2022 Health Equity and Quality Committee Recommendations Report

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I. Executive Summary

The Department of Managed Health Care (DMHC or Department) convened a Health Equity and Quality Committee (Committee) to make recommendations to the Department for standard health equity and quality measures, including annual benchmark standards for assessing equity and quality in health care delivery required by Assembly Bill (AB) 133 (Committee on Budget, 2021). This report documents the recommendations developed by the Committee, which met over eight months in a series of public meetings.

The Department will consider the Committee's recommendations in establishing and enforcing the health equity and quality measures and benchmark standards for all DMHC-licensed full-service and behavioral health plans. The Department of Health Care Services (DHCS) will coordinate with the DMHC to hold County Organized Health Systems (COHS) health plans that do not hold a DMHC license to the same or similar standard, as allowed under DHCS' authority.

Health Equity and Quality Committee Recommendations

The Committee considered state and national trends related to health equity and quality as well as the intersection of multiple patient characteristics that contribute to disparate health outcomes, including race, ethnicity, sexual orientation, gender identity, language, age, income, and disability status.

The Committee recommended the following 13 quality measures for inclusion in the initial set of measures:

1. Colorectal Cancer Screening
2. Breast Cancer Screening
3. Hemoglobin A1c Control for Patients with Diabetes
4. Controlling High Blood Pressure
5. Asthma Medication Ratio
6. Depression Screening and Follow-Up for Adolescents and Adults
7. Prenatal and Postpartum Care
8. Childhood Immunization Status
9. Well-Child Visits in the First 30 Months of Life
10. Child and Adolescent Well-Care Visits
11. Plan All-Cause Readmissions
12. Immunizations for Adolescents
13. Consumer Assessment of Healthcare Providers and Systems (CAHPS) Health Plan Survey, Version 5.0 (Medicaid and Commercial): Getting Needed Care

The Committee recommended using annually adjusted Quality Compass®[1] national Medicaid performance scores as the benchmark for both Commercial and Medi-Cal health plans. The benchmark would leverage the current year of data released in the Quality Compass, which is based on the prior year's performance. For example, data reported for 2023 will be assessed against the national Medicaid performance scores for 2022. However, the Committee did not reach consensus on which national Medicaid percentile to use and had an evenly split vote on recommending either the 25th or 50th percentile as the benchmark. The DMHC Director will make the final decision regarding establishing the benchmark.

For measure stratification, the Committee recommended, in addition to the nine Healthcare Effectiveness Data and Information Set (HEDIS®)[2] measures that already require stratification by race and ethnicity, the remaining four measures also be stratified by race and ethnicity using the National Committee for Quality Assurance (NCQA) race and ethnicity reporting methodology. Furthermore, the Committee recommended stratification be required on additional socio-demographic characteristics as these data become available.

II. Introduction

AB 133 authorized the DMHC to establish health equity and quality measures and benchmark standards for all DMHC-licensed full-service and behavioral health plans with the goal of addressing long-standing health inequities and to ensure the equitable delivery of high-quality health care services across all market segments, including the Commercial individual, small and large group markets, and Medi-Cal Managed Care.

To inform the selection of quality measures and benchmark standards, the DMHC convened the Committee to make recommendations in the form of this report to the DMHC Director. The DMHC contracted with a consultant, Sellers Dorsey (facilitator), to assist with the implementation, administration, and facilitation of the Committee.

Based on AB 133, the Committee was tasked with the following:

- Recommending quality measures, which may include HEDIS measures and federal Centers for Medicare and Medicaid Services (CMS) Child and Adult Core Set measures, surveys to assess consumer experience, and other measures.
- Recommending health equity and quality benchmarks for the DMHC's consideration to address deficiencies.
- Considering effective ways to measure health outcomes in the absence of quality measures.
- Considering approaches to stratifying reporting of results by factors, including, but not limited to age, sex, geographic region, race, ethnicity, language, sexual orientation, gender identify, and income to the extent health plans or public programs have data that yields statistically valid and reliable results.

[1] Quality Compass® is a registered trademark of the NCQA.
[2] HEDIS® is a registered trademark of the NCQA.

- Considering measures of social drivers of health (SDoH).

Key implementation dates include:

- By March 1, 2022: The DMHC convened the Health Equity and Quality Committee.
- Measurement Year (MY) 2023: Health plans begin collecting data on health equity and quality measures.
- 2024: Health plans submit MY 2023 data to the DMHC.
- 2025: The DMHC publishes the Health Equity and Quality Compliance Report for MY 2023.
- 2026: The DMHC promulgates regulations to codify the Health Equity and Quality measures and benchmarks.
- January 1, 2026: Health plans required to obtain NCQA Health Plan Accreditation (HPA).

The initial set of measures will be collected and reported beginning in MY 2023 through at least MY 2027. After five years, the DMHC may reconvene the Committee to adjust or revise the measure set.

In the context of the DMHC's role as a regulator, the priority is setting a minimum floor of performance and ultimately a standard of care across California. Unlike other quality programs that focus on incentives to improve quality, this initiative leverages the DMHC's regulatory authority to require corrective action and take enforcement action when the health equity and quality benchmarks are not met. For data collected in MY 2023 and MY 2024, the DMHC may assess administrative penalties for procedural violations relating to health plan data collection, reporting, and corrective action plan implementation or monitoring requirements. It is anticipated the DMHC will codify the health equity and quality measures and benchmarks in regulation by 2026. Following promulgation of regulations, the DMHC may begin assessing financial penalties for failure to meet the health equity and quality benchmarks.

III. Summary of Health Equity and Quality Committee Meetings

On February 1, 2022, the DMHC announced the selection of the Committee, comprised of 22 individuals, with 17 voting members and five non-voting ex officio members (Appendix A). The 17 voting members represent individuals with varying expertise including consumer representatives, health plan representatives, providers, and quality measurement and health equity experts. The five non-voting members represent state agencies including the California Department of Insurance (CDI), California Public Employees' Retirement System (CalPERS), Covered California, Department of Health Care Access and Information (HCAI), and DHCS. The DMHC selected the Committee members based on each member's area of expertise and representation and knowledge of California's diverse communities. Selected Committee members were instructed to represent the best interests of the people of California and not only their affiliated organization. The Committee, and its members, were subject to the rules and regulations of the Bagley-Keene Act.

The DMHC convened the Committee nine times between February and September 2022. The initial meetings focused on developing the Committee's shared understanding of Committee goals, California and national trends related to health equity and quality, types of measures and focus areas, and guiding principles for measure selection. Later meetings in June and July focused on establishing a list of recommended measures, voting on the final list of recommended measures, and beginning benchmarking discussions. The meeting in August focused on establishing a benchmark methodology, determining measure stratification, and exploring the feasibility of disparities reduction strategies. September's meeting included a review of the draft report. Throughout these meetings, the Committee heard presentations from a variety of stakeholders, including the DMHC staff, Committee members representing consumers, Committee members representing state purchasers, Committee members with quality measurement and health equity expertise, and representatives from the California Health and Human Services Agency, Center for Data Insights and Innovation. A summary of each meeting and the materials presented at each meeting can be found on the DMHC Health Equity and Quality webpage.

IV. Framework for Health Equity and Quality

Defining Health Equity and Quality in the California and National Health Care Landscape

CMS defines health equity "as the attainment of the highest level of health for all people, where everyone has a fair and just opportunity to attain their optimal health regardless of race, ethnicity, disability, sexual orientation, gender identity, socioeconomic status, geography, preferred language, and other factors that affect access to care and health outcomes."[3]

There are many studies and reports that document the significant and persistent disparities in care across a range of socio-demographic characteristics. Despite significant health care expenditures, opportunity remains within both California and the broader United States health care delivery and payment system to improve and promote optimal and more equitable results in terms of health care quality, effectiveness, and ultimately, population health.

Throughout the Committee meetings, various subject matter experts discussed the nature of health equity, quality of care, and health disparities in California and nationally. While inequities in health and health care are not new, the significant impact of events in recent years – including social justice movements and the COVID-19 pandemic – has inspired greater focus on addressing existing health disparities.[4]

[3] *CMS Strategic Plan Pillar: Health Equity*, available at: CMS Strategic Plan Pillar: Health Equity Fact Sheet

[4] *Tying Health Equity to Quality,* Patient Safety and Quality Healthcare, available at: Tying Health Equity to Quality, Patient Safety and Quality Healthcare

As described by The Joint Commission " ...although health care equity is often viewed through a social justice lens, we understand it to be first and foremost a quality-of-care problem."[5] In essence, to achieve health equity necessitates improvements in quality. Implementation of the recommended health equity and quality measures and benchmarks by the DMHC, and ultimately the health plans the Department regulates, can contribute to improvements in the quality of care and reductions in health care disparities and associated outcomes. This can be achieved, in part, through the existing infrastructure and momentum generated by quality initiatives that provide a foundation for providers and health plans to measure and address health disparities and enhance care for historically marginalized communities. Through the quality and health equity recommendations described in this report, health plans can be held accountable for results and are urged to take an important step to driving resources toward efforts to advance health equity.

