DMHC Health Equity and Quality Committee

August 17, 2022

Housekeeping

For all Committee members:

- If any Committee member has a question, please use the “Raised hand” feature in Zoom
- All questions and comments from Committee members will be taken in the order in which “Raised hands” appear
- State your name and organization prior to making a comment or asking a question

Housekeeping

For all Committee members:

- The Health Equity and Quality Committee is subject to the Bagley-Keene Open Meeting Act. As such, Committee members should refrain from emailing, texting or otherwise communicating with each other off the record during Committee meetings

Housekeeping

For all Committee members:

- The Bagley-Keene Act prohibits “serial” meetings. A serial meeting would occur if a majority of the Committee members emailed, texted, or spoke with each other (outside of a public Health Equity and Quality meeting) about matters within the Committee’s purview

Housekeeping

For all members of the public:

- Written public comments should be submitted to the DMHC using the email address at the end of the presentation
- Members of the public should not contact Committee members directly to provide feedback

Agenda

1. Welcome and Introductions
2. Review July 13, 2022 Meeting Summary
3. Regulation and Enforcement Process
4. Benchmarking
5. Break
6. Measure Stratification
7. Public Comment
8. Closing Remarks

DMHC Attendees

1. Mary Watanabe, Director
2. Nathan Nau, Deputy Director, Office of Plan Monitoring
3. Chris Jaeger, Chief Medical Officer
4. Sara Durston, Senior Attorney

Voting Committee Members

1. Anna Lee Amarnath, Integrated Healthcare Association
2. Bill Barcellona, America's Physician Groups
3. Dannie Ceseña, California LGBTQ Health and Human Services Network
4. Alex Chen, Health Net
5. Cheryl Damberg, RAND Corporation
6. Diana Douglas, Health Access California
7. Lishaun Francis, Children Now

Voting Committee Members

8. Tiffany Huyenh-Cho, Justice in Aging
9. Edward Juhn, Inland Empire Health Plan
10. Jeffrey Reynoso, Latino Coalition for a Healthy California
11. Richard Riggs, Cedars-Sinai Health System
12. Bihu Sandhir, AltaMed
13. Kiran Savage-Sangwan, California Pan-Ethnic Health Network

Voting Committee Members

14. Rhonda Smith, California Black Health Network
15. Kristine Toppe, National Committee for Quality Assurance
16. Doreena Wong, Asian Resources, Inc.
17. Silvia Yee, Disability Rights Education and Defense Fund

Ex Officio Committee Members

18. Palav Babaria, California Department of Health Care Services
19. Alice Huan-mei Chen, Covered California
20. Stesha Hodges, California Department of Insurance
21. Julia Logan, California Public Employees Retirement System
22. Robyn Strong, California Department of Healthcare Access and Information

Sellers Dorsey Team

1. Sarah Brooks, Project Director
2. Alex Kanemaru, Project Manager
3. Andy Baskin, Quality SME, MD
4. Ignatius Bau, Health Equity SME
5. Mari Cantwell, California Health Care SME
6. Meredith Wurden, Health Plan SME
7. Janel Myers, Quality SME

Meeting Materials

1. July 13, 2022 Meeting Summary
2. Final Recommended Measure Set Workbook
3. Summary of 2021 National Quality Compass Data
4. Summary of California Plan Performance
5. Public Comment Handout

Committee Meeting Timeline

- Committee Meeting #8 – August 17
  - Finalize Benchmarking and Measure Stratification
- Committee Meeting #9 – September 12
  - Review Draft Report of Committee Recommendations

Questions

Review July 13, 2022 Meeting Summary

Sarah Brooks, Project Director

Questions

Regulation and Enforcement Process

Mary Watanabe, Director

Questions

Benchmarking

Sarah Brooks, Project Director

Andy Baskin, Quality SME, MD

Ignatius Bau, Health Equity SME

Meeting Materials: Benchmarking

- The benchmarking discussion will utilize the following:
  - Final Recommended Measure Set Workbook
  - Summary of 2021 National Quality Compass Data
  - Summary of California Plan Performance

July Meeting Recap

DHCS and Covered California

- State Purchasers
- **Plan Accountability Mechanism:** Contracts require enforcement and incentivize quality improvement

