Integrated Healthcare Association

# IHA's Health Policy Update

## Welcome

**Dolores Yanagihara, MPH**

Vice President, Strategic Design and Initiatives, IHA

# 2023 Stakeholders' events and communications

## In 2023, we'll continue to bring you key information and share IHA work that is

Timely

Tailored to your interests

Using familiar touchpoints

# Today's program

What to expect from each session

- Legislative and policy updates
- Office of Health Care Affordability
- Provider directories
- Wrap up

# Legislative and policy updates

**Athena Chapman**

Chapman consulting

# Legislative and Budget Dates

- **May 14** – May Revise budget released
- **June 2** – Last day for bills to be passed out of the house of origin
- **June 15** – **Budget bill must be passed by midnight**
- **July 14** – **Summer Recess**
- **August 14** – Legislature reconvenes
- **September 14** – Last day for each house to pass bills
- **October 14** – Last day for Governor to sign or veto bills

# Governor’s May Revise 2023

**May 14 – May Revise Budget Released**

**Significant Budget Shortfall**

**$9** billion higher than January estimate

**$31.5** billion in total

**No substantial reductions in health care spending/Governor’s priorities**

Reductions in other spending, trigger delay, funding shifts, borrowing from special funds and $2.5 billion Managed Care Organization (MCO) Tax

Includes $245.7 billion ($73.3 billion General Fund) for all health and human services programs in 2023-24

# Final Budget Bill

- On June 15, California legislators passed a $312 billion spending plan that addresses a $30.7 billion deficit
- The spending plan is very similar to the proposed May revise budget with no major cuts to health care. It also:
  - Does not involve any withdrawals from California's $37 billion rainy day fund
  - Does not increase taxes on individuals or businesses BUT tax filing deadline was extended into October 2023 which puts $40 billion of expected revenue in limbo
- Negotiations between lawmakers and Governor Newsom continue with a June 27 deadline to sign the budget bill
- Budget trailer bills to amend state law to implement the budget will also continue to be negotiated throughout the summer

# Managed Care Organization Tax

- On May 8, the Department of Health Care Services (DHCS) released an updated MCO Provider Tax proposal that would renew the MCO Provider Tax (MCO tax) which expired in December 2022, and had resulted in $2 billion in General Fund revenue annually.
- In the proposal, the MCO tax would begin on April 1, 2023, nine months earlier than planned resulting in approximately $3.7 billion in additional General Fund revenue.
- DHCS must submit its MCO tax proposal to the Centers for Medicare & Medicaid Services (CMS) for approval by June 30, 2023.
- The Administration also proposes to increase MCO tax revenue to achieve an approximately $5 billion annual state benefit ($19.4 billion over the proposed MCO tax period).
- The proposal also increases provider rates to 87.5% of Medicare for primary care, maternity care, and non-specialty mental health services in 2024, and to additional providers in 2025.
- More details to effectuate this proposal will be in budget trailer bill language.

# Unified Financing/Universal Coverage

## AB 1690 (Kalra) Universal Health Care Coverage.

- *This is now a two-year bill and will not advance this legislative year.*
- This bill states it is the intent of the Legislature to guarantee accessible, affordable, equitable, and high-quality health care for all Californians through a comprehensive universal single-payer health care program that benefits every resident of the state.
- AB 1690 was introduced in coordination with Assemblymember Kalra and the California Nurses Association, but it is anticipated that a full bill proposal won't be introduced until 2024.

## SB 770 (Weiner) Health Care: Unified Health Care Financing.

- *This bill has been referred to the Assembly Committee on Health.*
- This bill instructs California to seek a waiver from the federal government to allow Medicaid and Medicare funds to be used for a single-payer health care system.
- It requires the Secretary to establish a Waiver Development Workgroup to provide quarterly reports on the outcomes of waiver discussions with the federal government and the progress of the workgroup, and to submit a complete set of recommendations regarding the elements to be included in a formal waiver application and the legislative action needed by June 1, 2024.
- Fiscal costs have been assessed as indeterminate, but potentially in the low millions in 2023-24 and ongoing thereafter for establishing the new workgroup.

# AB 616 (Rodriguez) Medical Group Financial Transparency Act

- *This bill is in the Senate and has been referred to the Rules Committee for assignment*

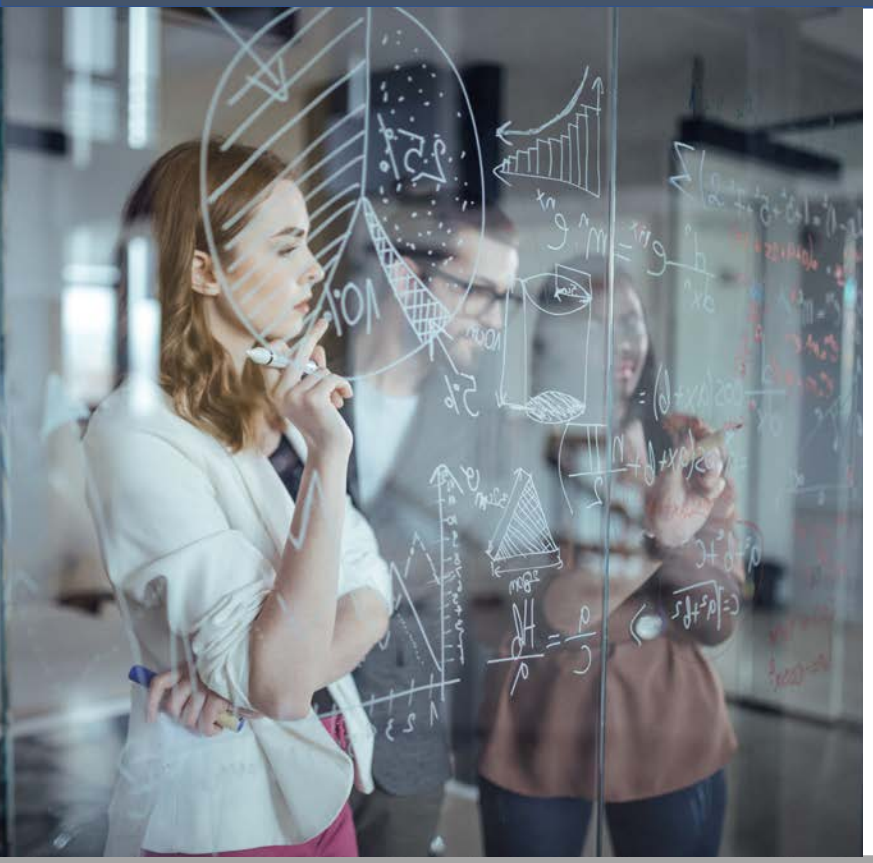
**This bill would:**

- Authorize the disclosure of audited financial reports and comprehensive financial statements of providers and physician organizations collected by the Office of Health Care Affordability (OHCA) and financial and other records of risk-bearing organizations made available to DMHC.
- Authorize OHCA and the Department of Health Care Access and Information to use confidential audited financial reports and comprehensive financial statements only as necessary to carry out functions of the office.
- Require certain physician organizations to produce or disclose audited financial reports and comprehensive financial statements to OHCA and that these be made available to the public.

# AB 1092 (Wood) Health Care Service Plans: Consolidation

- *This bill has been referred to the Senate Committees on Health and Judiciary.*
- AB 1092 expands regulatory oversight over health plan transactions, building on prior legislation which requires an entity that intends to merge with a health plan to give notice to, and secure prior approval from, the DMHC Director.
- This bill applies to health plans that merge or acquire other entities (e.g., a physician group).
- DMHC estimates the total cost of this bill to be approximately $1.23 million in FY 2023-24, $1.78 million in FY 2024-25, and $1.75 million in FY 2025-26 and annually thereafter.

# Other Policy Activities



- Health Care Payments Database (HPD)
- Data Exchange Framework (DxF)
- CalAIM
- OHCA – Separate panel presentation & discussion
- Public Option Proposal – Golden Choice
- DMHC – Health Equity Metrics

# Department of Health Care Access and Information (HCAI): HPD Program

- February 28, 2023: HCAI submitted the Long-Term Funding Options for the HPD Program report to the legislature; current funding expires in June 2025.
- HCAI's report to the legislature recommends annual total funds of $22 million be allocated to the HPD Program ($15.4 million in state funds) starting with Fiscal Year (FY) 2025-26.
- The HPD System has collected and processed over 16 billion total records of production data from CMS, DHCS, and commercial data submitters.
- The first public reports will be released in July 2023, and will include data from 2017–2021.
- 2023 public reports will include a snapshot of the overall data collected, an interactive visualization on chronic conditions, health care utilization, and demographics, and a report on pharmaceutical costs.