V. Process for Selecting and Developing the Recommended Health Equity and Quality Measure Set

Guiding Principles for Measure Selection

To drive the measure selection process toward a comprehensive and meaningful health equity and quality data set, the Committee used a number of guiding principles for measure selection. These guiding principles acted as a framework for Committee discussion of potential measures to recommend to the DMHC. The guiding principles were shaped by the experience of Committee members and the Committee goals and were informed through existing measure evaluation criteria used by the National Quality Forum (NQF) among other federal and national organizations.[6]

The Committee's guiding principles for measure selection included:

1. Alignment with other measurement and reporting programs including California specific programs and federal initiatives.
2. Opportunity for improvement within a measure and that improvement would enhance health outcomes for a specific high-impact aspect of health care.
3. Opportunity to identify and reduce disparities based on race, ethnicity, or other factors.
4. The extent to which required data is available or there are capabilities to collect and stratify data without undue burden.
5. The extent to which other audiences are using or could use the performance data for improvement.
6. How the quality measure reflects and supports California's priorities, including addressing health disparities and ensuring all Californians have meaningful and timely access to care.

[5] *Equity and Quality Connection,* The Joint Commission, available at: Equity and Quality Connection, The Joint Commission - Our Priorities

[6] *Measure Evaluation Criteria,* National Quality Forum, available at: Measure Evaluation Criteria, National Quality Forum - Criteria

The Committee highlighted the importance of alignment with other state and federal initiatives and the ability to collect data for meaningful measurement as key factors to consider. Similarly, the Committee concluded existing measures that were validated and shown to be reliable in assessing performance should be prioritized over creating new measures, given the limited timeframe for the DMHC to adopt measures, the extensive resources necessary to develop and validate measures and their subsequent benchmarks, and the need to establish benchmarks and stratify selected measures by race, ethnicity, and other demographic factors.

Process for Measure Selection

Recognizing the abundance of existing measures, the facilitator presented the Committee with an organizing framework of twelve measurement domains, or focus areas, commonly used to assess the performance of health plans and health care providers. The focus areas were determined through an environmental scan of federal and California programs, including DHCS, Covered California, the Integrated Healthcare Association (IHA), as well as programs in other states. To facilitate the subsequent measure review and selection process, measures were categorized to each of these focus areas to provide a mechanism to organize and concentrate on specific areas of measurement for Committee discussion.

The Committee understood that: 1) presentation of a focus area did not obligate inclusion of any of its measures; 2) some measures could be categorized in more than one focus area, and the Committee might move a measure to another focus area for discussion; 3) some measures were challenging to fit into any of the twelve focus areas; and 4) Committee members could suggest additional measures to be considered in any focus area, or even measures that did not clearly fit into any of the named focus areas. Committee members were invited to propose other focus areas or recommend alternative naming conventions. After Committee and stakeholder feedback, the Committee reached consensus on the following focus areas:

1. Adult Prevention
2. Chronic Conditions
3. Mental Health
4. Substance Use
5. Birthing Persons and Children
6. Access
7. Utilization
8. Specialty
9. Appropriateness of Care
10. Patient Experience
11. Population Health
12. Health Equity

To facilitate consideration of as many measures as possible, the Committee was presented with measure workbooks organized by focus area.[7] These workbooks were initially sourced from the *Buying Value Measure Selection Tool* created by the Robert Wood Johnson Foundation that was developed to promote alignment in quality measures used by public and private payors and helps state agencies, purchasers, and other stakeholders develop comprehensive measure sets.[8] Current as of March 2021, the tool contains over 800 measures reflecting major national measure sets and state-developed measures.

Utilizing this resource, the measures were categorized by the 12 focus areas. To help narrow the measures the Committee would be considering, the facilitator narrowed the list of measures by highlighting those measures that aligned with the guiding principles; that is, the measures were used in California programs including by DHCS, Covered California, IHA, and/or were otherwise widely used in federal programs. This process remained the same for all focus areas with the exception of the health equity focus area, which is not a focus area included in the *Buying Value Measure Selection Tool*, and for which measures were identified from independent research.

Based on Committee feedback and request, the facilitator provided measure characteristics including measure specifications, measure type (e.g., process, outcome, structural), whether the measure was risk adjusted, and whether the measure was defined as disparities-sensitive by NQF. The disparities-sensitive status is based on NQF's designation and refers to measures that identify differences in quality across institutions or in relation to certain benchmarks, as well as differences in quality among populations or social groupings (e.g., race, ethnicity, language).[9]

A robust discussion occurred about each focus area and the measures within them. In addition to the measures highlighted for discussion during meetings, the facilitator encouraged Committee members to propose additional measures for consideration, whether from the workbooks or from another source. Committee members leveraged their expertise and experience to propose measures they determined appropriate for further discussion and consideration, elevating several measures for discussion and voting that had not been initially identified by the facilitator. Throughout these discussions, members shared their experience with measures currently in use and the differing perspectives brought by payors, providers, consumer representatives, and data quality experts.

Where available, existing performance data was also provided for consideration. The data was identified through the NCQA Quality Compass, which contains plan-specific, comparative, and descriptive information on the performance of hundreds of health

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[7] *2022 Health Equity and Quality Committee Meeting*, Department of Managed Health Care, available at: DMHC 2022 Health Equity and Quality Committee Meeting

[8] *About Buying Value,* Buying Value Measure Selection Tool, available at: https://www.buyingvalue.org/about/about-buying-value/

[9] *Analysis of Measurement Gap Areas and Measure Alignment,* Core Quality Measures Collaborative, available at: https://www.qualityforum.org/Story/CQMC/Measure_Alignment_Report.aspx

plans, providing stakeholders the ability to conduct a detailed market analysis.[10] NCQA's Quality Compass also includes state and national level aggregated results which informed benchmark recommendations.

Committee Discussion – Measures

Throughout the meetings, the Committee discussed and prioritized measures to recommend to the DMHC. As context, the Committee was provided information about the five HEDIS measures that NCQA requires stratification by race and ethnicity, effective MY 2022. At the time the DMHC convened the Committee, NCQA was preparing to announce additional HEDIS measures that would be stratified by race and ethnicity in MY 2023. Having this information readily available aided the voting process because it highlighted measures where stratification by race and ethnicity would be most feasible, considering current data limitations. Additionally, this information helped prioritize measures with potential high impact and a known need for addressing disparities in California.

The presentations and public comments made to the Committee stressed the need for measures that could address drivers of morbidity and mortality. A primary theme of discussion was advancing measures where there was opportunity for improvement. Subsequently, the facilitator provided the Committee epidemiological and prevalence data, where available. This supported members' consideration of the prevalence of certain health conditions informing the potential for high impact.

The Committee also discussed the need for measures with adequate expected health plan member population for valid performance measurement. This included whether there would be a sufficient member population size in a measure denominator to stratify quality performance at the sub-population level by race, ethnicity, and language. Attention was also given to the setting of care (e.g., inpatient, outpatient, nursing facility, etc.) and feasibility of health plans to collect data for a given measure. In some instances, there could be potential technical challenges for health plans reporting certain measures.

An additional priority discussion centered on including risk adjustment. The Committee determined it would be applied only when included in the measure specifications as adding risk adjustment would require alterations to the specifications that the DMHC may not have the resources to make.

At times, the Committee favored measures or identified measures that reflected stakeholder interests but were not considered feasible or appropriate to recommend at this time. Several stakeholders expressed concerns for the obesity crisis and requested

[10] The source for data contained in this publication is Quality Compass® 2021 and is used with the permission of the NCQA. Quality Compass 2021 includes certain CAHPS data. Any data display, analysis, interpretation, or conclusion based on these data is solely that of the authors, and NCQA specifically disclaims responsibility for any such display, analysis, interpretation, or conclusion. Quality Compass is a registered trademark of NCQA. CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).

the Committee evaluate existing measures such as obesity and prediabetes or diabetes control. With respect to mental health, the Committee suggested measures that address both adolescent and adult populations, and that could help address the under-diagnosis of mental illness. Members also raised the challenges of ensuring access to mental health services for all Californians, including Californians who are immigrants, have a disability, are experiencing homelessness, or are from lesbian, gay, bisexual, and transgender, queer and/or questioning (LGBTQ) communities. Ultimately, the Committee determined that currently available measures in these areas or other areas of interest did not meet the measure selection criteria.