DMHC

- State Regulator
- **Plan Accountability Mechanism:** Regulation requires corrective action plans and enforcement action if health plans do not meet a benchmark

July Meeting Recap: Benchmarking

The Committee discussed whether national or California performance data would be best for benchmarking and determined:

- Use of national rather than California performance data would be more appropriate for benchmarking
- The use of California performance data would subject a significant percentage of plans to enforcement action

Definitions: Benchmarking

- **Percent/Percentage:** A part of a whole expressed in hundredths
  - For example, for Breast Cancer Screening, if a plan screens 6,791 out of 10,000 persons, then they have screened 67.91% of persons

Definitions: Benchmarking

- **Percentile:** A value on a scale of 1-100 that indicates the percent of the distribution that performs at or below it
  - For example, for Breast Cancer Screening, if the 25th percentile performance is 67.91%, then 25% of plans screened 67.91% or fewer persons. Conversely, 75% of plans screened greater than 67.91% of persons

Voting Overview: Benchmarking

The Committee will review and develop consensus around the following options. A single vote will be conducted at the end of the meeting

1. Commercial, Medicaid, or by Line of Business (LOB) Percentile as Floor
2. Common or Measure-Specific Percentile as Floor
3. Fixed or Annually Adjusted Percentile as Floor
4. Quality Compass Percentile (10^{th}, 25^{th}, 33.3^{rd}, 50^{th}) as Floor

Example: Commercial, Medicaid, or by LOB Benchmark

	Commercial 2021 Rate (%)	Medicaid 2021 Rate (%)
Measure Name	**National 25th Percentile**	**National 25th Percentile**
Child and Adolescent Well-Care Visits (WCV)	45.44	39.47

Strengths and Challenges: Commercial Benchmark

Strengths

- Consistency and simply defined common benchmark
- Clinical consistency for all patients in California

Challenges

- If Medicaid rates are significantly below Commercial, it may be difficult to meet the selected benchmark
- Differences in population characteristics

Strengths and Challenges: Medicaid Benchmark

Strengths

- Consistency and simply defined common benchmark
- Clinical consistency for all patients in California

Challenges

- If Commercial rates are significantly below Medicaid, it may be difficult to meet the selected benchmark

Strengths and Challenges: By LOB

Strengths

- Recognizes differences in membership and starting points between Commercial and Medicaid

Challenges

- Since Medi-Cal reflects a more diverse and lower income population when compared to Commercial, separate benchmarks will perpetuate existing disparities
- Implies acceptance of a different standard of care
- Administrative complexity for the DMHC

Example: Common or Measure-Specific Percentile as Floor

Measure Name	National 25th Percentile	National 33.3rd Percentile
Well-Child Visits in the First 30 Months of Life (W30) – First 15 months	74.41	77.08
Well Child Visits in the First 30 Months of Life (W30) – 15 months to 30 months	84.15	85.84
Child and Adolescent Well-Child Visits (WCV)	45.44	48.92

E.g., W30 and WCV are set at 25th percentile or W30 is set at 25th percentile and WCV is set at 33.3rd percentile, respectively

Strengths: Common Percentile as Floor

Strengths

- First in the nation initiative to establish a consistent minimum standard of care and enhance equity throughout California
- If a plan is meeting the established benchmark, enable plans to prioritize where performance is relatively lower
- Simplicity and standardized reporting
- Promotes advanced planning

Challenges

- May not recognize uneven performance across measures

Strengths and Challenges: Measure-Specific Percentile as Floor

Strengths

- Recognizes differences in performance across measures

Challenges

- Inconsistent minimum standard of care and may perpetuate inequities in care
- Greater complexity and administrative burden

Example: Fixed or Annually Adjusted Benchmark as Floor

- **Fixed:** Targeted performance will remain at the 2022 Quality Compass® performance rate throughout the 5-year period
- **Annually Adjusted:** Targeted performance will fluctuate as Quality Compass data is annually updated

Timeline: Fixed or Annually Adjusted Benchmark as Floor

- An annually adjusted benchmark relies on NCQA Quality Compass data release of data. Example, for 2023 benchmarks:
  - **July 29, 2022:** Quality Compass® 2022 for Commercial plans is released (based on MY 2021)
  - **September 30, 2022:** Quality Compass® 2022 for Medicaid plans is released (based on MY 2021)
  - **January 1, 2023:** DMHC regulated plans are required to begin reporting on 2022 Quality Compass data