# Public Option Proposal – Golden Choice

- UC Berkeley leaders Richard Scheffler, PhD, and Steve Shortell, PhD, released a research study on a proposed public option health insurance plan called “Golden Choice.”
- Leverages the delegated risk model of California’s delivery system, which allows insurers to transfer some or all of the risk of the costs of providing care to medical groups and IPAs.
- Key findings from the study indicate that Golden Choice would have the lowest premiums in 14 of the 19 Covered California regions and save $243 million ($1,389 per year per projected enrollee) in one year.
- IHA data was used by the authors as part of the analysis for this proposal.

# California Health and Human Services (CalHHS) – Data Exchange Framework (DxF)

- The DxF and the statewide data sharing agreement (DSA) will facilitate the exchange of health information among health care entities, government agencies, and social service programs beginning in 2024.
- The DxF DSA Signing Portal is now open for providers and healthcare entities to sign the DSA. State law requires most providers and healthcare entities to sign the DSA by January 31, 2023.
- CalHHS has allocated up to $47 million for DSA Signatory Grants that provide direct support to DSA Signatories to subsidize their efforts to implement the DxF. It includes two grant options for Signatories: QHIO Onboarding Grants and Technical Assistance Grants. This program opened for applications in mid-May 2023, and there will be three rounds of funding.
- There are two bills in the legislature related to the DxF:
  - **AB 1331 – DxF:** proposed changes to the oversight entity and establishment of a BOD.
  - **SB 582 – Health records: EHR vendor:** would require a stakeholder advisory group to consider whether standards for including electronic health record (EHR) vendors in the framework would be appropriate and would develop those standards if determined to be appropriate.

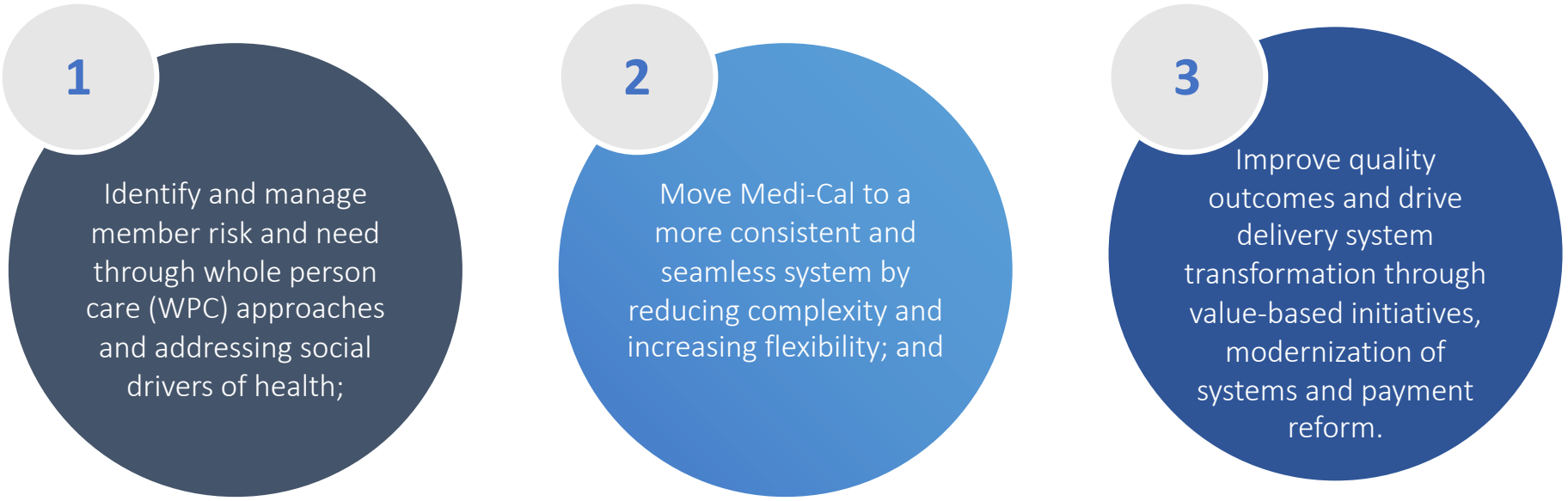
# DMHC – Health Equity Metrics

- In December 2022, DMHC published a report detailing recommendations for standard health equity and quality measures, including annual benchmark standards for assessing equity and quality in health care delivery as required by AB 133.
- The report documents the measures developed by the DMHC Health Equity and Quality Committee, which met over eight months in a series of public meetings.
- The DMHC will establish standards for health plan compliance starting in 2023, and will produce a Health Equity and Quality Compliance annual report beginning in 2025.

# California Advancing and Innovating Medi-Cal

CalAIM is DHCS' long-term commitment to transform Medi-Cal with the goal of offering more equitable, coordinated, and person-centered care.

## Goals of CalAIM include:



# Medi-Cal Initiative Implementation Timeline

### January 2022

- Enhanced Care Management (ECM) and Community Supports phase-in
- Benefits standardization
- Mandatory managed care enrollment

### January 2023

- Cal MediConnect transition to Dual-Eligible Special Needs Plans (D-SNPs)
- Statewide carve-in of institutional Long-Term Care
- Population Health Management Program

### January 2026

- Transition to statewide Managed Long-Term Services and Supports (MLTSS) and D-SNP
- Full Integration Plans pilots
- NCQA Health Plan Accreditation and Health Equity Accreditation

### December 2022

- Providing Access and Transforming Health (PATH) initiatives begin

### January 2024

- New Medi-Cal managed care contracts take effect

# Q&A

# Office of Healthcare Affordability panel

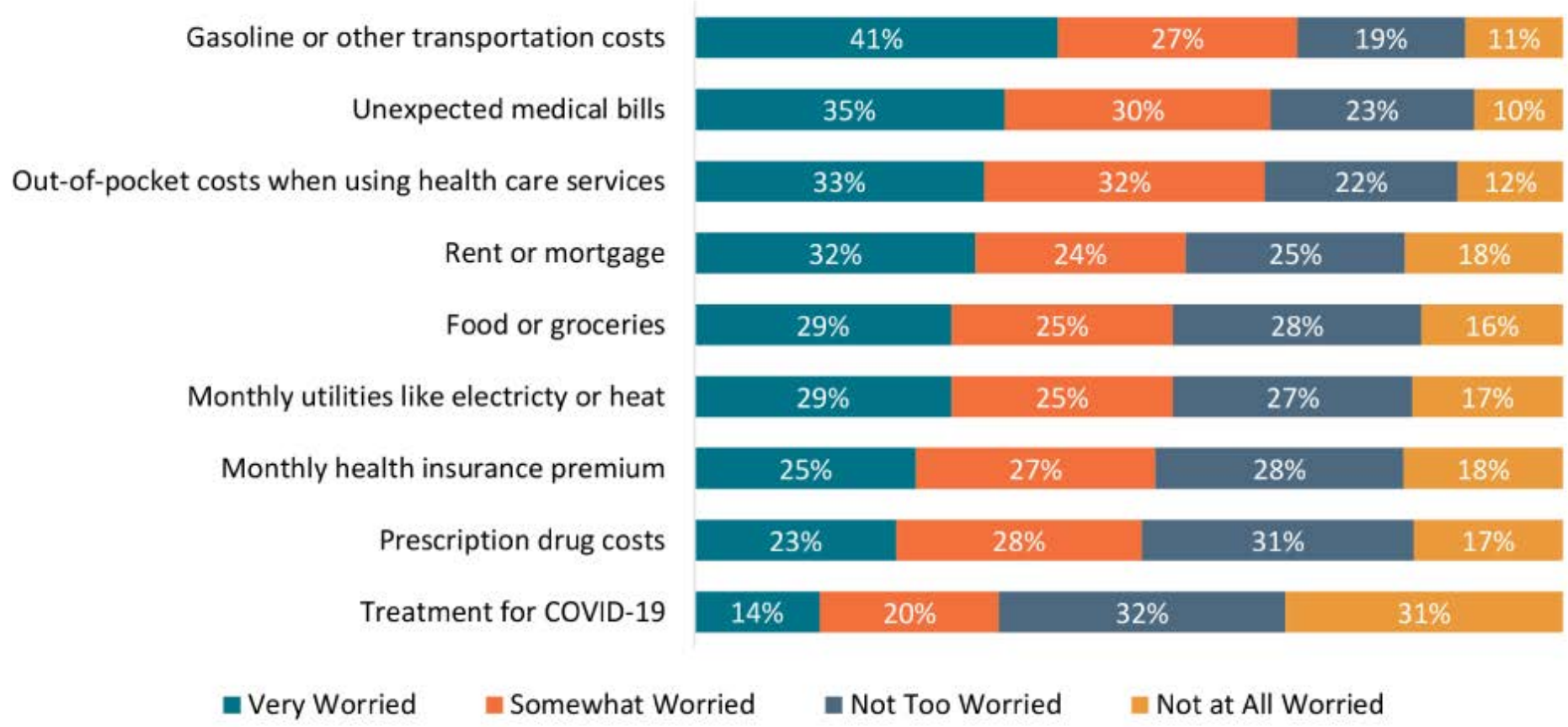
MODERATED BY:

**Athena Chapman**

Chapman consulting

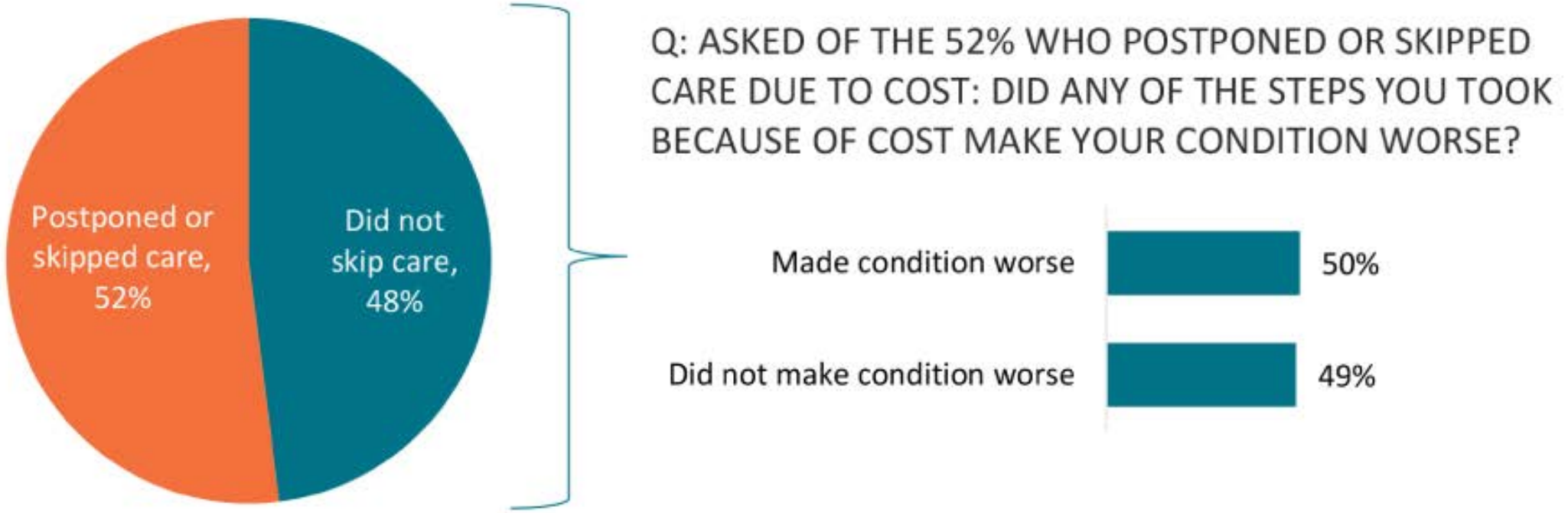
## Figure 9. Nearly Two Out of Three Californians Worried About Unexpected Medical Bills and Out-of-Pocket Costs

Q: HOW WORRIED ARE YOU ABOUT BEING ABLE TO AFFORD THE FOLLOWING FOR YOU AND YOUR FAMILY?




Lucy Rabinowitz Bailey, Rebecca Catterson, Emily Alvarez, and Sangeetha Noble, NORC at the University of Chicago, The 2023 California Health Policy Survey, CHCF, February 2023

## Figure 15. Half of Californians Say They or a Family Member Skipped Health Care in the Past Year Due to Cost; Many Say This Made Their Health Condition Worse



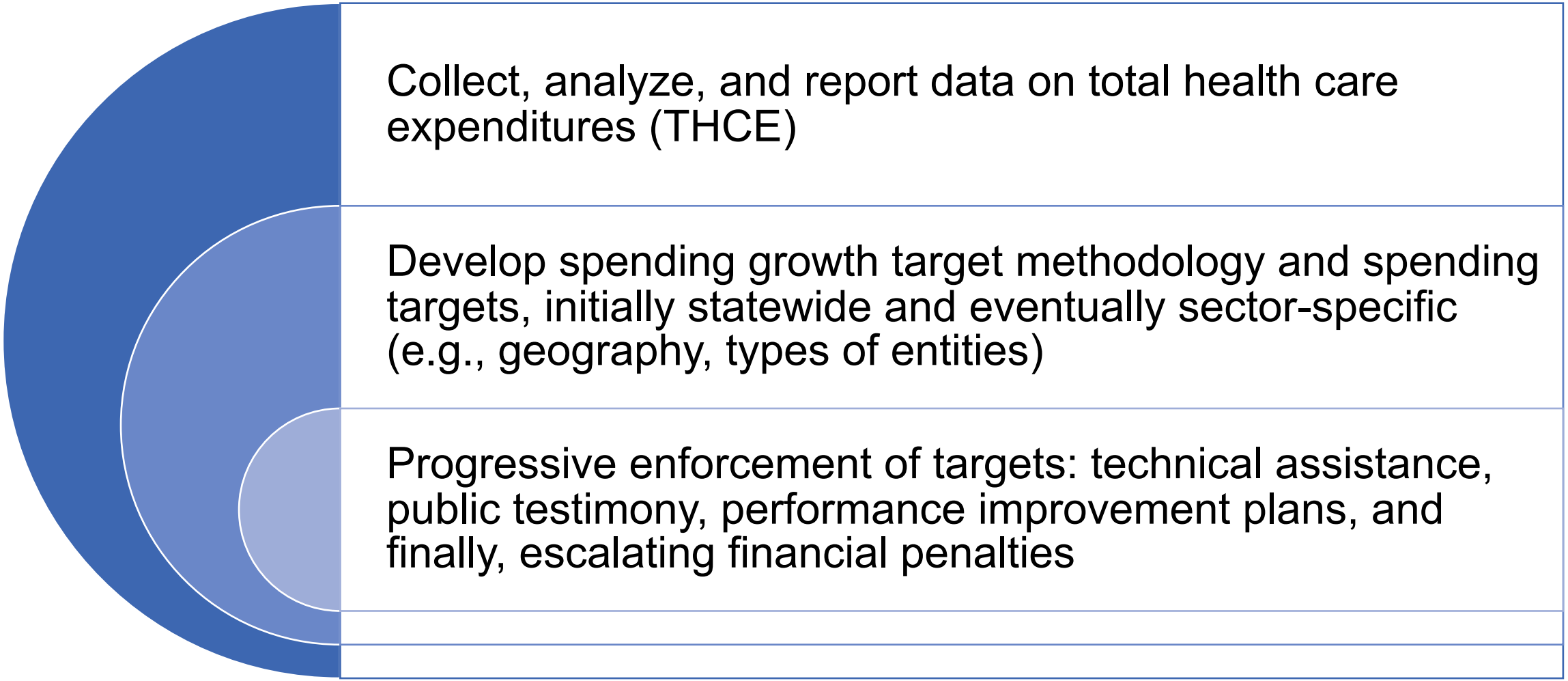

Notes: CHCF/NORC California Health Policy Survey (September 30–November 1, 2022). See topline for full question wording and response options. Figures may not sum due to rounding.

