STATE OF CALIFORNIA

DEPARTMENT OF MANAGED HEALTH CARE

HEALTH EQUITY AND QUALITY

COMMITTEE MEETING

HYBRID IN-PERSON/ONLINE/TELECONFERENCE MEETING

DEPARTMENT OF MANAGED HEALTH CARE

980 9th STREET, 2nd FLOOR

SACRAMENTO, CALIFORNIA

WEDNESDAY, JUNE 8, 2022

12:00 P.M.

Reported by: John Cota

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APPEARANCES

Voting Committee Members

Bill Barcellona

Dannie Ceseña

Alex Chen

Cheryl Damberg

Diana Douglas

Tiffany Huyenh-Cho

Edward Juhn

Jeffrey Reynoso

Richard Riggs

Bihu Sandhir

Kiran Savage-Sangwan

Rhonda Smith

Kristine Toppe

Doreena Wong

Silvia Yee

Ex Officio Committee Members

Palav Babaria

Alice Huan-mei Chen

Stesha Hodges

Julia Logan

Robyn Strong

APPEARANCES

DMHC Attendees

Mary Watanabe, Director

Nathan Nau, Deputy Director, Office of Plan Monitoring

Chris Jaeger, Chief Medical Officer

Sara Durston, Senior Attorney

Shaini Rodrigo, Staff Services Analyst

Sellers Dorsey Attendees

Sarah Brooks, Project Director - Facilitator

Alex Kanemaru, Project Manager

Andy Baskin, Quality SME, MD

Ignatius Bau, Health Equity SME

Mari Cantwell, California Health Care SME

Meredith Wurden, Health Plan SME

Janel Myers, Quality SME

Others Presenting/Commenting

John Ohanian, Chief Data Officer
Dr. Rim Cothren, Independent HIE Consultant to CDII
California Health & Human Services Agency,
Center for Data Insights and Innovation Office (CDII)

Reverend Mac Shorty
Community Repower Movement

Kristen Golden Testa
Children's Partnership

David Lown

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PROCEEDINGS

12:01 p.m.

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

AB 133, the budget bill from last year, charges this committee with making recommendations to the DMHC specifically on health equity and quality measures and benchmarks that should be utilized for oversight of managed care plans overseen by the DMHC.

As discussed in previous meetings, these recommendations will be made and put forth to the DMHC in the form of a report developed by Sellers Dorsey, representative of the Committee's positioning.

During last month's meeting we continued our discussion with our data quality subject matter experts from NCQA, IHA and RAND and from our quality and health equity subject matter experts on guiding principles for measure selection and we also continued the candidate measure selection process by focus area.

Last month's meeting was very fruitful. Wonderful. Hello. I'm sorry. There was active discussion by Committee Members and just really wanted to, again, thank you all for your participation and ongoing dialogue and looking forward to the discussion today and that continued engagement so thank you all.

Just as a reminder as we walk through each focus area today: We do not have to elevate measures for further consideration in each focus area; so

just wanted to mention that. I know we had a discussion about that last time. We will certainly be going through all the measures but it is okay for us not to select a measure for a focus area because it may be represented in another focus area, for example.

And with that, though, we do have a very packed agenda, as we always have, and we will get started quickly here. I am going to go ahead and pass it over to Janel Myers, my colleague, who will start with housekeeping

MS. MYERS: Thanks, Sarah. This meeting is being conducted in a hybrid format with opportunity for public participation in-person or virtually through video conference or teleconference.

Please note the following items for those joining in-person today: There is a sanitation station located in the back of the room where you will find masks and hand sanitizer. Masks are strongly encouraged. The women's restroom is located at the end of the corridor to the left. The men's bathroom is located just beyond the women's restroom on the other side of the catwalk. The entryway is near Suite 200. Both the men and women's restrooms can be accessed using code 5314. This code is also posted on the conference room doors.

Please remember to silence your cell phones. For our Committee Members there in-person please do not join the Zoom meeting with your computer audio. To ensure that you are heard online and in the room please use the microphone in front of you and push the button on your microphone to turn it on or off. The green light will indicate that it is on, red will indicate that it is off. Please remember to turn off your microphone when you are finished. Please speak directly into the microphone and move it closer to you if necessary

to ensure that everyone can hear you.

Questions and comments will be taken after each agenda item, first from the Committee Members and then from the public. For those who wish to make a comment please remember to state your name and the organization you are representing. If any Committee Member has a question please remember to use the Raised Hand feature. All questions and comments from the Committee Members will be taken in the order in which raised hands appear.

Public comment will be taken from individuals attending in-person first. For those making public comment at the podium there in front of the room please be sure to leave your business card or write down your name and title and leave it on the podium so that our transcriber can accurately capture your information. For those making public comment virtually please use the Raise Hand feature.

For those joining online or via telephone please note the following: For our Committee Members attending online please remember to unmute yourselves when making a comment and mute yourself when not speaking. Please state your name and organization before speaking.

For Committee Members and the public attending online, as a reminder, you can join the Zoom meeting on your phone should you experience a connection issue.

For the attendees on the phone, if you would like to ask a question or make a comment please dial *9 and state your name and the organization you are representing for the record. For attendees participating online with microphone capabilities, you may use the Raise Hand feature and you will be unmuted to ask your question or leave the comment. To raise your hand click on

the icon labeled Participants on the bottom of your screen, then click the button labeled Raise Hand. Once you have asked your question or provided a comment, please click Lower Hand.

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

As a reminder, the Health Equity and Quality Committee is subject to the Bagley-Keene Open Meeting Act. Operating in compliance with the Bagley-Keene Act can sometimes feel inefficient and frustrating, but it is essential to preserving the public's right to governmental transparency and accountability. Among other things, the Bagley-Keene Act requires the Committee meetings to be open to the public. As such, it is important that Committee Members refrain from emailing, texting or otherwise communicating with each other off the record during Committee meetings, because such communication would not be open to the public and would violate the Act.

Likewise, the Bagley-Keene Act prohibits what are sometimes referred to as serial meetings. A serial meeting would occur if the majority of the Committee Members emailed, texted or spoke with each other outside of the public Health Equity and Quality Committee meeting about matters within the Committee's purview. Such communications would be impermissible even if done asynchronously. For example, if member one emails member two who emails member three. Accordingly, we ask that all members refrain from emailing or communicating with each other about the committee matters outside of the confines of a public committee meeting.

MS. BROOKS: Sorry, apologies. Thank you, Janel. So just a

reminder, as Janel stated, that this meeting is governed by Bagley-Keene. And then just a friendly reminder not to use the Chat. I know it is much easier to share information through there but that is something we need to be careful of so just wanted to flag that. All right, so next slide, please.

All right, so Slide 9 walks us through today's agenda, which includes a presentation from John Ohanian to discuss the data exchange framework, completing the discussion on measures and disparities by focus area, narrowing measures to the final set, and a preliminary discussion on benchmarking. During Agenda Item 6, narrowing measures to the final set, is when we will begin a vote, so just wanted to kind of flag that is where we will vote today.

So at this time I would like to do a quick roll call of DMHC representatives, Committee Members and introduce the Sellers Dorsey team. Mary Watanabe?

MS. WATANABE: I'm here.

MS. BROOKS: All right. Nathan Nau?

MR. NAU: I'm here.

MS. BROOKS: Chris Jaeger?

MR. JAEGER: Present.

MS. BROOKS: Sara Durston?

Anna Lee Amarnath is not here today.

Bill Barcellona?

MEMBER BARCELLONA: Here.

MS. BROOKS: Dannie Ceseña? Dannie will be a little bit late.

Alex Chen?

MEMBER ALEX CHEN: Here.

MS. BROOKS: Cheryl Damberg?

MEMBER DAMBERG: (Waved.)

MS. BROOKS: Diana Douglas?

MEMBER DOUGLAS: I'm here.

MS. BROOKS: Lishaun Francis? I believe she is not able to join us today. Next slide, please.

Tiffany Huyenh-Cho?

MEMBER HUYENH-CHO: Present.

MS. BROOKS: Edward Juhn?

MEMBER JUHN: Here.

MS. BROOKS: Jeff Reynoso?

MEMBER REYNOSO: Here.

MS. BROOKS: Rick Riggs?

MEMBER RIGGS: Present.

MS. BROOKS: Bihu Sandhir?

MEMBER SANDHIR: Present.

MS. BROOKS: Kiran Savage-Sangwan?

MEMBER SAVAGE-SANGWAN: Present.

MS. BROOKS: Rhonda Smith?

MEMBER SMITH: Here.

MS. BROOKS: Kristine Toppe?

MEMBER TOPPE: Here.

MS. BROOKS: Doreena Marina Wong?

MEMBER WONG: Here.

MS. BROOKS: Silvia Yee? Next slide, please.

Palav Babaria? She will be a little bit late.

Alice Chen?

MEMBER BABARIA: Sorry. Palav Babaria is present.

MS. BROOKS: Thank you, Palav.

Alice Chen?

MEMBER ALICE CHEN: Present?

MS. BROOKS: Stesha Hodges?

MEMBER HODGES: Here.

MS. BROOKS: Julia Logan, I believe Lisa Albers, you are on at this time, correct?

MS. ALBERS: Yes, hi, I am here and Julia will be here in a bit. Thanks.

MS. BROOKS: Great, thanks, Lisa.

Robyn Strong?

MEMBER STRONG: I am here.

MS. BROOKS: Great. Next slide, please.

This slide just summarizes the Sellers Dorsey staff. Next slide.

So this slide really lists the meeting materials that you all received prior to this meeting. They are also posted on the DMHC website for reference for those of you who are online who would like to utilize or see that information. Committee Members should have received quite a bit of information as you can see here on the handout, or the slide, we have the agenda, presentation, the May meeting summary and transcript, a references and resources handout and then a number of focus area measures workbooks that were distributed as well.

Next slide.

So at this time committee meetings had been scheduled through August. Those are the meetings that we have. As you know, the report is due to DMHC September 30 of this year so we are on track to do that but have quite a bit of work to do in between here and now and then. This slide, though, does identify the steps which will be taken at each meeting to accomplish our process. So you can see the measure selection process, benchmarking and the review of the report. We will review this process in more detail later today.

We will now take quick questions and comments from Committee Members. As a reminder, please state your name and organization before asking a question or comment. And if you are in-person, please remember to turn your microphone on when you are speaking as well. Shaini, do we have any hands from Committee Members at this time? Great, Kristine.

MEMBER TOPPE: Yeah. Is the August meeting the last time the group will convene?

MS. BROOKS: So, yes, with respect to the work that we are doing right now for this report, yes, that is the last time this group will convene.

MEMBER TOPPE: Thank you.

MS. BROOKS: Any other questions or hands?

Do we have any non-Committee Member hands up or members from the public online that have raised their hands?

Any public comment in the room? All right, so next slide, please.