For further information on additional measures considered, see Appendix B.

Committee Discussion – Benchmarks

The Committee engaged in a robust discussion to consider the possible merits and challenges for each component of benchmarking. For measures where benchmark data did not currently exist, Committee members discussed the length of time a measure had been established and when data may become available. In some instances, a measure's technical specifications were recently adjusted which limited benchmark availability.

The Committee recognized that while Commercial and Medi-Cal health plans may be starting from different points, using the same benchmark data type provided an opportunity for the State to set similar expectations for health outcomes and standards of care independent of payor. Though there may be certain measures where one line of business outperforms the other, Medicaid performance for most measures is likely to be lower in large part due to socioeconomic and related SDoH. This highlighted concerns that adopting a Commercial standard may not be reasonable or attainable and therefore would likely result in a high volume of Medi-Cal health plans being disproportionately penalized, which would impact the magnitude of resources available to direct toward addressing disparities.

The Committee was committed to promoting equity and recognized this necessitated holding all payors to a single standard at both the aggregate level and for each sub-population. The Committee focused its discussion on the option of using the Medicaid 25th and the 50th percentile as the benchmark for Medi-Cal based on DHCS previously using the Medi-Cal 25th and now using the 50th percentile and to prevent Medi-Cal plans from being disproportionately penalized.

Further discussion surrounded whether to apply the same percentile value to all measures or choose different percentile values specific to individual measures. A percentile provides a value on a scale of 1-100 that indicates the percent of plans that performed at or below the percentile performance score. For example, if the 25th percentile performance score of a measure is 67.91% then 25% of health plans screened 67.91% or fewer persons. Conversely, 75% of health plans screened greater than 67.91% of persons. While there are differences in performance across measures and payors, the Committee recognized the distribution of performance varied such that

certain measures have greater ease or difficulty to achieve benchmarks in terms of internal systemic changes or shifts in patient behavior.

The Committee members expressed differences of opinion as to which percentile value to recommend for all measures. To support this discussion, the facilitator provided the Committee a summary of plan performance (Appendix E) to highlight the number of health plans that could be expected to improve on recommended measures based on a benchmark floor and bringing all health plans to a minimum standard level of care.

Some Committee members were apprehensive that the 25th percentile may not be aspirational enough, whereas other Committee members were concerned that a higher percentile, such as the 50th, may be unachievable for some measures and some health plans, and therefore was more appropriate in an incentive program than one based on an enforcement approach.

Several members favored the 50th percentile to create ambitious expectations for health plans as well as align with DHCS requirements and voiced that the 25th percentile may not drive performance to the highest potential. Other members expressed concerns that the pursuit of a higher percentile may worsen disparities if health plans are unable to make such quality improvements in a short amount of time and are subject to corrective action or financial penalties that would lessen resources to address disparities. Furthermore, to set a benchmark at the 50th percentile would require all health plans in California to perform better than all other Medicaid health plans in the nation, which may mean penalties for a significant number of health plans – as demonstrated in Appendix E.

Consideration was also given to implementing a phase-in approach that started at the 25th percentile and increased over time. This option elevated concerns that if the benchmark increased, those health plans that had not yet met the initial value would fall further behind. Recognizing both rationales, the Committee explored using the 33.33rd percentile or a phased approach in which the benchmark would start at the 33.33rd percentile and increase to the 50th percentile after some period of time. However, some members expressed similar concerns that this percentile value may also be unachievable or impractical, particularly for some sub-populations.

Ultimately, the Committee voted on three different percentile values (25th, 33.33rd, and 50th). The Committee vote led to a split decision between the 25th and 50th percentiles. While consensus was not met, the Committee agreed the priority was to establish a benchmark methodology that creates a pathway to advance health equity.

VI. Health Equity and Quality Committee Recommendations

Measure Recommendations

To institute a minimum standard of performance and reduce variation across health plans, while also facilitating greater understanding of where disparities exist, the Committee recommended health plans regulated by the DMHC report the measures listed below. These measures reflect the Committee's guiding principles and goals to

propose measures that enhance health equity by promoting higher quality of care, prioritizing disparities-sensitive measures, and advancing measure stratification to understand the outcomes of specific populations. Further measure characteristics, including measures that require NCQA stratification by race and ethnicity, are provided in Appendix D.

#	Measure Name	Description	NQF #
1	Colorectal Cancer Screening	The percentage of members 45–75 years of age who had appropriate screening for colorectal cancer.	0034
2	Breast Cancer Screening	The percentage of women 50–74 years of age who had a mammogram to screen for breast cancer.	2372
3	Hemoglobin A1c Control for Patients with Diabetes	The percentage of members 18–75 years of age with diabetes (types 1 and 2) whose hemoglobin A1c (HbA1c) was at the following levels during the measurement year: • HbA1c control (<8.0%). • HbA1c poor control (>9.0%).	0059
4	Controlling High Blood Pressure	The percentage of members 18–85 years of age who had a diagnosis of hypertension (HTN) and whose blood pressure (BP) was adequately controlled (<140/90 mm Hg) during the measurement year.	0018
5	Asthma Medication Ratio	The percentage of members 5–64 years of age who were identified as having persistent asthma and had a ratio of controller medications to total asthma medications of 0.50 or greater during the measurement year.	1800
6	Depression Screening and Follow-Up for Adolescents and Adults	The percentage of members 12 years of age and older who were screened for clinical depression using a standardized tool and, if screened positive, who received follow-up care. • Depression Screening: The percentage of members who were screened for clinical depression using a standardized tool. • Follow-Up on Positive Screen: The percentage of members who screened positive for depression and received follow-up care within 30 days.	*NA*

#	Measure Name	Description	NQF #
7	Prenatal and Postpartum Care	The percentage of deliveries of live births on or between October 8 of the year prior to the measurement year and October 7 of the measurement year. For these women, the measure assesses the following facets of prenatal and postpartum care. • Timeliness of Prenatal Care: The percentage of deliveries that received a prenatal care visit in the first trimester, on or before the enrollment start date or within 42 days of enrollment in the organization. • Postpartum Care: The percentage of deliveries that had a postpartum visit on or between 7 and 84 days after delivery.	1517
8	Childhood Immunization Status (CIS 10)	The percentage of children 2 years of age who had four diphtheria, tetanus, and acellular pertussis (DTaP); three polio (IPV); one measles, mumps, and rubella (MMR); three haemophilus influenza type B (HiB); three hepatitis B (HepB), one chicken pox (VZV); four pneumococcal conjugate (PCV); one hepatitis A (HepA); two or three rotavirus (RV); and two influenza (flu) vaccines by their second birthday.	0038
9	Well-Child Visits in the First 30 Months of Life	The percentage of members who had the following number of well-child visits with a PCP during the last 15 months. The following rates are reported: 1. Well-Child Visits in the First 15 Months. Children who turned 15 months old during the measurement year: Six or more well-child visits. 2. Well-Child Visits for Age 15 Months–30 Months. Children who turned 30 months old during the measurement year: Two or more well-child visits.	1392
10	Child and Adolescent Well-Care Visits	The percentage of members 3–21 years of age who had at least one comprehensive well-care visit with a Primary Care Physician (PCP) or an Obstetrics/Gynecology (OB/GYN) practitioner during the measurement year.	*NA*
11	Plan All-Cause Readmissions	For members 18 years of age and older, the number of acute inpatient and observation stays during the measurement year that were followed by an unplanned acute readmission for any diagnosis within 30 days and the predicted probability of an acute readmission.	1768

#	Measure Name	Description	NQF #
12	Immunizations for Adolescents (IMA Combo 2)	The percentage of adolescents 13 years of age who had one dose of meningococcal vaccine, one tetanus, diphtheria toxoids and acellular pertussis (Tdap) vaccine, and have completed the human papillomavirus (HPV) vaccine series by their 13th birthday.	1407
13	CAHPS Health Plan Survey, Version 5.0 (Medicaid and Commercial): Getting Needed Care	This measure provides information on the experiences of Commercial and Medicaid members with the organization and gives a general indication of how well the organization meets members' expectations. The Getting Needed Care composite asks enrollees how often it was easy for them to get appointments with specialists and get the care, tests, or treatment they needed through their health plan.	0006

These recommended measures represent aspects of health which are important to advancing equity and quality in preventative care, maternal health, chronic conditions, and mental health across pediatric, adolescent, and adult populations. By requiring these measures, health plans have the opportunity to address disparities across different points of care. Prioritization of these measures reflects commitment to addressing disparities and improving the quality of care received. Such measures can work in tandem with the efforts of purchasers who can drive continuous improvement and hold health plans accountable through incentive payments and programs.