Lucy Rabinowitz Bailey, Rebecca Catterson, Emily Alvarez, and Sangeetha Noble, NORC at the University of Chicago, The 2023 California Health Policy Survey, CHCF, February 2023

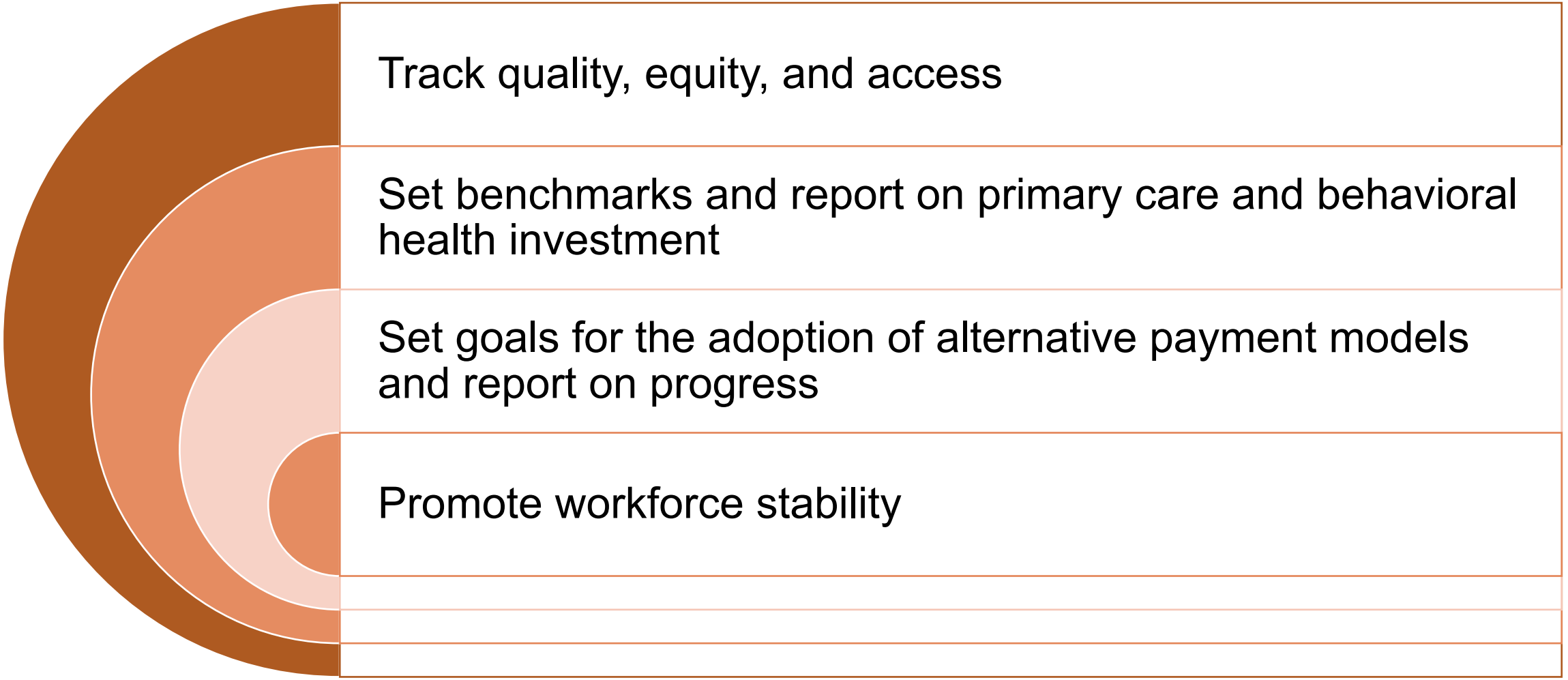
# Key Components

- Slow Spending Growth
- Promote High Value
- Assess Market Consolidation

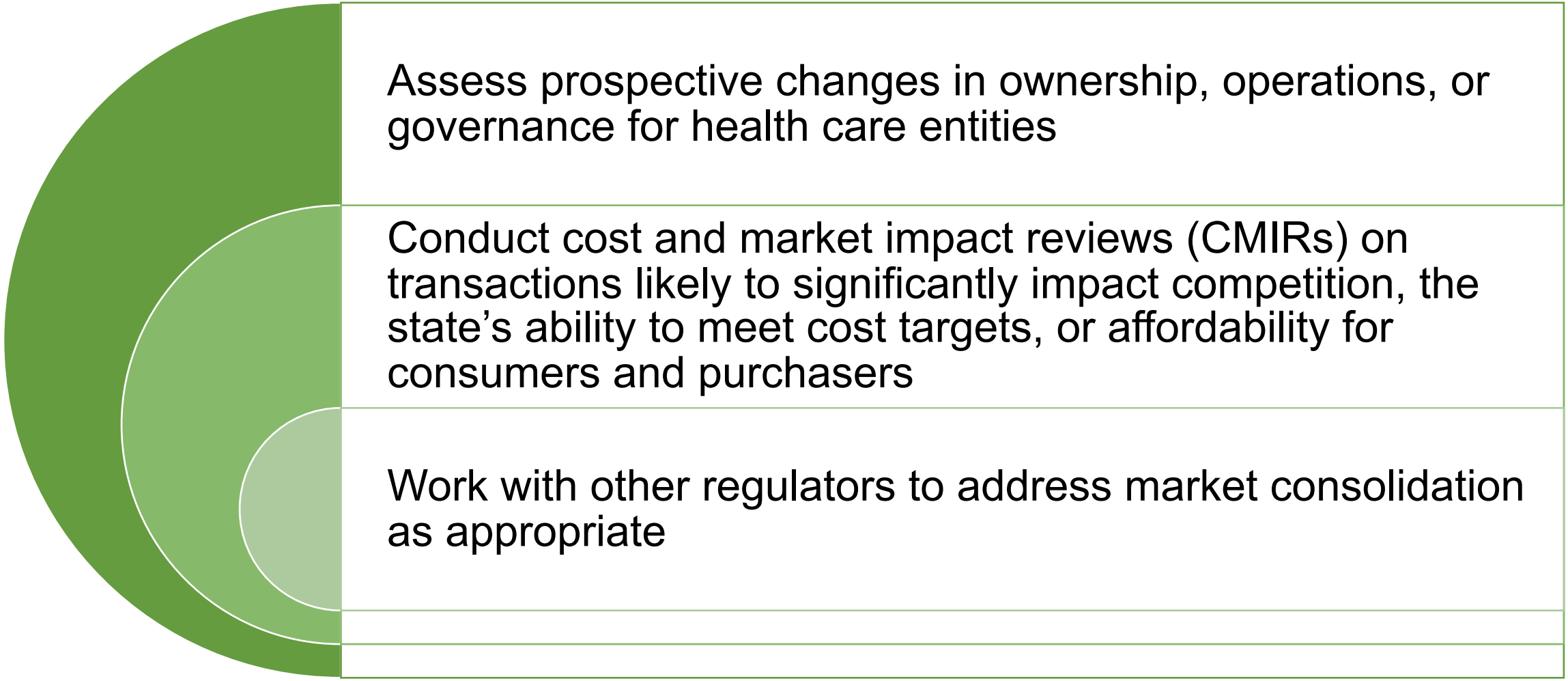
# Slow health care spending growth



# Promote high value system performance



# Assess market consolidation



# Milestones for 2023 and 2024

## 2023

- Convene the Health Care Affordability Board
- Convene Advisory Committee
- Develop spending target methodology
- Develop regulations on data collection for total health care expenditures and CMIR program
- Begin work on alternative payment model, primary care, and workforce stability components

## 2024

- Set 2025 spending target
- Collect 2022 and 2023 total health care expenditure data from payers, fully integrated delivery systems
- Adopt alternative payment model and workforce stability standards
- Collect notices of market transactions

# Update:
# Health Care Affordability Board, Advisory Committee

# Responsibilities of the Board and Advisory Committee

## Health Care Affordability Board

- Sets spending targets, both statewide and sector-specific
- Approves key benchmarks, such as statewide goals for alternative payment model adoption
- Appoints a Health Care Affordability Advisory Committee to provide input on a range of topics
- Members may not receive compensation from health care entities
- Eight members:
  - California Health and Human Services Secretary
  - CalPERS Chief Health Director (nonvoting)
  - Four appointees from Governor's Office
  - One appointee each from Assembly and Senate

## Advisory Committee

- May make recommendations, but no approval authority or access to nonpublic information
- Members appointed by the Health Care Affordability Board; representation to include:
  - Consumer and patient groups
  - Payers
  - Fully integrated delivery systems
  - Hospitals
  - Organized labor
  - Health care workers
  - Medical groups
  - Physicians
  - Purchasers

**Board and Advisory Committee are both subject to Bagley-Keene Open Meeting Act**



Source: HSC § 127501.11(a)(b)(d)

# Board Members

- **Dr. David Carlisle,** President and CEO of Charles R. Drew University of Medicine and Science
- **Dr. Mark Ghaly,** Secretary of the California Health and Human Services Agency
- **Dr. Sandra Hernández**, President and CEO of the California Health Care Foundation
- **Dr. Richard Kronick**, Professor in the Herbert Wertheim School of Public Health, University of California, San Diego
- **Elizabeth Mitchell**, President and CEO of the Purchaser Business Group on Health
- **Don Moulds**, Chief Health Director of the California Public Employee Retirement System (non-voting member)
- **Ian Lewis**, Political and Research director of the National Union of Health Care Workers
- **Dr. Richard Pan**, a pediatrician and former state Senator

Board member biographies are available on OHCA's website.