Example: Fixed or Annually Adjusted Benchmark as Floor

For example, the national Medicaid 25th percentile for Controlling High Blood Pressure:

	Measurement Year				
	2021	2022*	2023*	2024*	2025*
Fixed	50.6	50.6	50.6	50.6	50.6
Annually Adjusted	50.6	50.8	51.2	53.7	54.1

*Performance rates (%) included for example purposes only

Strengths and Challenges: Fixed Benchmark as Floor

Strengths

- Sets performance target well in advance for health plans

Challenges

- Does not account for measure specification changes that may emerge
- Does not reflect national improvement or degradation based on a multitude of factors
- Does not account for variance in quality due to unforeseen circumstances (e.g., COVID-19)

Strengths and Challenges: Annually Adjusted Benchmark as Floor

Strengths

- Accounts for variance in quality due to unforeseen circumstances (e.g., COVID-19)
- Plans are familiar with changing Quality Compass performance rates
- Assuming plan performance increases annually, the annually adjusted benchmark floor would be incrementally raised

Strengths and Challenges: Annually Adjusted Benchmark as Floor

Challenges

- Requires continuous adjustments
- Quality Compass release date may be late in the year giving plans less time to know performance targets for the upcoming year

Quality Compass Percentile as Floor

- A common Quality Compass percentile establishes a minimum standard of care for all health plans, regardless of line of business
- Common percentile provides clarity and simplicity for both health plans and DMHC

Example:
Quality Compass Percentile as Floor

Measure Name	National 25th Percentile
Colorectal Cancer Screening (COL)	56.11

E.g., For the COL measure, if the national 25th percentile was applied for both Commercial and Medicaid, all plans would be expected to screen at least 56.11% of adults ages 50-75

Quality Compass Percentile as Floor

Refer to Summary of Plan Performance Handout

Measure Name	Commercial Plans		Medicaid Plans	
	# of Plans Meeting 25th Percentile Benchmark	# of Plans Meeting 33.33rd Percentile Benchmark	# of Plans Meeting 25th Percentile Benchmark	# of Plans Meeting 33.33rd Percentile Benchmark
Breast Cancer Screening	16/16	14/16	22/24	20/24
Prenatal and Postpartum Care (PPC) -Timeliness of Prenatal Care	16/16	16/16	23/24	23/24
Well-Child Visits in the First 30 Months of Life (W30) -- First 15 months	7/16	4/16	2/18	0/18
Plan All-Cause Readmissions (PCR)	2/16	2/16	0/18	0/18

- Numerator is the number of Commercial and Medicaid plans meeting 25th percentiles and 33.33rd percentiles, respectively
- Denominator is the total number of plans reporting on the measure

Example:
Quality Compass Percentile as Floor

- Example of meaningful overall improvements
  - **Asthma Medication Ratio:** If every Commercial plan below the 25th percentile increased their performance to that benchmark, the average performance would go from 79.63% to 80.47%

Example:
Quality Compass Percentile as Floor

- Example of meaningful overall improvements
  - **Child and Adolescent Well-Care Visits:** If every Commercial plan below the 25th percentile increased their performance to that benchmark, the average performance would go from 44.78 to 47.04%

Questions

Break

Measure Stratification

Sarah Brooks, Project Director

Andy Baskin, Quality SME, MD

Ignatius Bau, Health Equity SME

Measure Stratification

- To comprehensively identify and address health inequities it is critically important to systematically measure and report on health care disparities in a standardized way
- Measure stratification provides useful and actionable information for targeted initiatives and appropriate health care interventions and strategies
- DMHC will require reporting of HEDIS measures stratified by race and ethnicity as required by NCQA

Recommended Measures with Required Stratification

8 of the 13 measures recommended by the Committee are required to be stratified by race and ethnicity

#	Measure Name	NCQA Requires Stratification by Race and Ethnicity
1	Colorectal Cancer Screening (COL)	Yes
2	Breast Cancer Screening (BCS)	Yes
3	Hemoglobin A1c Control for Patients with Diabetes (HBD)	Yes
4	Controlling High Blood Pressure (CBP)	Yes
5	Asthma Medication Ratio (AMR)	Yes
6	Prenatal and Postpartum Care (PPC)	Yes
7	Well-Child Visits in the First 30 Months of Life (W30)	Yes
8	Child and Adolescent Well-Care Visits (WCV)	Yes