So the May 18 meeting summary is included in your meeting packets for reference. We just wanted to check to see if there are any changes that should be made to that meeting summary and would just ask that you let us

know at this time if there should be. I am not seeing any hands raised from the Committee, in the room or online. And so with that we will finalize the meeting summary notes and those will be posted online for reference for you all and for the public as well. All right.

So we are lucky today to have John Ohanian today with us. He is the Chief Data Officer with the California Health and Human Services Agency and Director of the Center for Data Insights and Innovation Office. So I am going to turn it over to John at this time, who is going to walk through a presentation for you all.

MR. OHANIAN: Excellent. And just confirming you have my slides. Excellent. Good morning, everyone. Nice to see so many familiar faces, familiar names. I am excited to share with you our progress towards creating a data exchange framework for the state; and very much looking forward to a dialogue following this presentation in terms of now everyone feeling, okay, it is here, it is real, now how do we leverage this to serve more people and really achieve the goals that I know the DMHC and other departments are working towards to serve a whole person. So with that, I am going to take you through a quick summary of how we got here and where we are going and whoever is in charge of my slides I appreciate you taking us to the next.

So we are just going to cover real quick a overview of where we have been and where we are going and some considerations that we are already hearing.

Before I go any further I also want to call out that I have a colleague of mine here, Dr. Rim Cothren, who is our subject matter expert, brings decades of experience to this area and also the passion of let's get people

their health and social service information so that they can better live their life. So it is an honor to have him here as well to dig in some of technical details we will have later on, hopefully.

DR. COTHREN: Thank you, John.

MR. OHANIAN: Yes, welcome. And with that, the next slide. Excellent. So when we think about -- oh, one back, sorry.

When we think about the Health Information Exchange and exchanging people's information, having that sharing happen, we were -- a lot of the leadership looked at the existing Health Information Exchange network that was there that exists currently in California. We know that we are trying to build upon great success and great work that is happening out there but really set a strong vision of, we will be sharing information.

And the Governor signing that legislation, AB 133, Really put California on the track to advance its health and social services information exchange greatly by the passage of it. So what we continue to say and you will hear it later on is, we are not building technology but we are guiding the rules of the road of the exchange of information to be ultimately able to improve lives. Next slide, please.

So we went through this. You know, having a human-centered design approach to anything is important. When we look at the clients we are looking to serve we have about 25 different vignettes that we walk through. This one is near and dear to me because I spent about 10 to 15 years in San Diego working with the churn of individuals experiencing homelessness through our ER system, through our social service sector as well as our health system and saw a number of people that were facing challenges. If you go to the next slide, kind of

the experience.

We know that California is a big state. This is really building up on best practices that have happened. But in some areas of the state we do have people that are missing connections and really their social services and their health services are not as best aligned to help that person along their journey, especially someone who is in crisis who might not necessarily have the mental capacity or the personal capacity to be able to take these next steps and really rely on the care community to be better informed.

If you go to the next slide, in an environment where we are sharing we are able to coordinate. And that was one of the biggest things we saw in San Diego is the second that you were able to connect to providers, whether it was health and social or to health or to social service providers, it changed the trajectory of that person's success. Next slide, please.

So now that is kind of the why we are doing and here is where we have been. Interesting to look at the timeline and not realize that, really, California is in a catch-up mode with the rest of the country in terms of being able to set leadership and a direction of all health and social service information flowing. And so back in '96, but really more in particular as in, you know, in 2022, where we are headed is really where I wanted to focus here.

So we were able to, over the last eight months, convene our stakeholder group from September 2021; and in a month we will be landing a single data sharing agreement for the entire state of California as well as our data exchange framework principles and guiding it, as well as policies and procedures to effectively share and protect information. And a month later, August 1, releasing our approach to a digital identity strategy for the state.

Following that, we are then on a timeline of in six months having major providers sign on to the data sharing agreement by this January coming up and then a year later implementing their data sharing. And then we see that smaller providers, and we will get into this as well, have a few more years to come on board. Through that process we are also advising and working with social service organizations as well to be ready for that next step. Next slide, please

So these are the components of what I have just kind of shared. And maybe, Rim, you could drop in the Chat our data exchange framework site, which will have all of this information for everyone here as well, if possible, and we can go to the next slide.

These are those deliverables by July 1. So again, this is not the creation of technology, rather rules of the road. Go ahead to the next slide.

And this has been an extraordinary effort by stakeholders. You can see the number of more than 600 members of the public participating, key leadership. There is a number of our members I see on our, in the meeting today as well, providing perspectives, you know, I think a lot of direction of what to look for. A lot of the decisions I think we led to through this collaborative process. And really looking at continuing to lean into the vision and the why of what we are doing it to get individuals the appropriate information they need at their time of care. Next slide.

So if you look at the principles and the guiding principles, it was evident from the beginning and we were lucky to have TEFCA just released in the last month or so as well. If you hit, if you hit, advance one more slide or one more item you will see -- oh, go back, sorry. I guess the slides have been

translated well but there is another logo there about the consumer protection feeding in to the framework and these are kind of the guiding principles that are there. But that is the logo missing that you see. Okay, next slide.

And so I would say that where we stand right now is that we have a couple of key questions that we are challenged with.

Number one is the fact that a number of sophisticated providers, large providers are exchanging information and this is not new to them. What we are left with is a lot of small providers, rural providers, social service providers, health and social service providers that have not yet made that leap, either to an EHR or to having their EHR connected to an exchange.

And so the continuing conversation has been with this requirement, what can the state do to help support these, these efforts? And right now the governor put in his budget but, you know, it won't be final until the end of June, but there is about a quarter of a billion dollars, between $50 million in technical assistance grants as well as 200 million in transformation grants with respect to CalAIM and getting providers ready for that next leap. So it is a great opportunity for us to get out there and bring providers up to that next level of sophistication. Next slide, please. Thank you.

So with respect to digital identity, we thought that was really kind of a component that this group probably is looking at as well, is how to have a statewide digital identity strategy? And what does that make up of and what would our role be? It could be as simple as the market kind of bearing and creating where it goes or the state standing up a digital identity registry, and anywhere in between. So we are looking at what makes the most sense but we are looking at what criteria makes up a digital identity.

And if you go to the next slide, we have a little bit of a slide that we will share with you because it is not in this deck but of what we are not going to be sharing. But you can see here, it is not a collection of sensitive information. This is information that is given out in most cases to regularly identify individuals in terms of a name, an address, phone number, things of that nature. We are staying away from certain areas that people are uncomfortable about. We can get into that a little bit later as well. Next slide.

So the one last piece is you know, Undersecretary Mijic and the Secretary talked about these puzzle pieces that we are putting together at an agency level. So whether it is DMHC or DHCS, DSS, but they all roll into some of these longitudinal and probably more expansive person-centered approaches. Whether it is Cradle to Career or the Master Plan on Aging, how do we take this service delivery and really wrap it around an individual.

And we know that without such things as a digital identity strategy that spans across departments, or without a requirement to share, which the market has, you know, kind of grown a certain way but in others hasn't because of not having that requirement, but also have that agreement in place. These efforts are really going to hopefully leverage what the data exchange framework provides in terms of a new capacity and infrastructure that doesn't currently exist.

And so we are working with each of these initiatives early on, like all of you, to say, what did we not think about? What are the concerns? Because operationalizing this, now is that next wave, and that takes all of us. So I just appreciate the time this morning to share. And I think this is my last slide but we can go to the next one and see if there.

Yeah, I just put this up there because I continue. In my own

journey when I was taking care of my parents and grandparents I experienced it, but also in the social service sector that, you know, we are 22 years into the 21st century, we should be able to deliver something like this to Californians, is really my motivation. And in such, you know, give people the power to take care of themselves in ways that they currently might not be able to. So with that, I will just open it up for questions.

MS. BROOKS: Great, thanks so much, John. It looks like we have got a hand up already. Rick, did you want to go ahead?

MEMBER RIGGS: Hi, good morning, John, Rick Riggs from Cedar-Sinai, thank you for your presentation. Just a couple of questions that -- I know this is not a data infrastructure exchange, you know, information session; however, I just have a couple of questions.

One, this will be or won't be mandatory or what is the, is there a bend to that?

And two, are there components of the data exchange elements that are aligned with perhaps some of the fields or pieces that we may be thinking about in this particular workgroup?

MR. OHANIAN: Yeah, great question. I think the second part is why we are here so I would say that that's, that's, you know. I would be curious, and I think that is what Rim and I are curious about, are what are the key issues that are and flags that are raising in this group so that either we can respond to what we have thought about and where we are at on that decision or, hey, you know what, that is a good point and we need to jump into that. What I have been sharing with everyone is it has been a huge effort just to get this agreement and the policies and the framework established for a July 1st date and so in some

cases those thoughts have not been considered or they have been on a parking lot to say we need to address that.

To your first point, it is a requirement. So AB 133 requires that health and social service providers share information. The PMPs will get into more of the nuances as well as the sharing agreement in terms of well, what type of information and who is required to see it, how does it, you know, what are the nuances of what that means? Because sharing information can mean a lot of different things from queries to true exchange.

MEMBER RIGGS: Great, thank you.

MR. OHANIAN: I encourage everyone, we have our next data, actually final meeting in June and we can send you guys the invites that you are welcome to. It is June 3rd, or sorry, June 23rd, Thursday, June 23rd.

MS. BROOKS: Great, thanks, John. We will get that information out to the workgroup members.

MR. OHANIAN: Thank you.

MS. BROOKS: It looks like lots of hands are going up. Kiran.

MEMBER SAVAGE-SANGWAN: Thanks, Sarah. Thanks for being here, John, nice to see you again. I am wondering just for the purposes of this group, you know, I can say a couple of the issues that have come up that I think are related to the data exchange framework.

One is, you know, these are supposed to be quality and equity measures so there has been a big question around what can we do on the racial equity side with the data that we have. And so I think it will be helpful if you could talk a little bit about how the data exchange framework is going to strengthen our statewide collection of demographic and social determinants of

health data and how that might be, how that might enable us to do more in terms of accountability for equity.

And then the second piece that I think is related to that as well is, you know, this group is focused on quality and equity measures as they pertain to health plans. And one of the other issues that has come up is, well, what information outside of demographics do health plans have or not have. For example, if we want to look at quality around dental care and that is not part of the health plan. So if you could also talk a little bit about how the data exchange framework might help us pull all that information together so that we really can move forward. I think some of the things that this group thinks are important but feel like there might be logistical barriers to.

MR. OHANIAN: That is great. I am going to let Rim jump in here.

DR. COTHREN: And those are a bunch of really good questions. I will start off by reminding people that this is still something that is in flight. We have proposed some guidelines as part of our public comment documents that will be published in July and so I can speak to what we is in our current vision.