Benchmarking Recommendations

The Committee reached consensus on using national Medicaid data to set benchmarks for both Medi-Cal and Commercial health plans and applying a consistent percentile value across all measures that is annually adjusted as Quality Compass data are released. Furthermore, the benchmark for each current measurement year will be the Quality Compass performance associated with the selected percentile based on the prior year's measurement. For example, the performance target for MY 2023 will be the selected percentile result determined from MY 2022's performance. The Committee did not reach consensus in determining a specific percentile value to recommend and had a split vote on using the 25th or 50th percentile. The DMHC Director will make the final decision regarding establishing the benchmark.

These recommendations will promote greater equity by holding health plans accountable for meeting a minimum standard of care across all racial and ethnic groups and market segments. The imposition of a performance benchmark floor has the potential to improve the quality of care delivered, in part by obligating health plans that were initially at the low-end of the spectrum to increase their quality to meet the new standards. These benchmark conditions are a critical step in driving resources to reduce disparities.

Measure Stratification Recommendations

Of the 13 measures recommended by the Committee, NCQA currently requires nine to be stratified by race and ethnicity for MY 2023. By prioritizing consideration of HEDIS measures that NCQA will require stratification by race and ethnicity, the Committee expects that health plans will report their performance on these nine HEDIS measures, both for all their Commercial and/or Medicaid members, and for their Commercial and/or Medicaid members stratified by race and ethnicity using the NCQA race and ethnicity methodology. NCQA requires organizations seeking NCQA HPA to submit annual audited HEDIS and CAHPS results by accredited population to assure the quality of performance results.

In addition, the Committee recommends the DMHC require health plans to report their performance on the four additional measures by race and ethnicity, using the NCQA methodology. Though this will require additional work for the health plans, it positions the state to lead nationally in data collection and health plan requirements. Until state and federal initiatives address data collection and analyzes barriers for stratifying measures by other demographic data, the Committee recommends that the DMHC require health plans to report what demographic data they have collected and for what percent of their membership, along all these demographic characteristics. For example, health plans may report the percentage of members who self-report gender identity and/or sexual orientation.

VII. Recommendations for Future Consideration

In addition to the measures and benchmark recommended by the Committee, there were a number of additional recommendations made by the Committee for the DMHC to consider in future revisions to the measures, including additional accreditation requirements, further stratification by demographic data and measures for future development and consideration. The Committee members expressed interest in reconvening the Committee after one to two years of data is reported to the DMHC to discuss potential adjustments. A more detailed discussion of these recommendations is included below.

Additional Accreditation Requirements

The Committee recommended the DMHC require all health plans to obtain NCQA Health Equity Accreditation (HEA) and require health plans to report on the RAND Corporation's Health Equity Index (HEI), should it be approved by CMS and determined to be usable by Medi-Cal and Commercial health plans regulated by the DMHC.

Proposing a requirement for NCQA HEA aligns with current DHCS and Covered California requirements to obtain this accreditation. It also further advances the recommended measure set by providing an actionable framework to improve health

equity statewide.[11] Through the accreditation, the DMHC will have an additional mechanism to evaluate health plan progress on addressing health equity by assessing a health plan's commitment to directing resources and reinforcing expectations for stratified reporting on the recommended measures. Furthermore, the HEA requires health plans to report both the HEDIS Race/Ethnicity Diversity of Membership and the Language Diversity of Membership measures, which can serve as process measures to indicate completeness of data on the demographics of a health plan's population. Of note, mandating such a requirement by the DMHC would require statutory authorization.

Similarly, while the HEI is presently proposed for Medicare Part C and D Star Ratings, if in the future it could be applied to the DMHC regulated health plans, this too could reduce disparities by driving equity and focusing resources on more effective interventions for impacted enrollees.[12]

Availability of Demographic Data

The Committee recognizes that, over the next five years, there are pending or expected 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. The Committee emphasized the ability to capture such data is critical in understanding the intersectionality of different populations or subgroups that may have significant impacts on or exacerbate barriers to health equity as well as uncover disparities within sub-populations. For example, a study published in 2016 by Torre et al establishes that while the incidence of cervical cancer appears lower for Asian Americans when compared to non-Hispanic White Americans, when disaggregated by ethnicity, rates are much higher in Vietnamese and Cambodian but lower in Chinese and Asian Indian sub-populations.[13] As such, if and when it is possible, the Committee recommends the DMHC require California health plans to collect and use these other demographic data to stratify the recommended quality measures to unveil disparities that may exist at the sub-population level.

While Committee members recognize collecting race, ethnicity, language, sex, sexual orientation, gender identity, age, income, disability status, tribal affiliation, and geographic location data are imperative to address and ameliorate disparities, the infrastructure to do so is not yet sophisticated enough for collecting, reporting, and analyzing this type and level of detail of data. Due to the reporting limitations experienced in California and nationally, creating substantive disparities reduction and measure stratification recommendations at this time was challenging. Related to data collection and analysis, Committee members emphasized that the ability to

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[11] *NCQA's Health Equity Accreditation Programs*, National Committee for Quality Assurance, available at: NCQA's Health Equity Accreditation Programs, National Committee for Quality Assurance - Health Equity Accreditation

[12] Note to: *Medicare Advantage Organizations, Prescription Drug Plan Sponsors, and Other Interested Parties,* CMS, available at: Medicare Advantage Organizations, Prescription Drug Plan Sponsors, and Other Interested Parties, CMS

[13] *Cancer statistics for Asian Americans, Native Hawaiians, and Pacific Islanders, 2016: Converging incidence in males and females,* CA: A Cancer Journal for Clinicians, available at: Cancer statistics for Asian Americans, Native Hawaiians, and Pacific Islanders

disaggregate race and ethnicity data beyond the Office of Management and Budget categories is essential to get a true sense of outcomes within race and ethnicity.[14] Though the Committee was interested in recommending specific disparity reduction goals, this was not feasible without national benchmarking data. By 2025, it is unlikely national stratified data could be used to validate and benchmark California health plan performance by stratified race and ethnicity groups, and there are questions about statistical significance from small sample sizes for stratified race and ethnicity groups on each performance measure, or other demographics.

While these limitations persist, the California Health and Human Services Agency Data Exchange Framework will be mandatory for health plans in the future – implementation begins in January 2023 on a rolling basis until 2024 – and will create a system in which this data is more readily available. Beginning in January 2024, California's Data Exchange Framework will require all health plans to utilize the Office of the National Coordinator (ONC) Version 2 standards for the collection of race and ethnicity, language, age, sexual orientation and gender identity, and social needs data. The recently released ONC Version 3 standards include disability status data which will provide health plans the tools to collect and report on measures across demographic factors. There may also be similar national and federal efforts in tandem with the Data Exchange Framework that support California's data collection efforts. The goal of gathering this data will advance understanding of specific disparities and opportunities to improve health equity in California.[15] Henceforth, despite the demographic specific data limitations, should the DMHC adopt and enforce the recommended measures, it will provide a starting point for collection and will better position health plans for the forthcoming requirements.

Measure Concepts and Issues for Future Consideration

The Committee discussed additional concepts that would be favorable to recommend if relevant measures were available and feasible. There were also discussions regarding quality measures that were more relevant for health care providers rather than health plans. The Committee considered including measures that specifically address health equity outcomes but after conducting research on the national landscape it was determined that high-quality measures to assess health equity are not presently available. However, when measures become available to accurately assess health plans for health equity the DMHC should consider including such measures.

