

There being no further questions or comments on the regulatory updates, Ms. Ryan-Solon turned the meeting over to Dr. Schwartz.

Dr. Schwartz presented the updates on membership and utilization in the absence of Ms. Leverich-Castaldo, Chief Administrative Officer and Acting Chief Financial Officer. On the MetroPlus dashboard, Dr. Schwartz added that the only driver to the slight decrease of medical spend at H+H was due to the recent retroactive State cuts for the COVID-19 adjustment in place as of April 2020. Dr. Schwartz briefly described the trends for the CRM implementation, Behavioral Health (BH) in-sourcing and primary care provider (PCP) assignment.

Dr. Schwartz reported on membership by line of business (LOB), noting that the numbers have already increased since the slide deck was submitted. From January 2020 to January 2021, MetroPlus membership has grown by almost 100,000 new members. Enrollment trends align with trends seen by other Health Plans.

Dr. Schwartz reported on the status of MetroPlus' market share for membership.

Dr. Schwartz reported on the claims-based activity for COVID-19 diagnostic and antibody testing, noting that the numbers are an underestimate of testing because a lot of the tests that the Plan's members are receiving is not coming through in claims.

Dr. Schwartz reported on the inpatient claim activity for COVID-19 related admissions. Due to claims lag, the current increase in COVID-19 admissions is not yet reflected in the data but is expected to catch up. Average length of stay (ALOS) for inpatient admissions increased during the peak of the pandemic and is now trending down to a more typical ALOS.

Dr. Schwartz presented the financial performance updates as reflected in the included slides, in the absence of Ms. Leverich-Castaldo, Chief Administrative Officer and Acting Chief Financial Officer. NY State implemented a COVID-19 rate adjustment, retroactive to April 1st, 2020 which decreased the premiums for the Medicaid LOBs due to lower utilization during the pandemic. There was a decrease in the use of medical services in the 2nd quarter of 2020. Utilization of services started to pick up in the 3rd quarter and almost returned to baseline utilization in the 4th quarter. NY State conducted an independent assessment, where despite the return to almost normal utilization of medical services in the 4th quarter and the additional cost of medical expenses around testing, the premiums that were paid were determined to be higher than what the Plans needed to cover medical expenses and the State adjusted premiums, which will be reflected in the 1st quarter of 2021.

Dr. Schwartz reported that in addition to the COVID-19 rate adjustment, NY State implemented rate cuts.

Dr. Schwartz reported on the NY State budget initiatives for FY 2021. There is a new 1% across-the-board (ATB) reduction coming, after 1.5% ATB reductions in 2020. The elimination of the subscriber premiums in the EP LOB is expected to have an impact on the Plan but will remove a barrier to coverage.

Board Members noted that the elimination of the Medicaid and MLTC quality pool incentives hurts the Plan because the Plan has always performed well on quality measures, and the State should want to incent quality. For re-enrollment, there were a couple of years where the Plan's net new membership growth was very low, so the automatic re-enrollment gives the Plan a longer period of time to show new members all of the positive changes it has made in the customer experience.

Board members asked for clarification in the slides on the difference between the 2020 utilization due to COVID-19 was low, so the State made a negative adjustment to the premium, and in the 2021 budget showing an increase due to COVID-19.

Dr. Schwartz clarified that the budget impact is an additional negative rate adjustment, not a positive rate adjustment.

Dr. Schwartz responded to Board questions saying she agreed with the remarks about the quality pool and this was a very difficult decision for the State. Quality is not a standalone item, because it feeds into value-based payment (VBP) arrangements that the Plan is eager to promote. The Plan is hoping that once the State's financial circumstances stabilize, that this will be the first thing that gets restored. In anticipation of the quality pool being restored, the Plan continues to keep the structures in place because quality is important, and the Plan needs the funding to continue running it. The Plan has a lot of investment in making sure that quality is maintained and since the Plan believes the quality pool elimination is only for a short-term period, the Plan will avoid making any drastic changes to the infrastructure where possible.

Dr. Schwartz added\ that maintaining a relationship with the Plan's members is exactly what the Customer Experience department is focusing on. This is not just contacting the members when it is time for them to re-certify but working on what the Plan can do for the members throughout the year and increasing the value the member gets by being covered by MetroPlus.

There being no further questions or comments, Dr. Schwartz turned the meeting over to Mr. Roger Milliner, Chief Growth Officer.

Mr. Milliner discussed the engagement that the Plan had with Marwood Group, consulting firm. Marwood conducted market analysis to be able to provide feedback to the Plan on how it can grow. Mr. Milliner described the Sales department related recommendations.