The US Core Data for Interoperability or USCDI calls out a minimum set of clinical data to be exchanged among organizations and what we are proposing is to align with Version 2 of that specification. So from a standpoint of demographics that includes not only race and ethnicity. That initially might be large aggregated groups but supports more detailed race and ethnicity code sets and preferred language. But Version 2 also includes social determinants of health information, sexual orientation and gender identity information as well.

We are also watching Version 3 of that data, which includes

disability information, tribal affiliation and some other useful information. Version 3 hasn't been finalized yet but we will continue to watch that because I think that that will also add in here.

As part of the documents that are out for public comment we have identified the data that we are suggesting that both health care providers and plans exchange. And so that aligns for providers with information-blocking requirements except that we are stepping up to Version 2 of USCDI, so they would be required to exchange all electronic health information as defined by the federal government. And plans required to exchange the same information that CMS has called out for plans that are regulated by CMS to exchange with their beneficiaries, so that includes claims, encounters and USCDI-specified clinical data. So it is a large set of data.

As you know, the data details and standards associated with social determinants of health are still emerging and so that is less well-defined in the documents right now but that, again, is something we are continuing to monitor.

MR. OHANIAN: Thank you.

MEMBER SAVAGE-SANGWAN: Thank you.

MS. BROOKS: Kristine.

MEMBER TOPPE: Thank you, Kristine Toppe from NCQA. John, nice to hear your presentation, this is great; and Rim, thanks for that explanation, it was very helpful.

I definitely second Kiran's questions and appreciate her teeing that up because I think we are very interested in the intersection of how all of these, the data exchange framework will support the quality measurement that this group is considering.

And I did, I had a question as it related to CalAIM and the population health dashboard, I think is the reference for it. And if there is a kind of plan, if the, if those things are interconnected as part of this? Because I know that that effort is intended to kind of streamline the way that that work is being done by plans going forward.

MR. OHANIAN: Yeah, and I know for those on the line as well as others. And I would say it is similar to these conversations that we are having. We are continuing to unpack that.

MS. BROOKS: Bihu, it looks like you have got your hand raised.

MEMBER TOPPE: I think she is speaking but we can't hear her.

MS. BROOKS: Thank you for telling us, Kristine. It looks like you're on mute. Can you hear her now?

MR. OHANIAN: I can't.

MEMBER TOPPE: Oh, you can?

MR. OHANIAN: Okay, not.

MS. BROOKS: Maybe we can switch the mic. There we go, perfect.

MEMBER SANDHIR: Sorry. That's better.

MEMBER TOPPE: Yes, thank you.

MEMBER SANDHIR: This is Bihu Sandhir AltaMed and I was just stating that I am actually relieved to hear about this initiative. I think it is very essential with what we are doing. Not only does it -- it is more a comment that not only does it help, obviously, our social determinants of health and health equity measures, but as we are considering the measures moving forward, looking at all the substantive measures that we are looking at, this is absolutely

essential for our utilization measures because if we don't get real time data on when the patient has been in the emergency room or an inpatient, which is really a challenge right now, especially with our substance abuse, you know, measures and our mental health measures, we really cannot. It is not actionable. We are not able to really intervene in the time that we are that we need to intervene.

And I think that is something we just need to -- So there is really -- I think this is an essential part of what we need to do moving forward for us to be successful. Or even as we discuss what measures to choose we have to really take that into account. Thank you.

MR. OHANIAN: Thank you for that. Totally agree.

MS. BROOKS: Doreena.

MEMBER WONG: Yes, thank you, Doreena Wong from Asian Resources, Inc. Yes, I agree, you know, with all the other comments about the really key connection between this effort and our effort. That having this data is kind of, as Bihu said, is kind of essential for us, not only for utilization, but just in terms of addressing and looking at outcomes and addressing health disparities.

But I had a specific question about the, the disaggregated data, especially the disaggregated race and ethnicity data. And I understand that perhaps now we are looking at aggregated, maybe only the aggregated categories, but I am wondering what the timeline is? Because I think the sooner we can get to trying to move towards disaggregated data then the more I think we can really get to quality. And so I am just wondering, you know. I know that, I don't know, was it Raymond you were saying, you were going to different versions but I didn't get a sense of the timing of this.

MR. OHANIAN: Yeah. So I can, I can start and if Rim has, I mean,

these are. It was funny, we did a little prep yesterday and it is difficult not to be able to answer some of these questions because they are very practical ones. But in terms of the timing, a lot of it is how we fare, you know, almost a year from now, a year and a half from now when folks are actually exchanging. So there is going to be a timing issue from when there is that exchange to when we can aggregate and go forward. So the best I can tell you is that you see kind of a timeline of when there is going to be a mandated exchange and then that is probably when we can expect it. But if there are early wins or ideas that your folks have, I know Nathan has been participating, if there's other ways that we can leverage it in that meantime or be as successful as possible that is what we are looking to learn here. Rim?

DR. COTHREN: Yeah, I will just add a little bit more to that. You're right, the federal requirements are for the OMB or CDC aggregated race and ethnicity categories. They allow, the standards allow for disaggregated information. But most of the systems that our stakeholders are using today don't support disaggregated collection of that information or the users aren't collecting disaggregated information. So that is something that we are going to have to work on through the culture as well as through the technical standards and I think it will just continue to be an ongoing effort that we're going to need to put in place.

MEMBER WONG: Can I just add just one thing? If you are looking to requirements, there is AB 1726 that requires CDPH and a couple of other agencies to collect disaggregated race and ethnicity data. So please take that into mind because that is a mandate, you know, and it is not, you know, voluntary, thank you.

MS. BROOKS: Thank you, Doreena.

Doing a little time check. It looks like we have a couple more questions that we can go through. So I see Bill, your hand is up, I am going to have you be the last one, not quite yet. Silvia is up next. Silvia.

MEMBER YEE: Thank you for the presentation, it has been really useful. Everyone has already noted the connections.

I wanted to ask just very specifically, as I was looking through the slides, about the incorporation of home and community-based services and supports within the information that is been collected. I can't quite tell from the slides how or whether they are incorporated. And the receipt of home and community-based services and supports and particularly personal care assistance, for example, is so critical to those who use it to being able to stay healthy and well and really important information for providers to have. I think health care plans are only, are now assuming more and greater connection with home and community-based services and so I am wondering how that incorporation is happening on the data end?

MR. OHANIAN: Yeah, well, I could start and then if Rim wants to pick up. I think the big part of our movement is through the social determinants of health and ensuring that this data is. And like you said, there are, there are some that are doing it, there is more and more happening. But we want to see it happening across the board and at scale. So in some communities this work is happening. We have community-based organizations that are either tying in to some kind of intermediary that gather data exchange. Some social service organizations are actually creating some kind of like community exchange that then will interact with the Health Information Exchange in their community.

But like I said, it is all over the board so I think a big part of those technical assistance grants, I think a big part of where we all as a state need to, you know, we are going to be getting our own house in order in terms of us getting our data collection in a way that makes better use of the data and the insights that come along with it. But also, there is learning that happens outside at these provider levels.

So OHI (phonetic), which has been incorporated into CDII as a part of our start-up, has been releasing state health information guidance documents, in terms of how to share, the appropriate way to share different types of information. We are now exploring from a social service side furthering that as well so it will be a big part of education and awareness that will happen as a part of this process.

MS. BROOKS: Thank you, Silvia and John. Ed, it looks like you have got your hand up next.

MEMBER JUHN: Ed Juhn, Inland Empire Health Plan. Maybe just to add to that. You know, for the rules of the road, could you maybe talk a little bit about the role of health information exchanges and maybe engagement with county and public health departments and how they might be able to connect into this framework to provide information to reduce some of the disparity work that we are thinking through today?

MR. OHANIAN: Yeah. Rim, do you want to jump in on that one?

DR. COTHREN: Sure. So there is a robust collection of health information exchanges in California now. In fact, one of the earliest health information exchanges in the country started exchange in the '90s here in California. We still see health information exchanges and HIOs or health

information exchange organizations as an important component of the data exchange framework, as facilitators for exchange as aggregators of community information about patients, and so they will continue to figure into the data exchange framework.

MS. BROOKS: Thank you. All right, Bill.

DR. COTHREN: We can't hear you, Bill.

MS. BROOKS: Just a moment, we are just doing a sound check.

MR. OHANIAN: I am not able to hear him? Are you?

MS. BROOKS: Okay, so he can't hear but I think, Bill, what you were saying is that there was a request at some point, I don't have information on this so I am just repeating what you are saying, of $45 million for HIO; is that right? And that you have some concerns about the fact that perhaps that wasn't funded in the budget and questions about how entities are to proceed given the fact that there are just grants that are being given out at this point that may be lower in nature monetarily. Is that a fair summary of what you just said? Okay, that is why he said. I am not sure if you have a response to that, John or Rim?

MR. OHANIAN: I don't, I don't know about that particular item. I just, I got, I am leaning on what the governor put in the budget in terms of -- or recommended in the budget, the 250 million for transformation and technical assistance. So unless, Rim, you know about, sorry, can't answer that one then.

MS. BROOKS: Check on the mic down there as well. All right, so that is it for comment in the room.

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

Do we have any public comment in the room? If you would like to come up to the mic. And then also just a reminder to make sure it is green.

(Public comment in the meeting room was not broadcast through the microphone.)

MS. BROOKS: Thank you for your comments, sir. We will ensure that John and Rim, it sounds like there is a little bit of an issue with that mic, we'll check it. But John and Rim, I think there were just some concerns expressed around privacy data being shared and ensuring that it is protected for individuals, in particular low-income individuals.

So I think unless you have -- did you have a response, a comment on that, John? My apologies.

MR. OHANIAN: No. I would say absolutely. I think HIPAA is obviously of paramount concern and privacy. You know, we always joke the P in HIPAA is for portability so this is really the guiding principle of getting this work done and getting data shared. But of course absolutely the utmost forefront is keeping people's information private and confidential. You only have one time to do something really well. And I will say that we are, but we can answer any other questions that people have about how, how we plan and what we have included as parameters and rules, we can take that offline as well.

MS. BROOKS: All right. Any other public comment in the room?

Well, John and Rim, we'd like to thank you so much for your time, we truly appreciate it. Lots of great questions from the Committee Members and wish you the best of the rest of your day today, so thank you so much.

MR. OHANIAN: Thank you very much, goodbye.

MS. BROOKS: We will move on to the next slide. So we will briefly revisit the guiding principles for measure selection and then continue the discussion around measures by disparities and focus area now. So just kind of, I

will go through this quickly as this is information that you all have heard at several meetings. Next slide.

All right. So as mentioned in earlier Committee meetings, and today, the goal of this Committee is to make recommendations to the DMHC for standard health equity and quality measures, including annual benchmarks used to assess equity and quality in California. Next slide, please.

All right. So at a high level this is the proposed process for measure selection. During this meeting we will continue to review and prioritize measures by focus area, similar to what we have done in prior meetings.