The Committee expressed interest in measures regarding prostate cancer, anxiety, suicide, and immunizations that would include the COVID-19 vaccine, but was not able to identify measures to recommend due to a lack of high-quality measures being available and the desire to have a parsimonious set. Suggestions were also given to measure access to interpreter services and translated materials, cultural competency and cultural humility, or to address issues of discrimination. Two measures were

[14] *Office of Management and Budget Standards*, Office of Management and Budget, available at: Office of Management and Budget Standards
[15] *Data Exchange Framework,* California Health and Human Services, available at: Data Exchange Framework

identified but did not receive enough votes to be included in the Committee's recommendations. A reoccurring topic raised both by the Committee and through public comment, was obesity. There was great interest from the public to support obesity reduction strategies, however the proposed obesity measures did not meet the guiding principles for measure selection. Despite the importance of these topics, there were constraints related to currently available measures and practicality of creating new measures in the allowable timeframe. The Committee recommended the DMHC consider the availability of such measures in future revisions to the measures.

Given the recommendations made by the Committee apply to both DMHC-licensed full-service and behavioral health plans, the Committee emphasized the importance of accurately measuring behavioral health processes and outcomes. Committee members expressed the significance of capturing the appropriateness of behavioral health care services. Four measures related to behavioral health were identified through this process but ultimately did not receive enough votes to be included in the Committee's recommendation.

The Committee recognized a new NCQA proposed measure for social needs screening and intervention that could provide an opportunity to advance data collection and where to direct attention on SDoH.[16] At the time of Committee discussions and due to its stage of development, specifically the timeframe for implementation and availability of meaningful results, the Committee concluded it was too early to propose this pending measure for inclusion in the final recommended measure set.

The Committee discussed that, while access is a critical component of receiving high quality and equitable health care, there were no satisfactory measures. Instead, measures that reflect access to care were covered in other focus areas and addressed by the DMHC's enforcement of timely access and network adequacy standards.

The Committee concentrated on enabling greater data collection to facilitate improving health disparities. The quality measures that NCQA selected for race and ethnicity stratification were a primer for priority, whereas other measures presented concern for how stratification may occur across race, ethnicity, or other variables. Of the 13 measures selected for the final recommended set, nine are currently required for race and ethnicity stratification by NCQA.

Likewise, measures without benchmarking data available were challenging to advance forward. For example, although a measure on long-acting reversible contraception was not voted for inclusion, the Committee suggested the DMHC consider requiring it for health plans should benchmark data become available in the future.

The Committee also recognized that there are few nationally recognized measure stewards that conduct rigorous analytical and stakeholder processes to validate individual measures. Given that this process generally takes a few years and must meet

[16] *Proposed New Measure for HEDIS®[1] Measurement Year (MY) 2023: Social Need Screening and Intervention (SNS-E)*, National Committee for Quality Assurance, available at: NCQA Proposed HEDIS Measure

specific technical requirements, some topics Committee members expressed interest in did not have an appropriate measure. Alternatively, there were instances where measures were provided to target a particular area of Committee interest but were not workable in the California landscape due to a lack of data availability, or the modality or the setting used was not transferable to California health plans or would be too administratively burdensome to implement. Additionally, feedback from subject matter experts and state representatives stressed that creating a new measure for the purpose of this Committee may not be feasible.

VIII. Conclusion

The Committee meetings resulted in the recommendations outlined in this report for consideration by the DMHC Director for implementation beginning in 2023. These include 13 measures and a benchmarking methodology that creates a structure to advance health equity by instituting a minimum standard of care regardless of market segment.

The Committee recognizes that greater work needs to be done in terms of data collection to identify and address disparities. To that end, the Committee recommends that, in addition to the nine measures where stratification is already required by NCQA, the DMHC requires health plans to apply that stratification methodology to the remaining four measures.

Furthermore, as requirements around collecting additional demographic data expand, California health plans will have the opportunity to assess multiple demographic factors through additional stratified reporting requirements by the DMHC.

The Committee makes these recommendations with the intent to address health equity through approaches that attempt to understand the presence and drivers of health disparities more fully and require a uniform standard of care across lines of business to certify the care provided does not vary in quality due to individual characteristics.

The DMHC convened the Committee and will now consider the Committee's recommendations in establishing and enforcing the health equity and quality measures and benchmark standards for all DMHC-licensed full-service and behavioral health plans as required by AB 133. Ultimately, AB 133 also gives the DMHC Director discretion to adopt the health equity and quality measures. The Department will release an All Plan Letter in 2022 that lists the health equity and quality measures that all DMHC-licensed full-service and behavioral health plans will be held accountable to.

Consistent with existing law, the Department will consider the Committee's recommendations in establishing and enforcing the health equity and quality measures and benchmark standards for all DMHC-licensed full-service and behavioral health plans.

Appendix A: Committee Members

Voting Members

Anna Lee Amarnath, Integrated Healthcare Association. Within IHA, Dr. Anna Lee Amarnath is the General Manager of the Align. Measure. Perform. (AMP) Program and its overall strategy and execution. In addition to her AMP Program responsibilities, she works with key partners on the Encounter Data Governance Entity (EDGE), a cross-industry encounter data improvement project in California. Dr. Amarnath joined IHA from the California Department of Health Care Services (DHCS), where she worked as Medical Program Consultant, Chief Medical Quality and Oversight. Dr. Amarnath completed a fellowship in Quality, Safety, and Comparative Effectiveness Research at the University of California, Davis Medical Center. Prior to that, she completed a family medicine residency at Swedish Medical Center. Dr. Amarnath earned a medical degree and Master of Public Health from Tufts University School of Medicine and a bachelor's degree from Boston College.

Bill Barcellona, America's Physician Groups. Bill Barcellona is the Executive Vice President for Government Affairs for America's Physician Group (APG). APG represents over 300 physician organizations across the United States that deliver health care to patients enrolled under Medicare, Medi-Cal, and employer-sponsored coverage health plans. Bill has been an attorney since 1985 and has served on the CHHS Privacy & Security Advisory Board, helped to form, and implement the Symphony and Sanator provider registries. He currently serves on the Health Care Payments Data Advisory Board and the CHHS Data Exchange Framework Stakeholder Advisory Sub-Committee. He has worked in healthcare for over 20 years and previously served as a deputy director at the Department of Managed Health Care. Bill is also a graduate and former faculty member of the USC Price School MHA program.

Dannie Ceseña, California LGBTQ Health and Human Services Network. Dannie Ceseña has over 15 years of experience working with non-profits in program development and advocacy. His knowledge and leadership have assisted in the creation of two TGNC community health care clinics, and a monthly TGNC legal clinic in Orange County, CA. He is responsible for building We Breathe: Supporting Tobacco-Free LGBTQ Communities from the ground-up, and has established the program as a leader statewide, nationally, and even internationally. He has provided leadership and guidance for LGBTQ organizations who are new to working with the Department of Public Health, helping them navigate the complicated bureaucracy and ensuring LGBTQ project staff always have a place to turn with their questions and concerns. He is a graduate of CSU Long Beach with bachelor's degrees in English and Political Science and is a graduate of National University with a Master Degree in Public Health.

Alex Chen, HealthNet. Dr. Alex Chen, MD, MSHS, FAAP started his career as a Health Services Research tenure track professor at USC Keck School of Medicine's Children's Hospital Los Angeles, conducting research on health care equity and disparity. In 2014, Dr. Chen took a medical leadership role at AltaMed Health Services, one of the largest FQHC in the US, where he eventually became CMO. Throughout his term at AltaMed,

Dr. Chen stayed on as an Adjunct Scientist at RAND, continue to conduct research on pediatric quality of care and patient experience. At AltaMed, Dr. Chen oversaw the newly formed Health Equity Institute as well as the Quality Improvement Department, where many community-based interventions for the underserved to reduce health care disparity were implemented. Dr. Chen was recruited to be CMO for HealthNet in 2018, to continue to focus on improving health care disparity among the Medicaid population.

Cheryl Damberg, RAND Corporation. Dr. Cheryl Damberg is the Director of RAND's Center of Excellence on Health System Performance and holds the Distinguished Chair in Healthcare Payment Policy at the RAND Corporation. She is a nationally recognized expert in quality measurement and has worked to advance the development of measures of health equity. She is an international expert in pay for performance (P4P) and value-based payment (VBP) reforms and has advised Congress, federal agencies, the UK National Health Service, and the governments of Germany and South Korea on embedding performance-based incentives into provider payments schemes. Dr. Damberg was appointed in 2021 by the Comptroller General of the U.S. to serve on the Secretary of Labor's State All Payer Claims Databases Advisory Committee. In 2019-2020, Dr. Damberg was appointed by Governor Newsom to serve as Vice-Chair of the California Healthcare Payments Database (HPD) Review Committee to establish a plan for California's APCD, and she now serves as a member of the California HPD Advisory Committee which is providing guidance to the state of California as it implements the APCD.