Mr. Milliner reported that the Plan has expanded its business partnerships to over 15 organizations that can connect the Plan to its target audience. These partnerships will focus on generating referrals, conducting educational enrollment sales seminars, onsite marketing, joint media advertising, increased engagement through collaborative digital and social website integration, and many other strategies to help identify new opportunities.
There being no further questions or comments, Mr. Milliner turned the meeting over to Dr. Sanjiv Shah, Chief Medical Officer.

Dr. Shah reported on the Plan's 2020 Managed Care Consumer Guide performance. The consumer guide is an outward facing reflection of the Plan's quality and is measured on a star rating scale where the highest rating is five stars and the lowest is one star. The latest information is from measurement year (MY) 2019 and covers three major domains. One domain covers preventative care for adults, adolescents, pediatrics, maternal care, and women's care, where the rating is based on Quality Assurance Reporting Requirements (QARR) measures. The second domain focuses on chronic illnesses like diabetes, cardiovascular, respiratory, and behavioral, where the rating is based on QARR measures. The third domain focuses on consumer experience, which is based on a Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey that alternates between the adult and child side, year over year. In 2019, the CAHPS survey that was in this measurement was conducted on the adult consumer experience. MetroPlus was awarded the highest rating of five stars. Healthfirst was also awarded five stars. The rest of the NYC Health Plans were awarded three stars and lower.

Dr. Shah noted that a lot of work is being done in conjunction with community providers and H+H to improve the Plan's score, especially as it pertains to getting needing care. Board Members suggested that post COVID-19 pandemic it would be beneficial to do something to highlight the Plan's five-star rating.

Dr. Shah responded in agreement and added that it really reflects the hard work done across the Plan, a lot of it driven by the Quality Management department headed by Eleanor Sorrentino. Customer Experience now being its own department, focusing on the CAHPS piece and collaborating with H+H and providers to improve those ratings. MetroPlus performs similarly with the Medicare LOB, where the Plan preforms very well on the Healthcare Effectiveness Data and Information Set (HEDIS) measures and performs poorly in the CAHPS measures.

Dr. Shah reported on the Behavioral Health (BH) in-house transition updates. Network development remains the most critical piece, aiming to submit the majority of the network to NY State Department of Health (NYSDOH) by April 2021. One outstanding issue is with Utilization Management (UM), as the Board has already been made aware, the State is pushing the use of Level of Care Utilization System (LOCUS) and Child & Adolescent Level of Care Utilization System (CALOCUS) where the majority of Plans do not currently use these systems. Majority of Plans use InterQual or Milliman Care Guidelines (MCG) and MetroPlus has submitted as response to the State to request continuing to use InterQual. This is under review with the State and the Plan will make any necessary updates if the State decides that LOCUS & CALOCUS must be used. The Plan is working with its claims vendor to ensure it will be ready

to process the claims, and testing will be a big part to ensure accuracy with an April 2021 completion date. The Plan is required to develop a standalone customer service area that supports a 24/7 crisis line for the mainstream and Health and Recovery Plan (HARP) membership.

Dr. Shah reported that the Plan brought in a consultant that was the CEO of a BH Plan, to review the BH clinical program design and provide guidance on this implementation. Recruitment of BH staff is at approximately 9%, because the Plan is being financially cautious not to hire staff in new positions too soon. The majority of the staff will be hired in time for the onsite readiness review in July 2021. A lot of the Beacon staff will be available for the Plan to hire due to this transition and the Plan has scheduled multiple recruitment events with Beacon clinical staff to help with the hiring effort.

Dr. Shah explained that the State expects the Plan to mirror Beacon's BH network because if there is a sufficient number of members that use the Beacon providers for BH services, then the Plan is expected to contract with those providers unless an issue is identified, such as the provider's location is outside of the Plan's service area. There are 915 contracts that were distributed to providers and to update the number on the slide, a total of 376 contracts have been returned and are being processed, including a few major independent physician associations (IPAs) that will add major capacity to the Plan's network.

Dr. Shah and the Board members discussed the provider contracting process and progress to achieve network adequacy, including with Article 31 and 32 providers.

Dr. Shah replied that when the contracts are distributed and we have agreement on terms, then the Plan has to credential all of the providers. If a provider is in a non-delegated arrangement, then the provider will be individually credentialed. Article 31 and 32 providers directly credential their practitioners. Providers that are contracted and credentialed are captured in the Provider Network Data System (PNDS) report that is submitted to the State in April 2021 to show the Plan's network development. The next step is to load the providers and the fee schedules into the claims system so that testing can be completed. To summarize, the three steps are contracting, credentialing, and provider loading.

Board members and staff discussed MetroPlus efforts to develop VBP arrangements for BH.

There being no further business, Ms. Hernandez-Piñero adjourned the meeting at 3:17 PM.

EXECUTIVE SESSION

The Board reconvened in Executive Session at 3:17 P.M.

The Board reconvened in open session - there being no further business Ms. Hernandez-Piñero adjourned the Executive Session at 3:42 PM.