Today we will also review the prioritized measures based on discussion. During this process we may go from reviewing 20 to 30-plus candidate measures to about 10 to 12 measures or less. As we prepare to vote for the final measure set we do encourage you to consider your top 12 to 14 measures that will create a meaningful set with consideration of the knowledge and expertise that you bring to this Committee.

In July, we will review, identify and finalize benchmarks. Again, depending on how much progress we are able to make during today's meeting will determine kind of what the discussion will be at that future meeting.

During our last meeting in August we will focus on reviewing the draft as we have discussed.

And just as a reminder, this process is highly iterative and Committee feedback and discussion will support the development of the comprehensive measures. Next slide.

So again, you've heard this information before so I will go through it pretty quickly. The principles for measure selection are based on common

themes seen at the state, national, federal and other organizational levels and in accordance with the goals of the specific initiative for this Committee. As a reminder, the criteria are not meant to be absolute or literal but to provide guidance in thinking about each measure and the balance of the entire set as a whole. These principles for measure selection should not limit you from suggesting additional or new measures throughout this process. We will go through those principles quickly. All right.

Alignment with other measurement and reporting programs including California-specific programs as well as federal initiatives.

Considerations of the extent to which there is opportunity for improvement within a measure and that an improvement would enhance health outcomes for a specific high-impact aspect of health care.

The opportunity to identify and reduce disparities in race, ethnicity or other variables should be considered. Next slide.

The matter of feasibility around the extent to which required data is available or there are capabilities to collect and stratify data without undue burden.

And then the magnitude, sorry, the magnitude that other audiences are using or could use the performance data for improvement should be considered as well.

And finally, how the quality measure fits into California's priorities. So for example, alignment with the Governor's priorities or other state departments.

Let's do a sound check on the microphones real quick if that's okay. Let's go down the line. If everyone just wants to say hello.

MEMBER DAMBERG: Hello.

MS. BROOKS: Sorry, apologies, in the room here we are going to do a sound check with the mics. So we are going to start with you, Ed, if that is okay, just to see if your mic is working.

MEMBER JUHN: Hello.

MS. BROOKS: Bill.

MS. WATANABE: Can we just confirm for those on the phone that you can hear?

(Affirmative responses.)

MS. WATANABE: All right. We are going to keep going. Go ahead.

SPEAKER: Hello. Hello.

MS. WATANABE: Will someone give a thumbs up or something if you hear that?

MS. BROOKS: We can see you, Kristine, if you could be the thumbs up person. All right.

MS. WATANABE: Thank you. And I know everybody is hearing me. Go ahead.

SPEAKER: Hello.

MS. WATANABE: We have another microphone down at the end there.

SPEAKER: Hello.

SPEAKER: All right, I think we're good, thank you.

MS. BROOKS: Okay, so we think we're better on the mics. And we're okay with the public comment mic also? Just checking. Do you have a

thumbs up, Kristine?

MEMBER TOPPE: I am not. I don't hear the -- did someone just speak at the public comment mic? I don't hear anything.

MS. BROOKS: We will use a different microphone for the public comment then. All right, thank you for allowing us to resolve those. Oh, okay, thank you for letting us know that. We do apologize for any of the microphone issues. We thank you for flagging them for us, we will make sure that we will have wonderful notes and follow-up so that people can track anything that we have talked about thus far. But this is when we are really getting into the meat of things today in terms of moving through the remaining focus areas so I think good timing for us to make sure that the mics are working. All right, so we will move forward, let's see.

So, as a reminder, our team conducted a scan of the most common focus areas by utilizing national organizations, state programs and best practices from CMS core sets, NCQA HEDIS, AHRQ Medi-Cal, Covered Cal and waiver demonstration programs. So the scan did result in the creation of these 12 different focus areas that are listed on the slide.

As we have done in previous meetings we will discuss the California-specific or national disparities throughout the discussion of focus areas and measures for the Committee's consideration. There may be focus areas where we do not select measures in this initial process. While all of these measures and focus areas are important, there may not be a measure that aligns with the Committee's priorities, guiding principles and so on; or the focus area of may be addressed through measures included under a different focus area. Next slide, please.

So as a reminder, we took 800 measures and narrowed it down by these 12 focus areas. We looked at those different things that we talked about in terms of alignment with things such as California priorities. We identified green measures which are included on one tab in these measure workbooks, those are measures that we have put up for consideration for discussion. On the other tab are all of the other measures that are associated with that specific focus area. We certainly welcome you to look at those measures and if you would like to recommend one welcome that for conversation and discussion. All right, next slide, please.

All right, so we are going to get into adult prevention measures. So these are the different focus areas that we have gone through already so I am going to do a quick review of the measures that we have selected so far and then we will get into the following focus areas for discussion.

So as a reminder, during the April meeting, the committee preliminarily agreed upon cervical, breast, colorectal cancer screening measures. We will further discuss these measures later today as we narrow down the list of candidate measures to the recommended measure set of 10 to 12. Some discussion also occurred around obesity, vaccination and child measures. Those measures will be addressed under other focus areas later in the presentation today. Next slide please.

During the April meeting there was a lot of discussion and agreement that the hemoglobin A1c control for patients with diabetes measure should be considered as a candidate measure and in the May meeting there was committee consensus around the controlling high blood pressure and asthma medication ratio measures as well. Slide please.

In the May meeting there was Committee consensus around the following measures in the mental health focus area. So we have got depression screening and follow-up for adolescents and adults; follow-up after hospitalization for mental illness; and follow-up after ED visit for mental illness. Next slide please.

In the May meeting there was committee consensus around the following measures in the substance use focus area, pharmacotherapy for opioid use disorder and unhealthy alcohol use screening and follow-up. Next slide, please.

Also in the May meeting there was Committee consensus around the following measures in the birthing persons and children or child measures focus area, so there's a number of these. Cesarean rates, prenatal and postpartum care, contraceptive care for all women, childhood immunization status Combo 10. Next slide. Weight assessment and counseling for nutrition and physical activity for children/adolescents, topical fluoride varnish for children, well-child visits in the first 30 months of life, and then child and adolescent well-care visits.

And then finally in the May, thank you. In the May meeting it was determined that while access is a critical component of receiving high quality and equitable health care, there were no green measures that would be elevated to the candidate measure set. However, measures that capture access to care are covered in other focus areas and the Committee did request that language be included in the final report highlighting the importance of access. Next slide, please.

All right. So at this point we are going to move into the focus areas

that we haven't discussed yet. I am going to turn it over to Ignatius. I am going to turn it over to Ignatius and then we will open it up for -- I am going to turn it over to Ignatius to the lead now.

MR. BAU: Great. So continuing in our process. We have just given a little bit of data around disparities for the utilization measures that we are going to be looking at. So we know from national data that emergency department utilization is higher among Black and Latinx persons.

And we also know from national data that antibiotic prescribing is often inappropriate at a higher rate for Black and Latinx persons.

So let me turn it over to Andy to talk about some of the measures.

MEMBER RIGGS: We aren't hearing anything here.

DR. BASKIN: Can you hear me?

MS. BROOKS: Can you hear him now?

MEMBER RIGGS: Yes.

DR. BASKIN: Can I be heard?

MS. BROOKS: Yes. You can hear? Okay. Go ahead, Andy.

DR. BASKIN: Okay. So in the utilization measures area, this is an area where we are basically talking about volumes and services. How often something occurs or how often something should occur or shouldn't occur. There are five measures here. Once again a reminder that these measures are used in at least one of the current programs in California and that is how they got to this list.

The first two measures are actually very similar. This is avoidance of antibiotic use, one for acute bronchitis another for diagnosis of respiratory infections. Basically children up through adults as to whether they have received

an antibiotic within several days of the diagnosis of either acute bronchitis/bronchiolitis or upper respiratory infection. The idea being that for most of these cases antibiotics are inappropriate and that is why they usually should not be prescribed in the first few days. After that, obviously, if people aren't getting better it is a different story.

The cancer screening, the cervical cancer over-screening measure is a little different than the measures we talked about before. We certainly talked about the preventive measure that is cervical cancer screening and appropriate screening. This is screening for people who don't actually meet the criteria to be screened. So it is oftentimes the younger women who are screened for cervical cancer for which it is in most cases inappropriate. So this is over-screening, doing tests when it is not within the age group that is appropriate.

The ED utilization, emergency department utilization, is simply a count of -- well, it is not simply account, it is actually a risk-adjusted count. So looking at the severity of illness of the population what would be the expected utilization of the emergency room and is it higher or lower?

And the last one, frequency of selected procedures. This is actually a long list of procedures. I think it is about 20 or so procedures that are then stratified into age groups and how often these procedures are occurring. I will note that it is used in one of the current programs but this measure is actually being retired, if my recollection is the case. But it is currently in a program and whether it will stay in that program or not I obviously don't know in the future. But it is simply, once again, the frequency that these procedures -- it is all kinds of, some surgical procedures that are actually occurring.

So with that I will open it up for discussion for any support or lack of

support for any of these measures moving forward.

MS. BROOKS: And just a reminder to put your hand up on your computer whether you are in the room or online and we will go through the Committee Members. So I see Cheryl, you have your hand up.

MEMBER DAMBERG: Yeah, I actually had a question. I don't know why I am getting feedback. Are you guys getting an echo from me?

MS. BROOKS: No, we can hear you fine.

MEMBER DAMBERG: Okay. So I actually have some questions about the access measure so maybe I should hold until we're done talking about the utilization measures. I guess, a law of utilization, it seems like what is on this list is really kind of touching on overuse of care and so maybe it is just kind of a labeling or a framing issue.

But I am kind of curious because I think we know when we measure total cost of care across different sub-populations that, say for example, minority patients tend to have lower total cost of care and some extent, you know, researchers believe that is a function of under-utilization of services. So I am just kind of curious, did the team try to come up with other utilization measures that might sort of measure kind of overall use of, you know, like specialists or primary care, you know, relative to the majority population to compare and contrast?

MS. BROOKS: So, I don't, I mean, I think the measures you are talking about are kind of coming up with some measures; is that right, not previously identified measures. Is that correct or am I misunderstanding your question?

MEMBER DAMBERG: Well, as I am kind of looking down this list it

is not that I am necessarily opposed to what is on this list. I think of a lot of this as kind of overuse of health services. But I think I am still talking about a category that represents under-use of health services. So lower utilization of, say, specialty care, say, by Black patients. I don't think anything sort of in the current mix of utilization measures gets at something like that to say, you know, what should be appropriate utilization. Now, I recognize this is kind of a murky area, because you could potentially say that, you know, why patients are overusing services. But I still think we fundamentally believe that minority populations are under-utilizing services to necessarily achieve the same outcomes.

MS. BROOKS: Is there a measure you would recommend that we consider?