Diana Douglas, Health Access California. Diana Douglas is Manager of Policy and Advocacy for Health Access California, having joined the organization in 2019. As a consumer advocate, Diana is dedicated to fighting for quality, affordable health care for all and leads Health Access' work on a wide range of legislative and administrative issue areas, including the Commercial market, Medi-Cal, Covered California, and behavioral health. Prior to joining Health Access, she worked in the state legislature for State Senator Richard Pan and as a policy analyst for the American Lung Association. Diana received her Masters from the University of North Carolina at Charlotte, where she conducted research on social safety net programs and access to behavioral health care.

Lishaun Francis, Children Now. As part of the health team, Lishaun Francis leads Children Now's behavioral health portfolio. Prior to joining Children Now, Lishaun was an Associate Director at the California Medical Association. She provided policy support and analysis for California physicians on the issues of Medi-Cal, Workers' Compensation, and Health Information Technology. Lishaun spent over two years with the Legislative Analyst Office (LAO) where she provided fiscal and policy analyses to the State Legislature on issues of mental health, developmental disabilities, and alcohol and drug programs. In Washington DC, Lishaun worked as a Program Analyst for the U.S Department of Education, providing fiscal support on issues of higher education. Lishaun received her Masters of Public Policy from the University of Michigan, and her Bachelor of Arts in Sociology from Spelman College in Atlanta, GA.

Tiffany Huyenh-Cho, Justice in Aging. Tiffany Huyenh-Cho is a senior staff attorney in the health team at Justice in Aging. She focuses on issues involving low-income older adults dually eligible for Medicare and Medi-Cal benefits in California. She works in collaboration with government agencies and consumer stakeholders to develop and implement policies and initiatives to improve access to health care and long-term services and supports for low-income older adults in California. Prior to Justice in Aging, she provided direct legal services at a legal aid program in the Bay Area, helping individuals access health insurance and health care services. Tiffany earned her law degree from the University of Michigan Law School and her undergraduate degree from UC San Diego.

Edward Juhn, Inland Empire Health Plan. Dr. Edward Juhn is the Chief Quality Officer at Inland Empire Health Plan (IEHP) where he is responsible for leading the advancement of IEHP's holistic focus on Quality through transformative incentives, initiatives, and innovative solutions and partnerships. Prior to joining IEHP, he served as a Sr. Medical Director at Blue Shield of California where he worked on initiatives leveraging big data, advanced analytics, and technology-enabled service offerings. Dr. Juhn also has experience as a clinical scientist at an Intel-funded startup company and served as Chief of Healthcare Innovation and Strategy at Premier HealthCare. Dr. Juhn received his BA and MD from George Washington University, his executive MBA from New York University, and his MPH from Johns Hopkins University. He is board certified in Internal Medicine, a fellow of the American College of Physicians, and was a clinical instructor at Stanford Medicine.

Jeffrey Reynoso, Latino Coalition for a Healthy California. Dr. Jeffrey Reynoso is the Executive Director of the Latino Coalition for a Healthy California (LCHC) — the State's leading health policy organization advocating for health equity of California's Latinx community. For over a decade, he has worked on health equity and social justice issues spanning academia, government, and non-profit sectors at local, state, and national levels. Dr. Reynoso currently serves as a Board Member for the Insure the Uninsured Project (ITUP) and Commissioner for the California 100 Initiative. Dr. Reynoso holds a Doctor of Public Health (DrPH) from Harvard University, a Master of Public Health (MPH) from UC Berkeley, and a BA from UCLA. He is a son of immigrants from Mexico and grew up in California's Central Valley and North San Diego County. Growing up in a working-class immigrant family, he experienced firsthand the systemic barriers to equal opportunity for all and he believes that the future health and economic success of California is tied to achieving health equity for the Latinx community.

Richard Riggs, Cedars-Sinai Health System. Dr. Richard Riggs is the Senior Vice President and Chief Medical Officer for the Cedars-Sinai Health System and has served in that role since October of 2019. Dr. Riggs served as Chair of the Department of Physical Medicine and Rehabilitation at Cedars-Sinai 1997-2020 and is a Clinical Professor at Cedars-Sinai and a Health Sciences Clinical Professor at David Geffen School of Medicine at UCLA. He previously served as Vice President and Chief Medical Information Officer for Cedars-Sinai from 2015-2019. Additionally, he facilitated the launch of the California Rehabilitation Institute in 2016 as Chief Medical Strategy Officer and Chief of Staff. He has been intimately involved in the Cedars-Sinai health equity

work through participation as a member of the Health Equity Council, Executive Diversity and Inclusion Council and Cedars-Sinai core leadership for the Institute for Healthcare Improvement Pursuing Equity Initiative.

Bihu Sandhir, AltaMed. Dr. Bihu Sandhir is a board-certified Internal Medicine Physician Executive with more than 25 years of health care experience. She currently serves as Medical Director of Quality and Patient Safety at AltaMed. Prior to moving to California, she worked in Ohio for 17 years as Medical Director of Primary Care Quality and Executive Medical Director in two large Hospital Systems. She successfully led these Healthcare Systems achieve PCMH recognition and participate successfully in Medicare's innovation Projects: CPCI & CPC+. Dr. Sandhir has earned multiple honors and frequently serves as a distinguished speaker. She is passionate about quality and safety measures that will eliminate health disparities to those in underserved communities. In addition to her Executive role, Dr. Sandhir continues to practice medicine, specializing in Advanced Diabetes and Geriatric care.

Kiran Savage-Sangwan, California Pan-Ethnic Health Network. Kiran Savage-Sangwan is the Executive Director of the California Pan-Ethnic Health Network (CPEHN). CPEHN is a statewide multicultural health advocacy organization, focused on eliminating persistent health inequities and addressing structural racism in health care. Prior to becoming Executive Director in 2019, Kiran served as CPEHN Deputy Director and Health Integration Policy Director. Kiran has a background in immigrant and mental health organizing and advocacy. She also previously served as the Chairperson of the Sacramento Community Police Review Commission. Kiran graduated from New York University with a BA and a Master of Public Administration.

Rhonda Smith, California Black Health Network. Rhonda Smith is the Executive Director of the California Black Health Network, a nonprofit that works to advance health equity for Black Californians. Rhonda has served in various nonprofit leadership roles that include Consultant/Project Director for the LiveHealthy OC Initiative, a three-year initiative that aimed to transform the model of care of a network of FQHCs from a disease-focused treatment model to prevention and wellness model, providing whole person care approach. Before the LiveHealthy OC Initiative, Rhonda served as the Consultant/Statewide Project Manager for the Susan G. Komen® Circle of Promise California Initiative. Rhonda earned her MBA in Marketing and Operations Management from the Darden School of Business at the University of Virginia and her B.S. Degree in Civil Engineering from Virginia Tech.

Kristine Toppe, National Committee for Quality Assurance. Kristine Toppe, MPH, is the Assistant Vice President for State Affairs at the National Committee for Quality Assurance (NCQA), where she leads the engagement and support of states on identifying and implementing policies for quality improvement and meaningful evaluation of the healthcare system. She has over 20 years of experience and direct knowledge of state and federal public health policy and has supported NCQA's relationships in California since 2001. In 2020-2021, she served as an advisor on the Oregon Health Care Authority's Social Determinants of Health Measure Workgroup which was charged with recommending a measure for incentivizing the screening of individuals for health-

related social needs. Ms. Toppe holds a Master of Public Health from UCLA's Fielding School of Public Health and a Bachelor of Science from the University of Oregon.

Doreena Wong, Asian Resources, Inc. Doreena Wong, Esq., currently works at Asian Resources, Inc. (ARI) as its Policy Director, in its Los Angeles office. Before coming to ARI, Doreena was the Director of the Health Access Project at Asian Americans Advancing Justice – Los Angeles. She has over 30 years of experience as a civil rights attorney, with expertise in the areas of health care, language access and voting rights while working at a range of public interest legal organizations. Doreena is also a well-known social justice advocate who has helped to find several Asian American lesbian, gay, bisexual, transgender, and queer rights group, including API Equality-LA and the Asian Pacific Islander Lesbian, Bisexual, and Transgender Network. She graduated from New York University School of Law in 1987 as a second career after having worked as a health care professional for nine years.