Recommended Measures without Required Stratification

5 of the 13 measures recommended by the Committee are currently not required to be stratified by race and ethnicity

#	Measure Name	NCQA Requires Stratification by Race and Ethnicity
1	Depression Screening and Follow-Up for Adolescents and Adults	No
2	Childhood Immunization Status (CIS 10)	No
3	Plan All-Cause Readmissions (PCR)	No
4	Immunizations for Adolescents (IMA Combo 2)	No
5	Consumer Assessment of Healthcare Providers and Systems (CAHPS) Health Plan Survey, Version 5.0 (Medicaid and Commercial): Getting Need Care	No

Refresher: NCQA Stratification

Currently, for NCQA stratification, categories for Race are based on Office of Management and Budget (OMB) categories:

- White
- Black or African American
- American Indian and Alaska Native
- Asian
- Native Hawaiian and Other Pacific Islander
- Some other race
- Two or more races
- Asked but No Answer
- Unknown

Refresher: NCQA Stratification

Currently, for NCQA stratification, categories for Ethnicity are based on OMB categories:

- Hispanic/Latino
- Not Hispanic/Latino
- Asked but No Answer
- Unknown

Measures without Required Stratification

- For the 5 measures currently not required to be stratified by race and ethnicity, the Committee recommends requiring stratification by race and ethnicity using the NCQA stratification methodology for reporting only

Federal Demographic Data Standards: Sources

- Office of National Coordinator (ONC) for Health IT: Standards for Electronic Health Records (EHRs) (2015)
- ONC: U.S. Core Data for Interoperability Standards (USCDI) v1 (2020), v2 (2021), and v3 (2022)

Federal Demographic Data Standards: Race and Ethnicity

- ONC EHR and USCDI v1 standards include full disaggregation of race and ethnicity
- Uses Centers for Disease Control codes for over 925 races and ethnicities

Federal Demographic Data Standards: Language

- ONC EHR and USCDI v1 standards include comprehensive list of languages
- Uses International Organization for Standardization codes for over 500 spoken and written languages

Federal Demographic Data Standards: Birth Sex, Sexual Orientation, and Gender Identity

- ONC EHR and USCDI v1 standards include birth sex
- ONC EHR and USCDI v2 standards include sexual orientation and gender identity
- Uses SNOMED CT/HL7 codes for sexual orientation and gender identity

Federal Demographic Data Standards: Disability Status

- USCDI v3 standards now includes disability status
- Uses LOINC codes for disability status, based on Census questions

Federal Demographic Data Standards: Tribal Affiliation

- USCDI v3 standards now includes tribal affiliation
- Codes have yet to be identified

Application of Federal Demographic Data Standards to California

- California Health and Human Services Data Exchange Framework will adopt USCDI standards and codes for required demographic data elements
- All health plans will be required to agree to exchange data by January 2023
- All health plans will be required to exchange data beginning January 2024
- Health plans will be increasing their collection of these demographic data

Other Demographic Data

- Currently, there are data collection and analyses barriers for stratifying measures by other demographic data
- However, state (CalHHS Data Exchange Framework) and national initiatives will create new requirements for data collection
- Other demographic data may include but is not limited to disaggregated race and ethnicity, language, sex, sexual orientation, gender identity, age, income, disability status, tribal affiliation, and geographic location data

Other Demographic Data

- If and when California health plans are required to collect other demographic data and such data becomes sufficiently available for quality measurement stratification, the Committee recommends that the DMHC then require additional stratified reporting by such demographic data on the recommended measures

Questions

Transition to Recommendation Consensus Slide

Vote

Public Comment

Public comments may be submitted until 5 p.m. on August 24, 2022, to publiccomments@dmhc.ca.gov

Closing Remarks

Public comments may be submitted until 5 p.m. on August 24, 2022, to publiccomments@dmhc.ca.gov

Members of the public may find Committee materials on the DMHC website

Next Health Equity and Quality Committee meeting will be held on September 12, 2022