MEMBER DAMBERG: Really good question. You know, I was doing some thinking about this over the past couple of days as I saw the packet. You know, I think it is really something that looks more like an aggregate measure of, you know, something like, you know, number of primary care visits per year or, you know, something similar, kind of maybe on the specialty side. But I think it would require a little more spade work to kind of figure out what that would look like and I don't know how that sort of fits within sort of the time frame of this Committee. But I would note, you know, that that to me feels like a missing area.

MS. BROOKS: That is very helpful feedback. I know we have had discussion around kind of the creation of measures but I think there could certainly be some, if the Committee were in support of it, could be something included in the report around the issue that you are raising here and

consideration, and would welcome thoughts from others on that.

MEMBER DAMBERG: Yeah. I mean, I will try to give it some more thought. And then at some point during the call I'd like to come back to the topic of access whenever you feel like it is appropriate to talk about that.

MS. BROOKS: Sure. Thank you so much.

All right, I see, Diana, you have your hand up. We cannot hear you.

MEMBER DOUGLAS: I am talking now so hopefully you can hear me.

MS. BROOKS: Okay.

MEMBER DOUGLAS: Sorry.

MS. BROOKS: Sorry.

MEMBER DOUGLAS: Adjusting here.

MS. BROOKS: Thank you.

MEMBER DOUGLAS: Thank you. For the utilization measures, I think in some of the focus areas that we have I think there is probably agreement that it would be good to have a measurement there but there might not necessarily be the measures getting at the focus of the Committee that we might like to see and for me personally this is one of those focus areas.

I think getting to what was previously said, measures of over-utilization I would really want to approach with caution, especially unless we can parse out the differences between groups who might be over-utilizing versus those who might be under-utilizing. This especially comes to me when I am, when I am looking back at our guiding principle for why we are selecting criteria, which I know we have reviewed and reviewed again quickly here today. But

looking at in particular the opportunity for improvement and potential for high population impact but then also to opportunities to identify and reduce disparities.

And including a measurement, for example, for over-screening of cervical cancer, I don't know that that is something that has an impact on the people we are hoping to or reduce disparities, especially when we so far know that there are often under utilization in those areas.

And looking at also, for example, the EDU utilization. I noticed just in reading the descriptor of that, that it is sort of comparing the observed rates of ED use compared with what would be expected given population characteristics. And others here might know a little bit more about what that measure includes but for me, I am not sure if that really gets at our purposes here.

That being said, you know, I think if this is kind of the menu of utilization measures, I don't know if there are other measures of utilization out there that could really get at our purposes, which is to make sure that different groups are able to utilize services, and do choose to and are able to utilize services in an equitable way. Thank you.

MS. BROOKS: Thanks for your comments. Alice.

MEMBER ALICE CHEN: Can you guys hear me?

MS. BROOKS: We can hear you.

MEMBER ALICE CHEN: Excellent. Sorry I don't have my camera, I'm having some bandwidth problems. I want to build on what Diana said. And I think, you know, there are cases of overuse and under-use, both for disparities and overall. I think in general I have, I find the category of utilization challenging just because ultimately more than many other measures you need to know the

specific context of a given patient to know whether something is over or under use. And I think in the spirit of parsimony I would suggest skipping this category altogether given there are so many pressing and well-accepted, in-use, validated measures in other areas.

If we were going to choose one in this category I would favor the ED utilization. Again with a lot of caveats in that there are certain communities that choose to go to the ED for a variety of reasons, one-stop shopping, lack of access to primary care. Which again could be a measure of access but is fairly indirect and would require, again, more context to really be able to parse out. I will stop there.

MS. BROOKS: Thank you, Alice. Dannie.

MEMBER CESEÑA: Hi, this is Dannie from the California LGBTQ Health and Human Services Network. I just had a couple of things I wanted to bring up in terms of the cervical cancer over-screening. There is a large percentage of bisexual and lesbian women who are denied basic access to health care, such as pap smears, which is preventative care, as are transgender folks who are trans-masculine or non-binary. So that is where we are not going to see a lot of numbers, especially even if that data is not even being like kept, you know, sexual orientation, gender identity data. Which I know I brought up many times before but it is always good to bring it up again.

And then, you know, even looking at the age group, you know. This is where we are seeing Generation Z really start to, start to impact these different age groups because, as I mentioned before, over 27% of California's Gen Z identify somewhere outside of the gender binary. So that is something to think about.

And then the other thing I wanted to bring up: For selected procedures such as mastectomy, hysterectomy prostatectomy, is there going to be a difference between when these procedures were done due to like cancer screenings or something else versus gender transition type surgeries? Especially because many hospitals now have specific departments that do these types of surgeries for trans patients for their gender transition. Cedars-Sinai is one, UCSF, UC San Diego. So if we are starting to look at like removing specific reproductive organs or other organs we need to remember that some numbers could be skewed and not be so much as preventative care but due to gender transition; and how are we going to discern that?

MS. BROOKS: Good points, Dannie. And you have got your stats down; thank you so much. Ed.

MEMBER JUHN: Hi, Ed from Inland Empire Health Plan. Just building upon what some of the other Committee Members had shared. You know, one of the measures that I would just ask us to consider with caution, for example, would be the emergency department utilization because right now this measure is a HEDIS risk-adjusted measure for the commercial and Medicare product lines. Right now for the Medicaid population this risk adjustment would be relatively new. And if the intent is to set targets and penalties for sub-populations within the Medi-Cal membership, there might be some learning that needs to take place, especially if this is one that goes for consideration at year one. So just wanted to share that.

MS. BROOKS: Thank you, Ed. Bihu.

MEMBER SANDHIR: Thank you; this is Bihu Sandhir from AltaMed. And I actually agree with Diana with her comments that, you know, this

over-utilization I think is a concern. I think I am not sure how much, how much impact that is really going to -- When we are choosing these measures I think we, I remember in initial conversations we had discussed how it should have a, we are looking at something that has a large impact; and looking at these I am not convinced that they have the impact some of the other measures that we have been discussing have.

The other part here is avoidance of antibiotic use for bronchitis and respiratory infections. Those are measures we actually use more in our urgent care settings, we are already measuring that, and that is something that where we are, you know, that has been more of a focus area for that.

Emergency room utilization, I just asked Ignatius, there is appropriate emergency room utilization as well. It is inappropriate emergency room utilization is what we really worry about more than anything else. I don't know if there is a measure that really, a measure that, and if it is not there then I don't know if this is really worth it.

I personally think with the mental health measures where we have chosen some follow-up after hospitalization or ED use, those are also utilization measures in some way for like substance abuse or for mental health.

There is one suggestion which we are being measured on by our Medicare plans and that is ED follow-up after chronic diseases when you are admitted for chronic diseases. So is there some thought of maybe looking at that and seeing if that may have an impact for us because it aligns also with what else we were already working on, so that would be a suggestion that I have.

MS. BROOKS: Thank you, Bihu. On that measure is that a Medicare-specific measure?

MEMBER SANDHIR (OFF MIC): (Inaudible.)

MS. BROOKS: It's a HEDIS measure. Okay, okay, thank you.

MEMBER SANDHIR: It is a complex, actually a very complex measure, but it is a HEDIS measure.

MS. BROOKS: Okay.

MEMBER SANDHIR: It has got a lot of competence to it.

MS. BROOKS: Great, thank you.

All right, Palav.

MEMBER BABARIA: Thank you. Palav Babaria, California Department of Health Care Services. And agree with a lot of what has been said, especially around sort of the categorization of utilization and challenges with over and under-utilization.

I think two comments. One is that in the Medi-Cal program specifically when we have looked at our data I think under-utilization and engagement with the health care delivery system is often a bigger driver of poor quality and disparities than over-utilization, at least for Medicaid beneficiaries.

The second comment is, you know, agree that many of these measures are fraught for many of the reasons stated. I think if we did consider emergency department utilization, really thinking about, are there other measures that we are looking at that it can be used in combination with? So one of the things we have been talking about in the Medi-Cal program is, you know, trending both ED utilization but also some of the primary care engagement measures like infant and child well-child visits and adult annual preventative care measures and then looking at, you know, the ratios or the comparison because that tells a much more complete story of what is happening with that population,

what their access is, and whether or not receiving they are appropriate services in the appropriate modality and location than I think one measure alone can really tell.

MS. BROOKS: Thank you, Palav. Robyn.

MEMBER STRONG: Robyn Strong with HCAI. And actually it was really timely because Palav said exactly what I was going to bring up, except for one other kind of twist to that is I thought it would be interesting to see that emergency department utilization, maybe being able to bounce that off of, like she said, the primary care engagement appointments, say, per year. And also potentially PCP assignment. Making sure that there are assignments of a PCP to the member. And how any of those play against each other.

MS. BROOKS: Great, I am hearing some consensus coming together. Silvia.

MEMBER YEE: Hi, Silvia Yee from DREDF. Yes, I thought Palav's point and the measure that Dr. Sandhir mentioned is really interesting. I look at these utilization measures and had the same thought, that the story you want is not the numbers but how the numbers play in with other factors. I had a question about utilization, again, coming from my non-medical background. Utilization is when a person goes to a provider and successfully receives the service or shows up? I am just unsure.

MS. BROOKS: Go ahead, Andy, if you want to speak to that, yes.

DR. BASKIN: I mean, in this case it depends on the measure. So the utilization for emergency room is just that you showed up and you had an emergency room visit, you know. The selected procedures the same thing, you

had the procedure, that is simply what is being counted. The antibiotic ones, of course, is if you didn't have something so that you didn't get a prescription for an antibiotic. I mean, that is basically what is being counted.

Now, the inference is that there is, you know, that there is medical reasons that you should or should not have had these things; and to the extent that you think you can come to a conclusion of which is better or worse then that is the purpose of the measure. But certainly with the antibiotic ones, getting the prescription is considered a bad thing for the majority of patients.

Going to the emergency room one could argue is, you know, depending how you are relative to others or relative to the risk adjustment of what is expected, you could say that if it is higher then, you know, more people go to the emergency room because they, for many reasons, but one reason is because they can't seek care elsewhere and that is usually read into it.

MEMBER YEE: Well the reason I ask is because, I mean, lots of stories. Colleagues who go to a provider, get partway through perhaps and then it can't be completed for one reason or another disability-related. I know my colleague who went for a colonoscopy after preparing at home, a wheelchair user, had to hire a personal assistant to help her with that, with the preparation for it, showed up and was told that because of her condition or something she had to have a specialist be there with her for being put under for the procedure and told to come back next week and she basically insisted, no, no, I am prepared now.

And so I am just kind of curious, those kinds of when you get partway in. And I think this probably happens with other, other, other populations that experience discrimination or incomplete services. How that is counted, and

whether that -- I have always kind of wondered whether that sort of counted on your record against you in a way because you don't keep on, you don't continue on under the conditions you have been offered the service. Maybe this is not utilization as a measure but it just seems very connected to the reasons for why utilization isn't successful.