# Board's Role, Based on the Health Care Affordability and Quality Act

| | Matter |
|---|---|
| Approve | ▪ Advisory Committee Membership<br>▪ Methodology for setting and modifying spending targets<br>▪ Alternative Payment Model Adoption<br>▪ Primary Care and Behavioral Health Spending Benchmarks<br>▪ Health Care Workforce Stability Standards<br>▪ Policies for administrative penalties<br>▪ Exempted Providers |
| Establish | ▪ Statewide health care spending target<br>▪ Specific targets by health care sector<br>▪ Definitions of health care sectors<br>▪ Exempted Providers |
| Consult | ▪ Health Care Workforce Stability Standards<br>▪ Risk adjustment methodologies for reporting of data on total health care expenditures<br>▪ Equity adjustment methodologies for reporting of data on total health care expenditures<br>▪ Spending target enforcement |

| | Matter |
|---|---|
| Discuss | ▪ Director's presentation of key items for discussion, including (see Board manual for complete list):<br>○ Options for statewide health care spending targets<br>○ Collection, analysis, and public reporting of data<br>○ Risk adjustment methodologies for the reporting of data on total health care expenditures<br>▪ Rulemaking Packages<br>▪ Annual Report<br>▪ Baseline Report |

# Advisory Committee Members

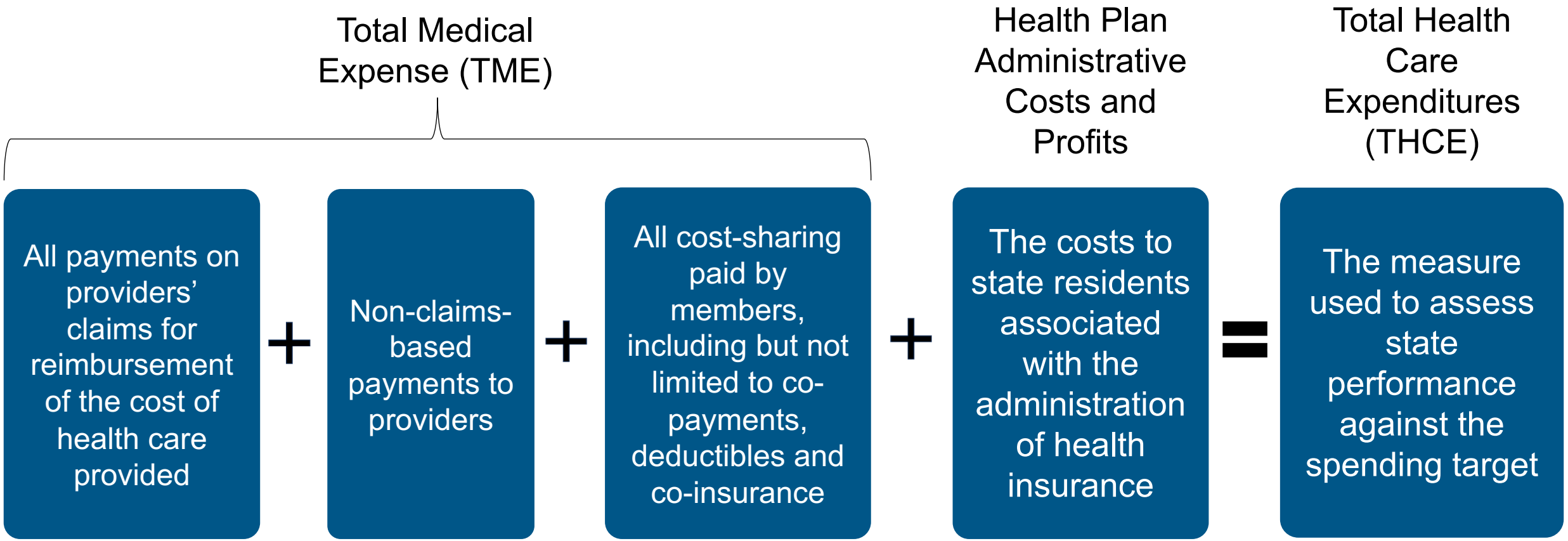
| Payers | Hospitals | Medical Groups | Physicians | Health Care Workers | Organized Labor | Patient Groups/ Consumer Advocates | Purchasers |
|---|---|---|---|---|---|---|---|
| Andrew See, Kaiser Foundation (FIDS) | Yvonne Waggener, San Bernadino Mountains Community Hospital District | David S. Joyner, Hills Physicians Medical Group | Adam Dougherty, Emergency Physician, Vituity | Hold Open | Joan Allen, SEIU-UHW | Anthony Wright, Health Access | Ken Stuart, CA Health Care Coalition |
| Aliza Arjoyan, Blue Shield CA (statewide plan) | Tam Ma, UC Health | Hector Flores, Family Care Specialists Medical Group IPA/IHA | Sumana Reddy, Acacia Family Medical Group | Hold Open | Ivana Krajcinovic, Unite Here Health | Kiran Savage-Sangwan, CPEHN | Abbie Yant, San Francisco Health Service System |
| Yolanda Richardson, SF Health Plan (local plan) | Barry Arbuckle, MemorialCare Health System | Stacey Hrountas, Sharp Rees-Stealy Medical Centers | Parker Duncan Diaz, Obstetrician, Santa Rosa Community Health | Hold Open | Carmen Comsti, CNA/NNU | Carolyn J Nava, Chair of the Diversability Advocacy Network | Suzanne Usaj, Wonderful Company LLC |
| | | | | | Hold Open | Rene Williams, United American Indian Involvement | |
| | | | | | | Mike Odeh, Children Now | |

# Update:
# Slow Spending Growth

# Health care entities subject to the spending target

| Payers | Providers | Fully Integrated Delivery System |
| --- | --- | --- |
| • Health plans, health insurers, Medi-Cal managed care plans<br>• Publicly funded health care programs<br>• Third party administrators<br>• Other entities that pay or arrange for the purchase of health care services | • Physician organizations<br>• Health facility, including acute care hospital<br>• Outpatient hospital department<br>• Clinic, general or specialty<br>• Ambulatory surgery centers<br>• Clinical laboratory<br>• Imaging facility | • A system that includes a physician organization, health facility or health system, and a nonprofit health care service plan and meets specific additional criteria |