Silvia Yee, Disability Rights Education and Defense Fund. Silvia Yee is a senior staff attorney at Disability Rights Education and Defense Fund (DREDF) where her work has included projects to increase physical and programmatic accessibility and disability awareness in the delivery of health care services, as well as impact litigation to increase access for people with disabilities in myriad aspects of public and private life. Over the past decade, Ms. Yee has presented and written on how disability health and healthcare disparities, civil rights, public health, and social determinants of health such as race and ethnicity, LGBTQ status, and income level intersect. Recently, she has had the privilege of co-teaching the disability rights law class offered at UC Berkeley School of Law. Prior to joining DREDF, Ms. Yee worked in private Commercial practice in Canada, and with the Health Law Institute at the University of Alberta. Ms. Yee received her B.Mus., M.A., and LL.B. degrees from the University of Alberta. Following graduation from law school, she clerked with Justice William Stevenson at the Alberta Court of Appeal.

Ex-Officio Members

Palav Babaria, California Department of Health Care Services.
Dr. Palav Babaria has served as the Chief Quality Officer and Deputy Director of Quality and Population Health Management of the California Department of Health Care Services since March 2021. She was formerly the Chief Administrative Officer of Ambulatory Services at Alameda Health System. Prior to that role, she served as Medical Director of K6 Adult Medicine Clinic. She also has over a decade of global health experience and her work has been published in the New England Journal of Medicine, Academic Medicine, Social Science & Medicine, L.A. Times, and New York Times. Dr. Babaria received her bachelor's from Harvard College, as well as her MD and Master's in Health Science from Yale University. She completed her residency training in internal medicine and global health fellowship at the University of California, San Francisco.

Alice Huan-mei Chen, Covered California. Dr. Alice Huan-mei Chen is chief medical officer at Covered California, the state's health insurance marketplace, which actively works to ensure that Californians can find affordable, high-quality coverage. Prior to joining Covered California, Dr. Chen served as deputy secretary for policy and planning and chief of clinical affairs for the California Health and Human Services Agency. For fifteen years, Dr. Chen was a professor of medicine at the University of California San Francisco School of Medicine based at Zuckerberg San Francisco General Hospital, where she served as its chief integration officer and founding director of the eConsult program. She subsequently served as inaugural chief medical officer and deputy director for the San Francisco Health Network. A graduate of Yale University, Stanford University Medical School, and the Harvard School of Public Health, Dr. Chen's training includes a primary care internal medicine residency and chief residency at Brigham and Women's Hospital.

Stesha Hodges, California Department of Insurance. Stesha Hodges is an Assistant Chief Counsel at the CDI and Chief of CDI's Health Equity and Access Office (HEAO). As Chief of HEAO, her work focuses on promoting equity and access in health coverage for historically disadvantaged groups. Stesha joined CDI as an attorney in 2008. Since 2010 she has worked to improve access to, and equity in, health coverage and care through work implementing the Affordable Care Act and health reform in California's health insurance markets. Stesha represents CDI and the Insurance Commissioner on health issues in proceedings of the National Association of Insurance Commissioners, and with a wide range of external stakeholders. Prior to joining CDI, Stesha worked as an attorney at the California Department of Social Services, as well as in private law practice. She holds a B.S. in criminal justice from California State University-Sacramento, and a J.D. from the University of the Pacific – McGeorge School of Law.

Julia Logan, California Public Employees Retirement System. Dr. Julia Logan serves as the Chief Medical Officer and Head of Clinical Policy for the CalPERS. She is charged with advancing health equity, behavioral health, and pharmacy policy as well as improving clinical quality. Dr. Logan has held leadership positions in the public, private, and academic sectors related to chronic disease management, quality

improvement, and patient safety, including serving as the Chief Quality Officer and Associate Medical Director of the California Department of Health Care Services. She is on the faculty of the California Department of Public Health's Preventive Medicine Residency Program. Dr. Logan is board-certified in Public Health and General Preventive Medicine and Family Medicine. She received her bachelor's degree in American Culture from Northwestern University, and MPH from UC Davis, and her MD from Drexel University College of Medicine.

Robyn Strong, California Department of Healthcare Access and Information. Robyn Strong is the Enterprise Data Operations Assistant Branch Chief within the Information Services Division of the HCAI. Robyn joined HCAI (formerly the Office of Statewide Health Planning and Development) in 1999 and has served in numerous roles, primarily related to data collection and validation of healthcare data including patient-level administrative, financial, utilization, healthcare payments (APCD), and cost transparency of prescription drugs. Prior to HCAI, Robyn worked for the California Public Health Foundation as a Health Surveyor and for the Employment Development Department. She earned her Bachelor of Science Degree in Business Administration from California State University, Chico and Certificate from the California Health and Human Services Leadership Development Academy at California State University, Sacramento in 2019

Appendix B: All Recommended Measures and Percent of Vote Received

Measures voted for Further Discussion in the first round of votes were ultimately not included in the Committee's final recommendation.

	Number of "Yes" Votes	Percent of Committee with "Yes" Votes (denominator = 17)	Pass/Not Pass/Further Discussion
Hemoglobin A1c Control for Patients with Diabetes	14	82%	Pass
Controlling High Blood Pressure	14	82%	Pass
Asthma Medication Ratio	14	82%	Pass
Prenatal and Postpartum Care	14	82%	Pass
Well-Child Visits in the First 30 Months of Life	14	82%	Pass
Colorectal Cancer Screening	13	76%	Pass
Breast Cancer Screening	13	76%	Pass
Immunization for Adolescents	13	76%	Pass
Depression Screening and Follow-Up for Adolescents and Adults	12	71%	Pass
Childhood Immunization Status (CIS 10)	12	71%	Pass
Child and Adolescent Well-Care Visits	12	71%	Pass
Plan All-Cause Readmissions	12	71%	Pass
Adult Immunization Status	10	59%	Further Discussion
Pharmacotherapy for Opioid Use Disorder	8	47%	Further Discussion
Obesity Prediabetes and Diabetes A1c Control	8	47%	Further Discussion
Meaningful Access to Health Care Services for Persons with limited English proficiency	8	47%	Further Discussion

	Number of "Yes" Votes	Percent of Committee with "Yes" Votes (denominator = 17)	Pass/Not Pass/Further Discussion
Patients Receiving Language Services Supported by Qualified Language Services Providers	8	47%	Further Discussion
Cervical Cancer Screening	7	41%	Further Discussion
Follow-Up After Emergency Department Visit for Mental Illness (FUM) – 30 days and 7 days	7	41%	Further Discussion
Topical Fluoride Varnish for Children	6	35%	Not Pass
Transitions of Care: Medication Reconciliation Post-Discharge	6	35%	Not Pass
Follow-Up After Hospitalization for Mental Illness – 30 days and 7 days	4	24%	Not Pass
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/ Adolescents	4	24%	Not Pass
Timely Follow-Up After Acute Exacerbations of Chronic Conditions	4	24%	Not Pass
Cultural Competency Implementation Subdomain: Quality improvement	4	24%	Not Pass
Cesarean Rate for Nulliparous Singleton Vertex (PC-02)	2	12%	Not Pass
Body Mass Index Screening and Follow-Up Plan	2	12%	Not Pass
Unhealthy Alcohol Use Screening and Follow-Up	1	6%	Not Pass
Avoidable Emergency Room Visits	1	6%	Not Pass
Contraceptive Care - All Women Ages 15-44 – Most & Moderately Effective Methods and Access to LARC	0	0%	Not Pass

Appendix C: Vote Count by Committee Member

Count of first round Committee member votes for Pass, Not Pass, and Further Discussion measures.

	Anna Lee Amarnath	Bill Barcellona	Dannie Cesena	Alex Chen	Cheryl Damberg	Diana Douglas	Lishaun Francis	Tiffany Huyenh-Cho
# of Yes Votes	15	14	24	0	13	15	0	18
# of No Votes	15	16	6	0	17	15	0	12

	Ed Juhn	Jeffrey Reynoso	Rick Riggs	Bihu Sandhir	Kiran Savage-Sangwan	Rhonda Smith	Kristine Toppe	Doreena Wong	Silvia Yee
# of Yes Votes	10	21	0	14	23	21	14	24	21
# of No Votes	20	8	0	16	7	9	16	6	9

Count of second round Committee member votes for Further Discussion measures.