MS. BROOKS: It looks like -- I think you are making some excellent points. I see you have your hand up, Ignatius, did you want to make a comment real quick?

MR. BAU: So I remember there was an avoidable ED utilization measure used in Oregon for its Medicaid program and it actually is based on a 2010 measure that Medi-Cal used here in California. So I just put those links in so that might be something that we want to come back and revisit and see what the status of those two measures might be.

MS. BROOKS: Thank you, Ignatius. All right, Doreena.

MEMBER WONG: Yes, thank you, Doreena from ARI. And thank you, Ignatius, for mentioning that because I actually want to kind of -- building on what the others have commented about these utilization measures versus if you really wanted access issue because I kind of see it as related. And also going back to Cheryl's comments about trying to talk about access issues.

Whatever we call it, utilization or access, I think, I agree that if we, you know, we overlay the use of ER with some other indicators like compare it with race and ethnicity, we would probably see different groups using it more or less. And some of the reasons I think people have already pointed out. Maybe it is because they don't use -- certain groups don't use preventive or primary care services. Especially I would just as an example, I know in our, in some

communities, if they don't, if the doctor doesn't speak their language they will just use ER for their regular care.

So if we could get to those issues and whether that is an access issue or a utilization issue, of why they may use the ER room or why they don't use primary care services. Anyway, I think that that is probably what we are trying to get at when we are talking about these measures and so to look for that. And whether we call it an access measure or a utilization measure, I would like to try to, try to hone down on that. And I would look forward to Cheryl's trying to figure out with that under-utilization would be, so thank you.

MS. BROOKS: Thank you, Doreena. Jeff.

MEMBER REYNOSO: Trying to figure this out. Jeff Reynoso with Latino Coalition for a Healthy California. I don't see any of these utilization measures have the option of stratification by race/ethnicity. Is that just a function of utilization based measures? And, you know, I think if we are going to explore a potential utilization measure I would be in support of measures that we could potentially stratify by race/ethnicity and have that reportable?

MS. BROOKS: Do you want to comment on that?

MR. BAU: So that is correct that most of the time when these measures are used they are not stratified. The one measure that I noted about avoidable ED utilization was stratified by California and by Oregon.

MS. BROOKS: Thank you. Not seeing any other hands raised I am going to ask Shaini if there are any hands from the public raised for public comment on this section?

Do we have any public comment in the room?

It looks like no so I am going to kind of summarize what I am

hearing from you all. I believe what I heard was that we will not move forward with any measures that are listed here under the utilization section.

However, there were some comments made that I think are important to note that should be considered for the report. In particular, the concept of under-utilization as compared to over-utilization and just looking at when that can happen and whether or not there are differences depending on demographics, and so on.

I also heard that we might want to look at recommending in the future some consideration of combining some visits with the ED utilization visit potentially and that there is an Oregon measure that we might want to look at as well.

Did I miss anything in my summary that I just made there from you guys? Cheryl has got her hand up. I'm sorry about that, Cheryl. Thank you, Shaini. Cheryl, did you want to go ahead?

MEMBER DAMBERG: Yeah. So I think what is a little tricky in this space is like utilization kind of ties with access and, you know, kind of appropriateness of care, so we have got kind of this constellation of things coming together. And, you know, I think the challenge is trying to separate out kind of needed ED visits from unneeded. But I do think that high rates of ED use can be signaling, you know, kind of an issue of overuse of a high-cost health care setting, but I think it can also be potentially symptomatic of what I am going to call poor access to primary care and primary care sort of after hours. So I am a little bit reluctant to, say, let go of something like the ED utilization metric.

And I do think that there is an opportunity to take some of the utilization data to construct some measures, some comparative measures that

would get at something about, you know, much lower utilization of, you know, if we think primary care is critical, and it is critical for lots of reasons in the health care system, and that use of primary care services is much lower amongst certain population subgroups. I would think that that type of measure could be useful in this space so I am a little bit reluctant to kind of walk away from everything in this category.

MS. BROOKS: Got it, thank you for your comments. Diana, I see you have your hand up.

MEMBER DOUGLAS: Thank you, Diana Douglas with Health Access California. I just wanted to note not just related to this focus area but as we look ahead to the report I hope that we will be able to capture some of what has come up in discussion as sort of missing measurements or areas where maybe the group would have liked to have had a measurement But there wasn't one that was a good fit. Just knowing that, you know, while we are convening now to get a set of measurements that will be good for a number of years, eventually these will be revisited and hopefully we will have more measurements and that this could possibly be used to inform directions, gaps, sort of that we have as well.

MS. BROOKS: Yes, I appreciate your comment, Diana. There certainly will be something like that in the report. I think we are taking close notes on everything that everyone is saying, not to make you nervous, but we are taking notes on what everyone is saying because it is important for us to reflect those things in the report as well. Thank you for flagging that.

MEMBER DOUGLAS: Thank you.

MS. BROOKS: Doreena.

MEMBER WONG: Yes, thank you. Doreena, ARI. I was -- so I am like, share a little concern about not including any measure under the utilization. Also because we also decided to do that not under the access measure because we couldn't find anything. I guess recommending not including a measure doesn't mean that we don't want one so I am wondering how we can get to the place where we can actually come up with something, you know. I know this process is, is moving along quickly and I don't know if it means having smaller group discussions or some way to -- I would really like to see something related to what we have been talking about, ER use compared, you know, stratifying it again or the Medi-Cal, the older Medi-Cal measure, to have an opportunity to explore that so we can see if that would be something we would want. But I don't know how in the process we can do that.

MS. BROOKS: So I know there -- Doreena, I think you are making excellent points and thank you. I know there has been discussion previously around kind of, you're right, the time frame of the Committee and when the report is due and kind of what the complications are around developing measures and that that can take years sometimes to do. But I think what is important is to capture what you all are talking about, similar to what Diana was saying before, in the report in terms of the important areas that you want to highlight.

And I think just also flagging, you know, as -- was it you, Bihu, I think that said, we don't necessarily not have, we don't not have a utilization measure on our list right now. We have some that are on here for consideration but under a different focus area, like mental health. So I just wanted to make sure I kind of just laid that out there.

But certainly hear everything that you are saying and think it is very important so thank you. All right, Cheryl, I see you have your hand up. Making sure you have a comment, yes?

MEMBER DAMBERG: Yes.

MS. BROOKS: Go ahead.

MEMBER DAMBERG: One thing that I neglected to bring up in this section but it again, once again, applies to the access space. Was there any discussion of ambulatory care sensitive admissions? Which again get at like a utilization issue but also are suggestive of problems with access?

MS. BROOKS: So I am not sure if any of the clinicians want to speak to that.

MEMBER SANDHIR: I don't think we've got to that yet. That was some of the in-patient. We haven't got but that is absolutely I think part of the conversation.

MS. BROOKS: So we will get there and I should have caught that.

MEMBER DAMBERG: Okay, so that is good to know that you are going to get there. But I tend to think of this measure, it is measuring an admission for something that could have been prevented through ambulatory care. So I kind of view it more in the ambulatory care space than I do as kind of a metric of hospital performance.

MS. BROOKS: Thank you so much, Cheryl. All right. Bihu.

MEMBER SANDHIR: I actually think it was Cheryl who said this and I think actually that you brought up the appropriateness of care measure set. And really all of these fall under that. And I think maybe we should consider putting a whole subset of just those and that might help actually clarify how these

measures work together. Because these are all part of an -- access is part of it. There is not multiple measures in there but that I think may help us here in this discussion.

MS. BROOKS: I think what I heard you say is potentially we are maybe thinking about instead of calling this utilization, calling it appropriateness of care.

MEMBER SANDHIR: Yes. And there's actually some others that we are going to get to which fall into the same category. Appropriateness of care is a term that I think we are using more and more, at least in our systems, to describe a lot of these measures. Utilization falls in there, inpatient admission falls in there and then we can tailor it based on which ones work.

MS. BROOKS: All right. So I will just say that what I did here is that there is discussion that still needs to be had on the emergency department utilization measure. So I think what we will do is we will include that one and move forward and then we can discuss it more in the later section and then take a vote on it.

We will now move on to specialty. Next slide, please. Next slide, please, thank you. All right, so I am going to turn it over to Ignatius.

MR. BAU: So in terms of specialties there, unfortunately, isn't a whole lot of data from California specific to specialties. We do know that Black, Multiracial and Latinx Californians do report the greatest difficulty finding specialists and when Andy discusses the actual measures we need to keep that in mind. Again, back to impact and disparities reduction are important principles to keep in mind as well.

DR. BASKIN: So this is Andy Baskin again. So this is a set of

measures, I understand we called it specialty measures and, you know, one would think that it is care received by specialists and in fact in some cases it is but in some cases these are just individual specialized type of care that didn't sort of fit into anyplace else and that are currently used in one of the programs in California. So they don't, they are all individual measures unrelated to each other, as you can see.

So osteoporosis management in women who have had a fracture and have had either the appropriate testing or the appropriate treatment. However I should, I want to specifically point out that this measure is for an older population, so it is women over 65, and we are not including Medicare in our thing, in our, in this program. And that is not to say there aren't over 65 in commercial insurance, but there are, but just keep that in mind in that.

Sepsis management is a very narrow focus area because it is people that are in a hospital with a diagnosis of sepsis and getting specific type of testing and care as part of a program for sepsis management in the hospital. So once again, it is a fairly small population relative to many of these other measures.

The INR, International Normalized Ratio, is a blood test that is done to monitor people who are taking Warfarin, which is a blood thinner. Now, Warfarin is something that is given for a lot of -- this is not a trivial population, but it is not a huge population either. This is commonly somebody with atrial fibrillation, irregular heartbeat that gets Warfarin to protect against blood clots, a very common one.

The Proportion of Days Covered, this is rate of filling of prescriptions to meet a threshold for certain medications, diabetes medicines, a

set of blood pressure medicines, and I am trying to remember the third one.

SPEAKER (OFF MIC): Statins. Statins.

DR. BASKIN: Oh statins, that's right, for cholesterol, that is the third one.

And the last one, the central line associated blood . This is a stream infection. This is an in-hospital type of measure similar to sepsis management. It is basically a count of people that are getting these infections that could be avoided and have been shown to be avoidable and minimizing those, that rate of infection. So once again, it is usually very sick people in a hospital so it is a very specialized or small population that we are talking about.

So that is those set of measures and I turn it over to you.

MS. BROOKS: Comments from the Committee? Bihu.

MEMBER SANDHIR: Bihu Sandhir from AltaMed. From a specialty measure perspective, the ones we are already somewhat measured on our med adherence measures, which is the proportion of days covered for diabetes medication, statins. So that is something we are, we are actually already working with.