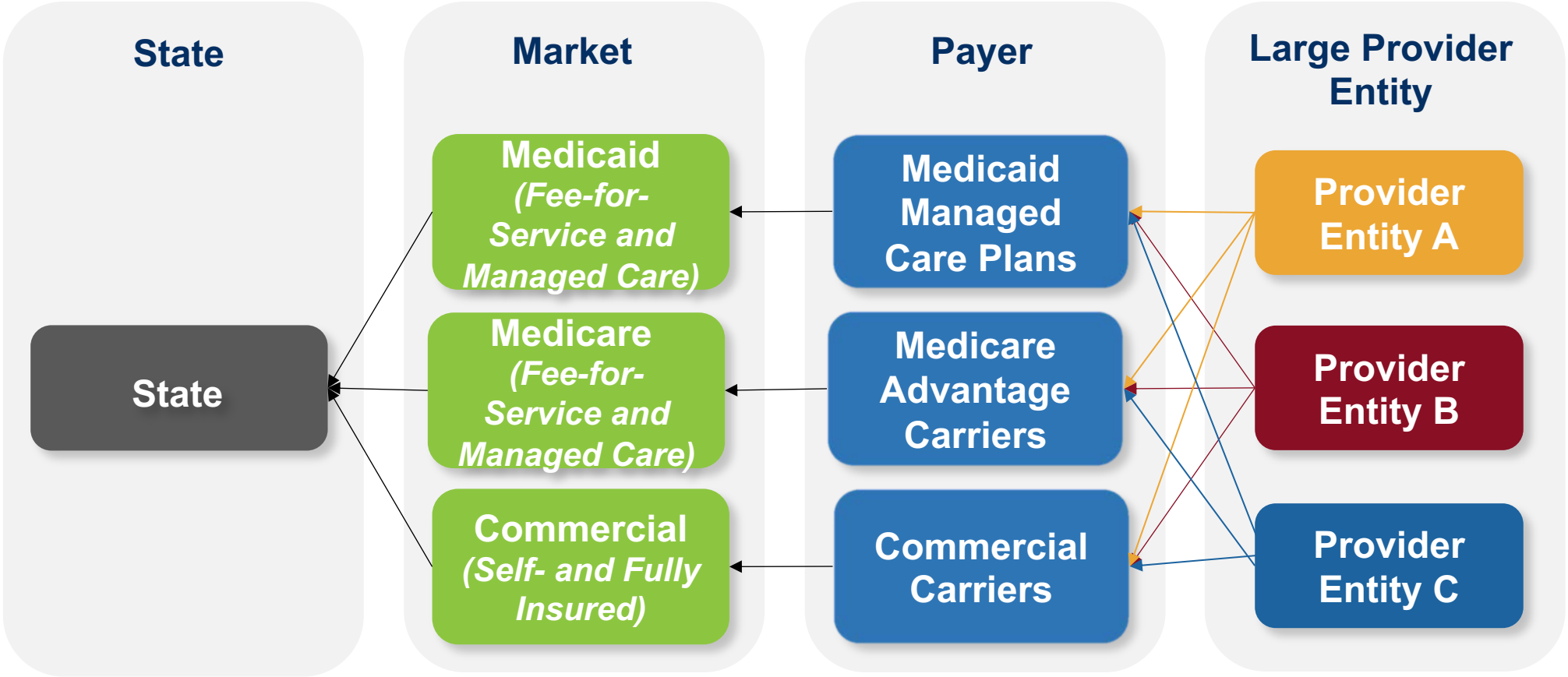
# What is being measured against the target?



# Categories used to report total medical expense

| Claims-based spending, e.g., | Non-claims-based spending, e.g., |
|---|---|
| • Hospital inpatient<br>• Hospital outpatient<br>• Professional primary care<br>• Professional specialty care<br>• Retail pharmacy | • Capitated, global budget, case rate or episode-based payments<br>• Performance incentive payments<br>• Payments to support population health and practice infrastructure |

# Four levels of reporting on spending growth in other states






HCAI Department of Health Care Access and Information

# Timeline: Enforcement

**Progressive enforcement:**
- Technical assistance
- Public testimony
- Performance improvement plans
- Financial penalties

## 2025

- Set target for 2026

## 2026

- First enforcement year

## 2027

- Data collection for first enforcement year

## 2028

- Reporting on 2026 data: progressive enforcement begins

# Update:
# High Value System Performance

# Focus areas for promoting high value system performance

| | |
|---|---|
| **APM Adoption** | • Define, measure, and report on alternative payment model adoption<br>• Set standards for APMs to be used during contracting<br>• Establish a benchmark for APM adoption |
| **Primary Care Investment** | • Define, measure, and report on primary care spending<br>• Establish a benchmark for primary care spending |
| **Behavioral Health Investment** | • Define, measure, and report on behavioral health spending<br>• Establish a benchmark for behavioral health spending |
| **Quality and Equity Measurement** | • Develop, adopt, and report performance on a single set of quality and health equity measures |
| **Workforce Stability** | • Develop and adopt standards to advance the stability of the health care workforce<br>• Monitor and report on workforce stability measures |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# Preliminary timeline for OHCA implementation of primary care, APM, and behavioral health workstreams

| | Primary Care | APM | Behavioral Health |
|---|---|---|---|
| **Research, development, stakeholder engagement** | 2023-2024 | 2023-2024 | 2023-2025 |
| **Define** | Spring 2024 | Spring 2024 | Spring 2025 |
| **Set contracting standards** | N/A | Summer 2024*+ | N/A |
| **Set benchmark** | Summer 2024* | Summer 2024* | Spring 2025* |
| **Regulations to support data collection** | Year-end 2024 | Year-end 2024 | Year-end 2025 |
| **Collect data** | Fall 2025 | Fall 2025 | Fall 2026 |
| **Report data** | Summer 2026 | Summer 2026 | Summer 2027 |

+Date specified in statute as July 1, 2024
*Board approval required

**All included in first annual report due June 2027**

# Public workgroup to engage stakeholders

OHCA will be launching a public workgroup to support the development of the primary care, alternative payment model (APM), and behavioral health definitions, data collection processes, and benchmarks.

The workgroup will:

- Ensure stakeholder engagement in key program development decisions about definitions and data collection.
- Provide input and feedback as OHCA develops recommendations for benchmarks for Advisory Committee and Board consideration.
- Identify and discuss the relationships and interactions between the APM, primary care, and behavioral health components.

Workgroup members will include representatives from:

- Patients/families
- Primary care clinicians
- Physician organizations (medical group, IPA, FQHC)
- Hospitals/health systems
- Health plans
- Consumer advocates
- Researchers/experts
- State departments engaged in related work

# Workgroup Topics

## Alternative Payment Models

- Discuss frameworks, data sources, and data collection approaches
- Discuss level of reporting for APM adoption
- Discuss key decisions for setting a goal for APM adoption.
- Discuss options for the development of APM standards.

## Primary Care Investment

- Discuss key decisions on definitions, measurement, and reporting
- Discuss key decisions for setting a benchmark for primary care spending

## Behavioral Health Investment

- Discuss key decisions on definitions, measurement, and reporting.
- Discuss key decisions for setting a benchmark for behavioral health care spending

# Stakeholder Engagement with OHCA

- Contact us at ohca@hcai.ca.gov with your comments and questions
- Subscribe to the OHCA listserv on the HCAI website
- Visit HCAI's public meeting page for Health Care Affordability Board and Advisory Committee materials and information
- Visit the OHCA landing page on the HCAI website for:
  - Board information, FAQs, fact sheet, statute link, and upcoming activities
  - Advisory Committee submission of interest form
  - Future regulations "workshopping" meetings and opportunities to provide input to OHCA on key aspects of implementation policy

# Performance Measurement at IHA – a foundation to build on

- Collect member level claims, encounters, eligibility, cost, and clinical data for over a decade
- Voluntary submission from Commercial, Medicare Advantage, and Managed Medi-Cal plans
- Calculate **quality, resource use, and cost measures** that have the biggest impact on care outcomes
- Use performance results for **incentive payments, awards, public reporting, and analysis**
- Identify insights about performance across different parts of the healthcare market

# Types of insights we've tracked and reported

## **Provider** quality and total cost of care variation

- By financial risk type — capitated, non-capitated, and mixed
- For provider organizations
- For Accountable Care Organizations (ACOs)

## **Plan** quality and total cost of care variation

- By commercial health plan and/or line of business
- By geography
- For existing and new Covered CA qualified health plans (QHPs)

## Other insights

- Primary care spending as a percent of total spending by product type and plan
- Quality and total cost of care for providers in non-financial risk sharing referral networks