	Anna Lee Amarnath	Bill Barcellona	Dannie Cesena	Alex Chen	Cheryl Damberg	Diana Douglas	Lishaun Francis	Tiffany Huyenh-Cho
# of Yes Votes	0	0	0	1	0	2	4	0
# of No Votes	7	0	0	6	7	5	3	0

	Ed Juhn	Jeffrey Reynoso	Rick Riggs	Bihu Sandhir	Kiran Savage-Sangwan	Rhonda Smith	Kristine Toppe	Doreena Wong	Silvia Yee
# of Yes Votes	0	5	0	0	0	5	2	6	3
# of No Votes	7	2	0	7	0	2	5	1	4

Appendix D: Characteristics of Recommended Measures

Measure Name	Steward	Focus Area	Type	NCQA Required for Stratification by Race/ Ethnicity	Disparities-Sensitive	Reported in California Medi-Cal Managed Care Accountability Set	Reported in Covered California Quality Transformation Initiative	Reported by IHA
Colorectal Cancer Screening	NCQA	Prevention/ Early Detection; Chronic Conditions	Process	Yes	Yes	Yes	Yes	Yes
Breast Cancer Screening	NCQA	Prevention/ Early Detection; Chronic Conditions	Process	Yes	Yes	Yes	No	Yes
Hemoglobin A1c Control for Patients with Diabetes	NCQA	Chronic Conditions	Outcome	Yes	Yes	Yes	Yes	Yes
Controlling High Blood Pressure	NCQA	Chronic Conditions	Outcome	Yes	Yes	Yes	Yes	Yes
Asthma Medication Ratio	NCQA	Chronic Conditions	Process	Yes	Yes	Yes	No	Yes
Depression Screening and Follow-Up for Adolescents and Adults	NCQA	Mental Health	Process	No	Yes	Yes	No	No

Measure Name	Steward	Focus Area	Type	NCQA Required for Stratification by Race/ Ethnicity	Disparities-Sensitive	Reported in California Medi-Cal Managed Care Accountability Set	Reported in Covered California Quality Transformation Initiative	Reported by IHA
Colorectal Cancer Screening	NCQA	Prevention/ Early Detection; Chronic Conditions	Process	Yes	Yes	Yes	Yes	Yes
Breast Cancer Screening	NCQA	Prevention/ Early Detection; Chronic Conditions	Process	Yes	Yes	Yes	No	Yes
Hemoglobin A1c Control for Patients with Diabetes	NCQA	Chronic Conditions	Outcome	Yes	Yes	Yes	Yes	Yes
Controlling High Blood Pressure	NCQA	Chronic Conditions	Outcome	Yes	Yes	Yes	Yes	Yes
Asthma Medication Ratio	NCQA	Chronic Conditions	Process	Yes	Yes	Yes	No	Yes
Depression Screening and Follow-Up for Adolescents and Adults	NCQA	Mental Health	Process	No	Yes	Yes	No	No

Measure Name	Steward	Focus Area	Type	NCQA Required for Stratification by Race/ Ethnicity	Disparities-Sensitive	Reported in California Medi-Cal Managed Care Accountability Set	Reported in Covered California Quality Transformation Initiative	Reported by IHA
Prenatal and Postpartum Care	NCQA	Birthing Persons and Children; Prevention/ Early Detection	Process	Yes	Yes	Yes	No	Yes
Childhood Immunization Status (CIS 10)	NCQA	Birthing Persons and Children; Prevention/ Early Detection	Process	No	Yes	Yes	Yes	Yes
Well-Child Visits in the First 30 Months of Life	NCQA	Birthing Persons and Children; Prevention/ Early Detection	Process	Yes	Yes	Yes	No	No

Measure Name	Steward	Focus Area	Type	NCQA Required for Stratification by Race/ Ethnicity	Disparities-Sensitive	Reported in California Medi-Cal Managed Care Accountability Set	Reported in Covered California Quality Transformation Initiative	Reported by IHA
Child and Adolescent Well-Care Visits	NCQA	Birthing Persons and Children; Prevention/ Early Detection	Process	Yes	Yes	Yes	No	Yes
Plan All-Cause Readmissions	NCQA	Appropriateness of Care	Process	No	Yes	Yes	No	Yes
Immunizations for Adolescents (IMA Combo 2)	NCQA	Birthing Persons and Children; Prevention/ Early Detection; Population Health	Process	Yes	No	No	No	Yes
CAHPS Health Plan Survey, Version 5.0 (Medicaid and Commercial): Getting Needed Care	Agency for Healthcare Research and Quality	Patient Experience ; Specialty Care; Access	Outcome	No	Yes	No	No	No

Appendix E: Summary of Plan Performance

The purpose of this table is to draw attention to the number of health plans that would be required to improve on recommended measures based on a benchmark floor and bringing all health plans to a minimum standard level of care, as recommended by the Committee. In this summary, both Commercial and Medicaid health plans are compared to Medicaid national performance percentiles. For example, if the national Medicaid 25th percentile was utilized for Controlling High Blood Pressure, four Commercial health plans and one Medi-Cal plan may be subject to corrective action or enforcement for not meeting the established health equity and quality benchmark. If the national Medicaid 50th percentile was utilized for the same measure, eight Commercial health plans and ten Medi-Cal plans may be subject to corrective action or enforcement for not meeting the established health equity and quality benchmark.

Measure Name	Commercial Health Plans*			Medicaid Health Plans*		
	# of Plans Meeting 25th Percentile Benchmark	# of Plans Meeting 33.33rd Percentile Benchmark	# of Plans Meeting 50th Percentile Benchmark	# of Plans Meeting 25th Percentile Benchmark	# of Plans Meeting 33.33rd Percentile Benchmark	# of Plans Meeting 50th Percentile Benchmark
Colorectal Cancer Screening	N/A	N/A	N/A	N/A	N/A	N/A
Breast Cancer Screening	16/16	16/16	16/16	22/23	20/23	15/23
Hemoglobin A1c Control for Patients with Diabetes – HbA1c Control (<8.0%)	16/16	16/16	15/16	15/15	15/15	12/15
Hemoglobin A1c Control for Patients with Diabetes – HbA1c Poor Control (>9.0%)	16/16	15/16	14/16	17/17	17/17	15/17

Measure Name	Commercial Health Plans*			Medicaid Health Plans*		
	# of Plans Meeting 25th Percentile Benchmark	# of Plans Meeting 33.33rd Percentile Benchmark	# of Plans Meeting 50th Percentile Benchmark	# of Plans Meeting 25th Percentile Benchmark	# of Plans Meeting 33.33rd Percentile Benchmark	# of Plans Meeting 50th Percentile Benchmark
Hemoglobin A1c Control for Patients with Diabetes – HbA1c Poor Control (>9.0%)	16/16	15/16	14/16	17/17	17/17	15/17
Controlling High Blood Pressure	12/16	11/16	8/16	23/24	20/24	14/24
Asthma Medication Ratio	16/16	16/16	16/16	16/23	15/23	10/23
Depression Screening and Follow-Up for Adolescents and Adults	N/A	N/A	N/A	N/A	N/A	N/A
Prenatal and Postpartum Care (PPC) –Timeliness of Prenatal Care	12/16	10/16	9/16	23/23	23/23	20/23
Prenatal and Postpartum Care (PPC) – Postpartum Care	14/16	13/16	12/16	23/23	23/23	19/23
Childhood Immunization Status (CIS 10)	16/16	16/16	16/16	20/23	20/23	15/23

Measure Name	Commercial Health Plans*			Medicaid Health Plans*		
	# of Plans Meeting 25th Percentile Benchmark	# of Plans Meeting 33.33rd Percentile Benchmark	# of Plans Meeting 50th Percentile Benchmark	# of Plans Meeting 25th Percentile Benchmark	# of Plans Meeting 33.33rd Percentile Benchmark	# of Plans Meeting 50th Percentile Benchmark
Well-Child Visits in the First 30 Months of Life (W30) – First 15 months	16/16	16/16	13/16	2/17	0/17	0/17
Well-Child Visits in the First 30 Months of Life (W30) – 15months to 30 months	15/16	15/16	15/16	8/17	6/17	4/17
Child and Adolescent Well-Care Visits	14/16	14/16	7/16	8/17	4/17	3/17
Plan All-Cause Readmissions (PCR)	16/16	16/16	16/16	17/17	17/17	15/17
Immunizations for Adolescents (Combo 2)	12/16	9/16	6/16	20/23	20/23	17/23
Consumer Assessment of Healthcare Providers and Systems (CAHPS) Health Plan Survey, Version 5.0 (Medicaid and Commercial)	13/14	11/14	8/14	5/14	4/14	1/14

**Denominator varies depending on number of health plans publicly reporting data or reported no data is available.*