But from a specialty perspective, the challenge that we see really in the field is access. It is really not -- these, these are measures that are very, very highly specialized and I don't think the impact is as large. Even for the osteoporosis measure this a very small number of patients so I am not sure that the impact would be that large, especially in our population that we are focusing on.

But I don't know if this is where we could consider having an access measure about how you can get in to see a specialist, how soon you can

get in to see a specialist, because that is our biggest challenge with the population of patients that we are talking about. Just something to consider.

MS. BROOKS: Thank you, Bihu. Ed.

MEMBER JUHN: Ed, Inland Empire Health Plan. So when I look through these specialty measures, some of these measures like sepsis management and central line associated bloodstream infection measures, it is going to likely require access to EMR data for the entire in-patient population. So I am not sure if necessarily these measures are designed to be calculated from claims data alone but in order to appropriately stratify and reduce disparities for these pieces, given that some of this might require more heavily on EMR data that plans may or may not have access to readily, it potentially might, again, require some learning or opportunities on how to actually get this information timely to be able to close on the disparities you are looking for.

And one of the other measures, the INR monitoring for individuals on Warfarin. Again, you know, how readily would this data be available for plans to quickly receive and then report out and find ways reduces disparities. Again, those, those pieces come to mind for me.

MS. BROOKS: Thank you, Ed. Cheryl.

MEMBER DAMBERG: Sorry, I had to get you off of mute. So I agree, I don't think this is the right list of measures. And I know we collectively are going to have to, you know, shrink this list to get down to that 10 or 11 set of measures. But it feels to me like some measures that you had included under the chronic condition measures really also serve as specialty measures; you know, blood pressure control, you know, diabetes, blood sugar control and, you know, management of asthma. So I am wondering whether, you know, those

sets of measures could serve kind of cross-cutting just in terms of trying to winnow the set, and they are high priority areas. I would say that.

And then per a comment that was made a moment ago. I think the other thing, and this is why I want to get back to talking about access at some point, and I know I missed the last meeting, is that there are measures on the CAHPS survey that get at specialty access. And I know from my many years running the patient experience survey in the state of California, that was oftentimes a measure where there were low ratings, you know, across the board, and I suspect that there would be disparities in that measure. So I would like to, you know, if you are trying to categorize by specialty type measures, you could add a patient experience measure into this mix.

MS. BROOKS: So I know we do have a couple of patient experience measures later on in the discussion under patient experience, that makes sense, but I am going to take note of that, Cheryl. And then also just kind of your comment around chronic conditions. That was really helpful as well, thank you. Diana.

MEMBER DOUGLAS: Thank you. Diana Douglas with Health Access California. I think looking at these measures, I know it was noted at the beginning that the first one, osteoporosis, clearly affects an older population that might not be as, who we are targeting here exactly, DMHC regulated plans.

But I think, looking at some of the other measurements also. So looking at number 5, the central line and also number 3 on the INR for Warfarin, it seems that those also might be largely affecting older populations since those over 65 tend to be more likely, for Warfarin would be more likely to be treated. So I just wonder how, how relevant those are to the bigger population that we

are looking at here.

In terms of the other two, I just think in general when we are looking at specialty measures, I agree with the previous comments that really access is what we are looking to when we're looking at access to specialists and how long different populations take to be able to see a specialist after referral from their primary care provider and what disparities exist there, rather than maybe what these are getting at, which is, I think a little bit out of left field from what I would, I would consider looking at for a specialty measure. But if there are other access measures or other ways to measure whether people are able to see specialists, you know, within their area and within an appropriate time frame I think that might be more what I would be looking for from a consumer's perspective.

MS. BROOKS: Thank you, Diana. Nathan and I were just sidebarring a little bit just because I was asking what available and all that so we get a little bit about that so thank you. Julia.

MEMBER LOGAN: Yeah, thank you, Julia Logan, CalPERS. Yeah, and just really echoing what some of the other folks have said about these measures. That really in the spirit of parsimony these measures are almost really too narrow in population and in scope to really rise to the top and to be able to really be able to stratify in the ways that we would need and want them to be stratified. So, yeah, just thinking in terms of the amount of measures, these wouldn't be the ones that we would look to first. MS. BROOKS: Thank you, Julia. Ignatius.

MR. BAU: So maybe to help move this along, we looked at, we bypassed for the time being in the access measures, a green measure that was a CAHPS, Consumer Assessment of Healthcare Providers and Systems

measure, that included two questions, easy for the respondent to get necessary care, tests or treatment, and respondent got appointment with specialist as soon as needed. So those might be ones that we will go back and revisit given this discussion.

MS. BROOKS: Thank you, Ignatius. All right, so let me see -- excellent point and taking note of that.

Shaini, do we have any public comment hands raised online?

Is there any public comment in the room on specialty measures?

So I am going to kind of summarize what I heard, which is that we are not going to move forward specifically with any of these measures; but making the point that access to specialists is key and important. And so really needing to do some thinking about that and whether or not we can pull in some CAHPS measures as Ignatius mentioned specifically that might address that and others have raised that as well as being important. So that is what I am hearing but let me know if I am misrepresenting.

Great. So we are going to move on then. Next slide, please. So we are going to move on to coordination of care disparities and I am going to turn it over to Ignatius.

MR. BAU: Coordination of care is another one of those areas in which we really wish there were better measures and so the one that we are highlighting here in terms of disparities is that we know that hospital readmissions, avoidable hospital readmissions, continues to be a challenge and issue for how care is coordinated and that is particularly true among Black, American Indian, Alaska Native and Latinx Californians. And then let me turn it over to Andy.

DR. BASKIN: This is Andy Baskin. For your consideration we have two coordination of care measures that we call green measures because they are currently used in California programs and these are actually very commonly used outside of California programs as well. There are two of them.

The first one is medication reconciliation. This is post-discharge from an in-patient stay at a hospital. So you were in a hospital for a reason, you were discharged, and somebody, once you got into the out-patient setting, basically reconciled your current medication list with what had happened prior to admission so that you get your medications right. It is actually very important and does not occur as often as it should.

The second one, but it is specific to, once again, discharges from a hospital, that is the patient population we are talking about. Plan all-cause readmission is what it basically says, is that people that were discharged from a hospital, how often were they re admitted to a hospital within a 30 day period of time? And that is really a reflection of outpatient care. So as Cheryl mentioned before in one of the other measures, it is not really measuring, you know, ED utilization, it is measuring whether you get good care to avoid ED utilization.

Well, this is one of those measures that if you are getting good out-patient care, you have been referred back to a physician, you have had follow-up care. And if that all went according to plan and you were appropriately followed-up it would be less likely that you would then have to be readmitted into a hospital. So it is really a reflection of good out-patient care after an admission, that is how you do well in this particular measure.

So open it up for discussion.

MS. BROOKS: Cheryl.

MEMBER DAMBERG: Okay, you get to hear from me a lot today. So once again I think in the care coordination space it didn't seem as though this list contains anything from the CAHPS survey. So there are coordination of care measures on that survey that I suggest be considered for inclusion.

MS. BROOKS: Cheryl, I just took note of that. It looks like Bihu has her hand up.

MEMBER SANDHIR: Bihu Sandhir from AltaMed. I think these actually fall under appropriateness of care measures and that is -- and I actually think these are very important measures for what we are trying to do. This does, it is good care for the patient but it is also cost of care. I think we think that considerations when we are choosing measures. So my recommendation is that we need to really look at these and consider including them or at least having another look at them.

I think transitions of care, that is something we do actually for most of our patients and it is good care for our patients. There is definitely room for that. The Health Information Exchange is going to be very important.

The plan all-cause readmission, I am open to any other subsets of that. I don't know with ambulatory sensitive conditions or, you know, others, but I think these are things that we are really already really should -- we really have to consider to continue to look at because this is affecting cost of care in the long run and it is the right thing for our patients.

MS. BROOKS: Just for a clarification question for me. I hear you highlighting that we should you are interested in moving these measures forward for future discussion.

MEMBER SANDHIR: I am.

MS. BROOKS: But are you also asking that they be moved under the appropriateness of care?

MEMBER SANDHIR: This is not really coordination, it is appropriateness of care.

MS. BROOKS: Okay, thank you. Thank you. Kiran.

MEMBER SAVAGE-SANGWAN: My concern is neither of these are disparity-sensitive and there are, you know, there are, I think, fairly significant disparities issues around coordination of care, as Ignatius discussed. And I am wondering if there is anything just a little bit broader that exists around appropriate follow-up after hospitalization, appropriate follow-up after emergency department, similar to the mental health measures but for all other types of visits, that we could consider that might capture a larger population such that you could look at disparities?

MS. BROOKS: I am going to ask all of my clinical experts in the room, is there a just straight follow-up after ED utilization measure that doesn't have -- No? Okay. Kiran, I hear, I think what I heard you say is that you are looking for something that is just about follow-up after ED or something similar to that; is that right?

MEMBER SANDHIR: I think we discussed adding that to the appropriateness care. We were going to look at that, the avoidable ED utilization.

MS. BROOKS: Yes.

MEMBER SANDHIR: And then we have the follow-up ones in our depression, in our mental health measures.

MS. BROOKS: Yes.

MEMBER SANDHIR: So I think we have addressed those.

MS. BROOKS: Yes, I think --

MEMBER SAVAGE-SANGWAN: Those are only for mental health so I am wondering if there's any --

MS. BROOKS: Yes.

MEMBER SAVAGE-SANGWAN: Everyone else who goes to the hospital or the emergency department for something other than mental health, is there any way that we measure follow-up with primary care when indicated, et cetera?

MS. BROOKS: Go ahead, Andy.

DR. BASKIN: Yeah. I am not aware of the measure as you stated. There is -- the only measure that I am aware of is a measure out there that says you went to an emergency visit and notification was made to your primary care physician that you were in the emergency room. And then, of course, that opens up the door for the doctor to know you were there and potentially request follow-up or not as they deem necessary. But I am not aware of one that blankly said you went to emergency room and how often were you followed up for all-cause reasons.

MS. BROOKS: Ed.

MEMBER JUHN: Hi, Ed, Inland Empire Health Plan. So of these two, the transitions of care: med rec post- discharge. You know, one of the things that comes to mind is, you know, do we have a sufficient population size to then stratify at the sub-population level, so that we can appropriately stratify by race and ethnicity? You know, when you compare number one to number two, number two seems potentially a bigger population size to, again, address some

of the disparity pieces that we need to address. Whereas number one feels like more of a reliance or dependence but on adequate volumes and populations to make this meaningful to, you know, impact at the state level.

MS. BROOKS: So I think I heard you say, maybe potentially, there could be some issues with denominators.

MEMBER JUHN: Yes.

MS. BROOKS: Number one. Okay, thank you. Silvia.