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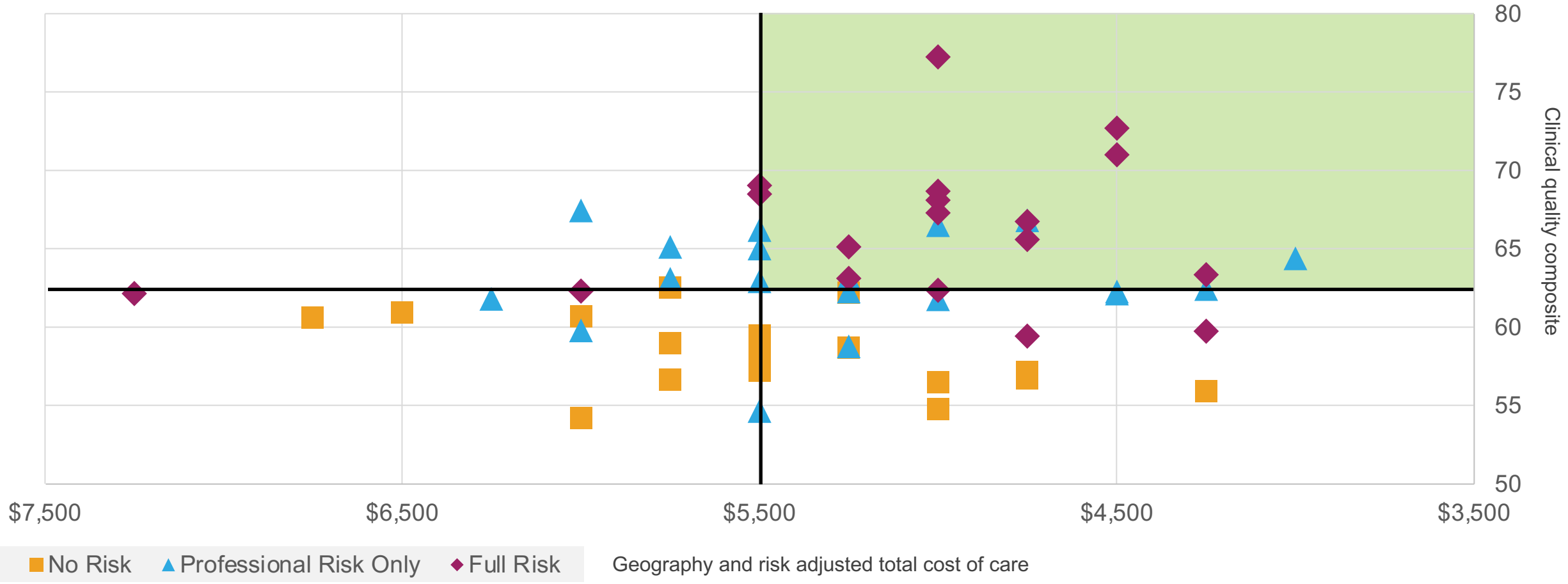
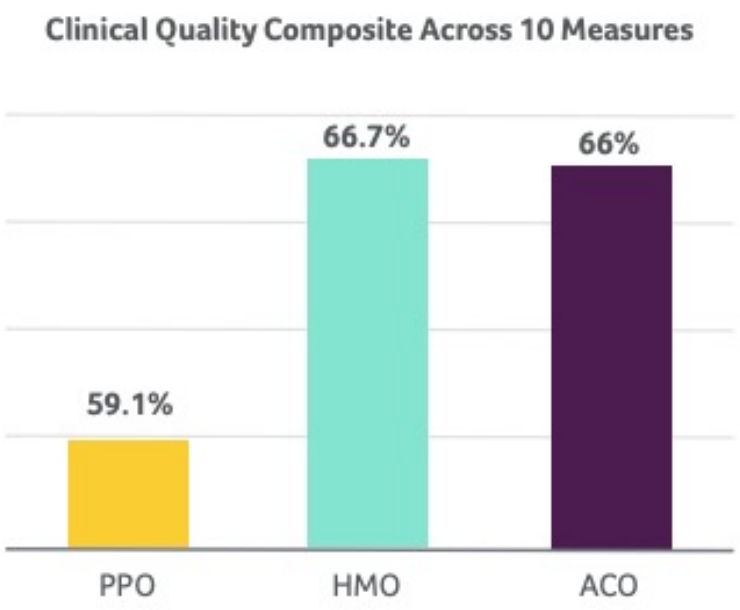
# Pairing quality and cost performance by financial risk type

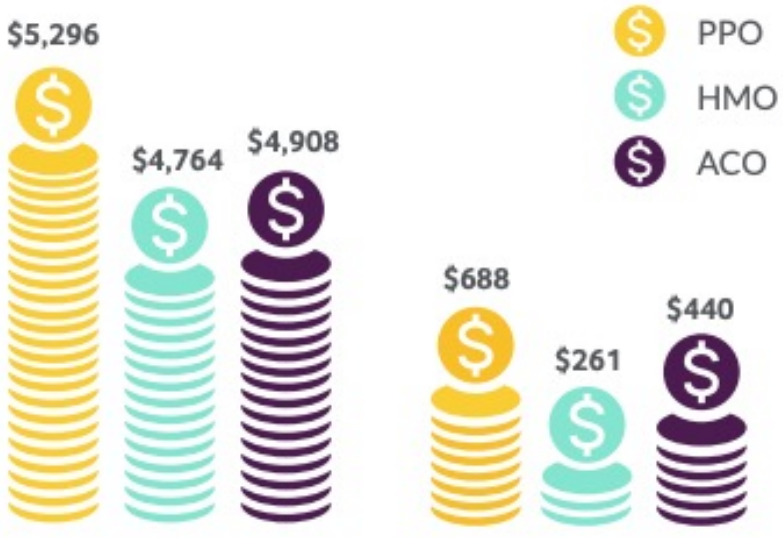


# Exploring quality and cost performance by product type

**Better Clinical Quality** Associated with ACOs and HMOs



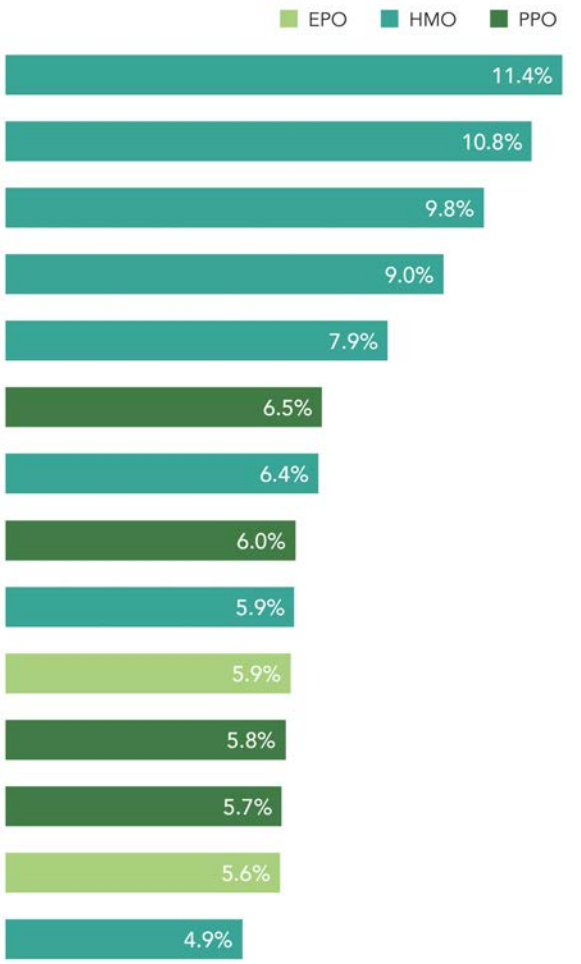

**Lower Costs** Associated with ACOs and HMOs




*Total cost is geography and clinically risk adjusted

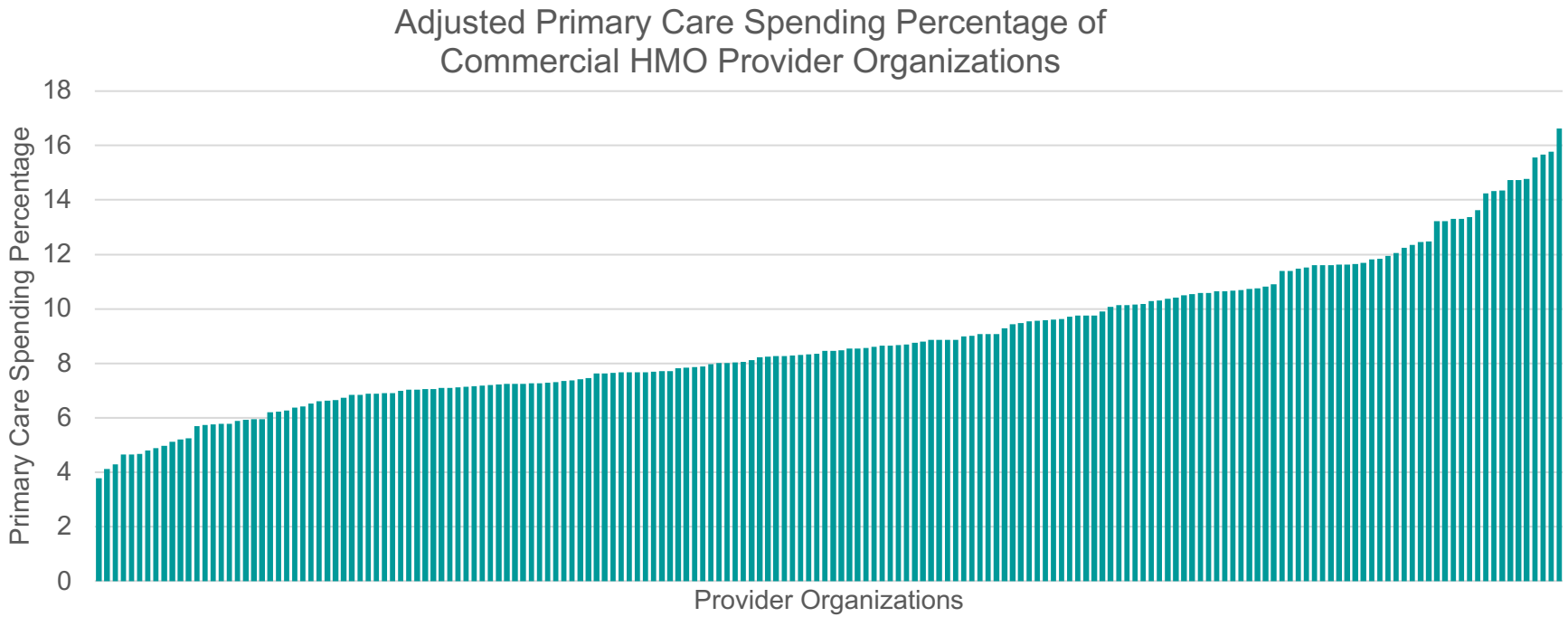
# Measuring primary care spending percentage

**Figure 2. Adjusted Primary Care Spending Percentage, by Health Plan Product**



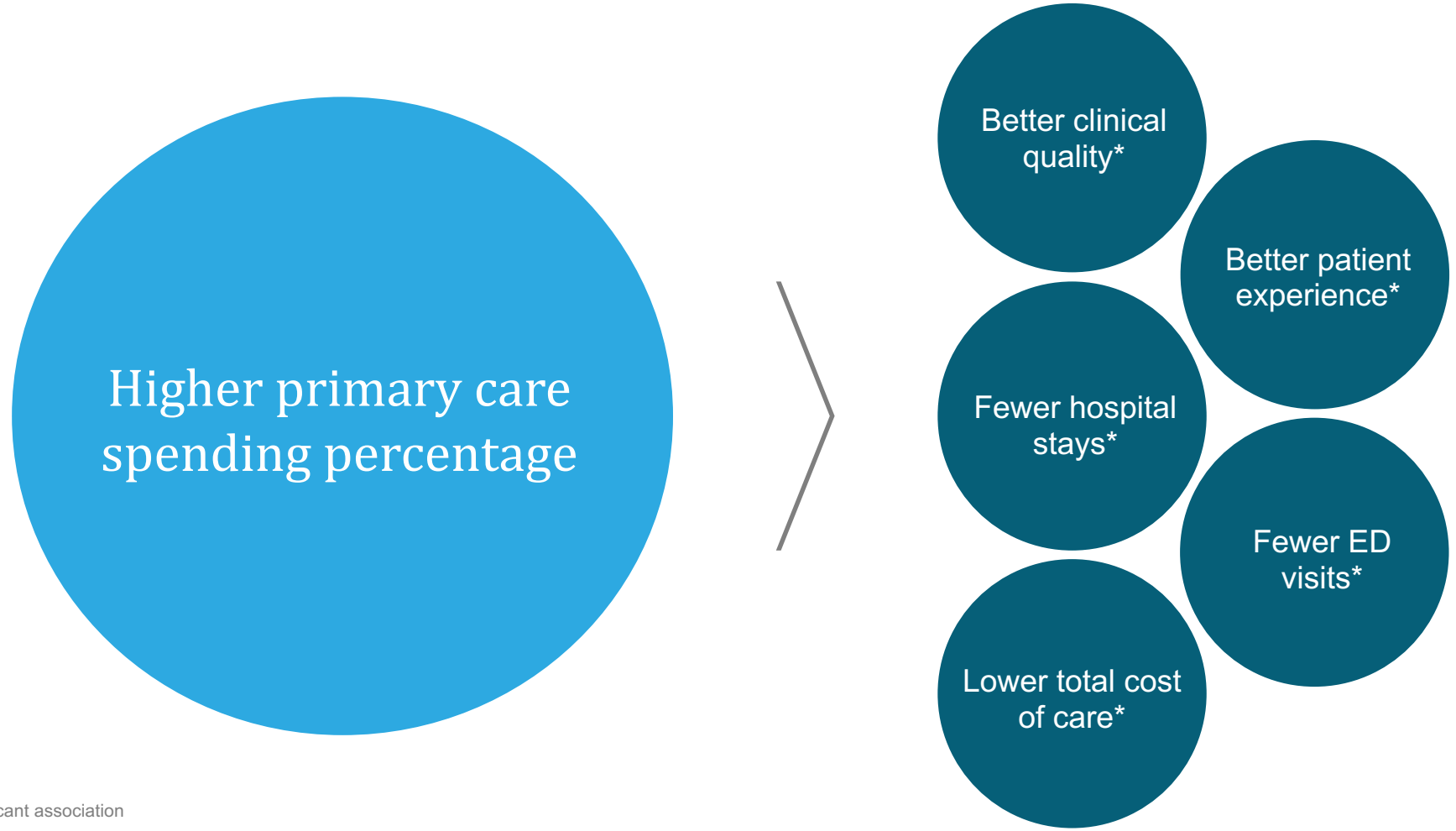

Notes: *EPO* is exclusive provider organization. *HMO* is health maintenance organization. *PPO* is preferred provider organization.

Source: Authors' analysis of IHA primary care data set, 2021.



# Analyzing primary care spending relationship to outcomes

Completed for Commercial HMO provider organizations




*Statistically significant association

Source: D. Yanagihara, et al., Investing in Primary Care: Why it Matters for Californians with Commercial Coverage , CHCF, April 2022



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# Digging in further to gather primary care spending insights

BY
## Year
- 2019
- 2020
- 2021

BY
## Payer type
- Commercial
- Medicare
- Medi-Cal

BY
## Product
- HMO
- PPO
- EPO

BY
## Health plan
BY
## Provider organization
BY
## Geography

**Includes:**

- Primary care spending percentage
- Primary care spending $ PMPM
- Separate for children and adults



IHA

# Q&A

Integrated Healthcare ASSOCIATION

# Provider directories

**Jacqui Darcy**

Symphony General Manager, IHA

# Key legislative activity

## AB 236 (Holden) Provider Directories

### Background:

This bill would require health plans and insurers to annually audit and delete inaccurate listings from its provider directories and ties existing requirements to accuracy benchmarks and penalties.

### Fiscal Impacts:

- Include a significant workload increase to almost all DMHC program areas if it were to implement this bill resulting in a “large, but indeterminate, fiscal impact.”
- The California Department of Insurance also estimated this bill would require $72,000 in costs for FY 2023-24, $168,000 in FY 2024-25, and $88,000 in ongoing costs.

### Next Steps:

Has been referred to the Suspense File of the Assembly Appropriations Committee

# Key legislative activity

## Federal Legislation on Provider Directories

- U.S. Senate Finance Committee hosted a hearing titled “Barriers to Mental Health Care: Improving Provider Directory Accuracy to Reduce the Prevalence of Ghost Networks.”
- Dr. Rideout (CEO) testified on behalf of IHA and highlighted the work of Symphony and the need for an industry solution with a single utility to reduce administrative burden and improve accuracy
- Based upon draft legislation that was authored by the Senate Finance Committee and seeks to strengthen the requirements for Medicare Advantage and Medicaid managed care organizations to maintain accurate provider directories

# Key themes at the state and federal level

| | |
|---|---|
| **Inclusion of critical data elements** | Network participation, panel status, phone number, and office location |
| **Mental & BH Providers** | Additional focus on access to Mental and Behavioral Health providers |
| **Standardization** | Continued need for education around the complexity of the problem and need to drive standardization and alignment across the line of business and across states |
| **Accuracy – enforcement & process** | • Focus on health plan responsibility and enforcement through regulation and/or penalties with some stick for providers (SB 137 includes the ability to withhold provider payment) and likely trickle-down impact<br>• Accuracy is currently measured by telephone surveys (both by regulators, senators, secret shoppers and consumer reports) and timely access surveys |



IHA

# Q&A

# Thank you!

We'd appreciate your feedback, please take the survey!

A recording of today's event will be sent out to all attendees

**Questions?** Get in touch at events@iha.org

**Special thanks** to Athena Chapman, Vishaal Pegany, Andrew Kiefer, Beth Cappell, Dolores Yanagihara, and Jacqui Darcy