MEMBER YEE: Silvia with DREDF. Yeah, I am wondering about that too a little bit. This is a really critical one for many reasons, other than just the medication, for many. And I am thinking of the link between these two as well. I just think a lot, I have heard a lot of stories about people who are discharged and they are discharged to homes without proper equipment, without getting personal care systems in place, without the things that will help them to get better when they are in the community. And it doesn't necessarily lead to an acute admission. It will lead, though, to a slow, slow loss of health over a sustained period of time, incredible stress amongst family members, friends, as they are all trying to take care of someone who is not prepared with the supports they need to be in the community. I don't know how to capture that.

I do understand that the coordination of care is linked to appropriateness of care. I think there is something specific here too about coordination of care. This is a measure that is also particularly important, of course, to people with disabilities who may have higher care needs when they return to the community. So I -- once kept here, there is something here I think that is important but I don't know of any measures that capture it. There are some, there is a lot of development amongst home and community-based

measures, HCBS measures, quality measures, as an attempt to try and capture what that is and what quality is in that arena. Does that link it to any of this?

MS. BROOKS: I think you are making some very important points and a little bit about what I hear is just about the experience of the individual when they are discharged, potentially, or when they are sent home from a procedure or something of that sort and kind of what -- how they are set up, right, and if there is something to measure that. I don't know that -- I am not aware of a measure like that. I am looking at my lifelines around the room. And I don't see a measure but I think it is an important point that you're making and so something that we can certainly look at including in the comments in the report. And Andy, you may have a comment as well.

DR. BASKIN: Yeah. And I am not aware of a specific measure, either, although I've been in discussions about them, like, you know, if nursing care at home was, you know, how often did it occur within 24 hours and outreach, those sorts of things. But basically all of those things that you mentioned are the strategies that the health plans use to prevent all-cause readmission. They look at their own data and say, well, gee whiz, if someone was discharged and they were recommended a home health aide, you know, how soon did that occur? Did it occur in a timely fashion? And that is their strategy but I am not aware of it being put into a measure for formal measurement for a purpose like this.

MS. BROOKS: Thank you, Silvia. Doreena.

MEMBER WONG: Yes, thank you, Doreena Wong from ARI. I guess maybe something more specific or direct than just readmissions, I think, to get to what Silvia and others have been trying to talk about or identify? Like -- or

even what Kiran was saying. Are there any questions about kind of necessary referrals? You know. I know that we have one, I think about mental health referrals in the mental health section. But this also goes to maybe referrals to specialists, right, from the primary care physician. I'm not sure if there is anything in the patient satisfaction measure about getting referrals.

I think, I think, I am not sure if there is anything about referrals for the social determinants of health, either. But at any -- I think that to try to get to whether or not the they actually get some kind of a referral or service, you know, after they get discharged or they need some follow-up from the emergency room. I think that that would get to more of looking at outcomes and seeing whether or not there are differences based on race or ethnicity. I am not sure if I am making myself clear but, you know, maybe a question around, you know, referrals, are they receiving referrals for services?

MS. BROOKS: So I think, Doreena, I could refer back to Cheryl, I know made a comment about looking at the CAHPS survey in terms of there was a coordination of care measure and I would have to look at that specifically. I think it sounded like it was related to specialists potentially. But definitely I hear your comments and took notes on them so thank you. I see Rick has a comment.

MEMBER RIGGS: Hi, Rick Riggs from Cedars-Sinai. Just a comment about the transitions of care, the medication reconciliation. It does indeed, you know, occur. We are on the hook for readmissions and oftentimes the readmissions are prevented by doing the, by the hospital performing the post-discharge medication reconciliation. So I don't know that the health plan, since it is not necessarily any type of, you know, charge or submission claim that

they would have record of, of those types of things, so I think that is one thing to consider.

The other thing I just want to point out is that there are multiple comments in the Chat. I know you have asked us not to utilize that but I just wanted to point out that there are several different pieces in there.

MS. BROOKS: Thank you, Rick. Yeah, I have not been checking the Chat. Just a reminder to please not use the chat for Bagley-Keene purposes. But we will take a look at it and see if there are any resources or references that we need to provide and make sure that everybody receives those following this meeting. Bihu.

MEMBER SANDHIR: Sarah, thank you. Bihu Sandhir AltaMed. I think actually made very good points, Silvia and Doreena, because these are, this is a very complex measure, transitions of care. So although it says medication reconciliation post-discharge, that is our way of measuring it. But what it is actually is a visit that you are, you are required to reach out to the patient within 7 or 14 days, well, within 7 days, we do it within 2 days, actually, in our health system. And you are supposed to connect with the patient and get them in or even connect with them on a telehealth visit. And what you are doing is not only medication reconciliation but it is DME and referrals to specialists and coordinating that.

And the impact is, that of course, because it is very common when patients leave the hospital that their medications are all messed up. It is just -- it is unfortunate but that is the reality. So what you are trying to do is prevent that readmission for the wrong reason. So that is really what this visit is about. It is actually a wonderful visit for the patient if you do it right and there is a charge for

it. There is a modifier, there is a code that drops if you do it right. And we are being measured on this for all of our Medicare plans at this point.

It is a very important measure. So I do think there is a large impact because it is actually really good care for the patient. This is when they are the most vulnerable, when they are coming out of the hospital when they have been very ill and this is when they need their hand to be held the most so I do feel that that is why it is an important measure to think about.

MS. BROOKS: Thank you, Bihu. Silvia.

MEMBER YEE: Yes. I just wanted to follow-up with what Doreena said and now Bihu. I mean, care coordination is a Medi-Cal service. In private plans maybe it is less, it is less recognized as such, but there is a code that drops, thank you, Bihu. I mean, that is, that is just a number I guess, but it would be something, are people getting these visits and to have that stratified would be very, very useful information. Are people who are speaking non-English languages getting that in the appropriate language? Are people in difficult home situations getting that and so forth? I mean, I just think that there is a lot that can be seen from that, even if it is not an existing measure.

MS. BROOKS: Cheryl, I see your hand is up.

MEMBER DAMBERG: Yeah. There is one measure that I don't think we've discussed here. Maybe it was on your list, I haven't gone through your list. But it is a measure that, you know, I know CMS has been focused on, which is timely follow-up after acute exacerbations of chronic conditions and it covers a number of key chronic conditions, diabetes, asthma, hypertension, congestive heart failure, coronary artery disease, COPD. And it is, it is really kind of getting at a care coordination issue and, you know, maybe there is an

opportunity here to add such a measure because it covers a pretty broad waterfront, which is, I think, going to help with denominator issues and stratifying results.

MS. BROOKS: Any comments from Committee Members with respect to, I think you said timely follow-up after acute exacerbation of chronic conditions; is that right?

MEMBER DAMBERG: That's right.

MS. BROOKS: Did I get it right?

MEMBER DAMBERG: Yes. And if you're not familiar with that measure I can certainly share information on it.

MS. BROOKS: I am not seeing any hands in the room? Shaini, do we have any hands online for public comment? Great. Hi, Kristen, you can go ahead with your public comment, thank you.

MS. GOLDEN TESTA: Hi, this is Kristen Golden Testa with the Children's Partnership. Thanks for this conversation, the opportunity to comment. With regard to coordination of care, I would agree with several of those on the panel who have spoken about looking at the CAHPS measure, that does look at whether needed care was received.

And I don't think there is a measure but I would ask that the report reflect that it be valuable to develop and create a validated measure of closed loop referrals to make sure that individuals are getting the care that they are being referred to. This is going to be the bedrock of the Medi-Cal's population health management. The cornerstone is care coordination so we need to be able to have some measure of that basic care coordination that is happening across the board on unneeded care from referrals.

MS. BROOKS: Thank you, Kristen. Do we have any other hands raised? Hi, David, David Lown, go ahead.

MR. LOWN: Yeah, hi, thank you for the opportunity. Two comments.

One, following up on Cheryl's comment. I hadn't actually heard of the timely follow-up for acute exacerbations of chronic conditions but that is a really nice composite measure of really important conditions and making sure that care is being provided so I second that.

And then to the previous speaker's public comment. There actually was a measure that was created from scratch from experts in the field for the Prime Program under the Medi-Cal waiver, the 2015 waiver, timely -- now I am trying to remember the title. Timely receipt. Maybe it was specialty care referral. Timely follow-up on specialty care referral was specifically what was just described. It was created and validated over a number of years across multiple public health systems and we could certainly provide more detail on that information, on that, on that particular measure.

MS. BROOKS: Thank you, David. All right. Shaini, do we have any other hands raised?

Do we have any public comment in the room?

All right. So what I am hearing, all right, is that we are going to plug these measures under the appropriateness of care focus. We are moving forward with transitions of care: medication reconciliation post- discharge and plan all-cause readmissions. We are also going to look at the CAHPS survey on needed care, I believe it is. We will clarify that with you, Cheryl. And then also just kind of summarizing that with some very important discussion around kind of

Silvia's point post-discharge, when you go home what your experience is and so on, and then kind of access to care in terms of people getting visits. And then I know there was also mention of the timely follow-up after acute exacerbations of chronic conditions. Did I miss anything in my summary? Kiran, go ahead, sorry.

MEMBER SAVAGE-SANGWAN: There was also a suggestion from Palav in the Chat that I think should go on the list about follow-up after hospitalization within 7 days.

MS. BROOKS: Thank you, Kiran.

MS. MYERS: Hi, Sarah, this is Janel Myers. That measure, the follow-up after hospitalization with 7 days, if someone could provide that with us, I am not familiar with that measure. So if that is accessible that would be great, thank you.

MS. BROOKS: Thank you, Janel. So Palav, we will follow-up with you to get some more information on that measure then. All right.

So we have talked a little bit about it and we will go to the next slide, please. We talked a little bit about it but -- one more, there we go -- but we are going to move into patient experience. So I am going to turn it over to Ignatius to take it away.

MR. BAU: So patient experience is obviously really important. This is distinct from access measures in terms of ability to access either primary care or specialty care or other kinds of needed treatments. This is more the qualitative reporting on how the patient experienced the care in terms of were they treated with respect, courtesy, et cetera. So we know from national data that there are these disparities using the most common measures of patient experience for Asians, Native Hawaiians, Pacific Islanders, Blacks and Latinx,

specifically in managed care. And next slide.

We also have some data specific to commercial enrollees in health plans in California and this highlights that sometimes, as Cheryl noted previously in a comment and the Chat, how people rate when they are asked to survey that. Next slide.

Blacks, there is some evidence that Blacks tend to be more satisfied or rate higher and that Asians are less satisfied and rate lower. And so there is a little bit of controversy about when you get to the stratifications whether or not you are reflecting those cultural differences rather than their actual experiences.

DR. BASKIN: This is Andy Baskin. As you can see under the patient experience, the only thing we have listed is subsets of the CAHPS survey. That is not to say that there aren't other patient experience measures out there, they are just not very commonly used or universally used. There are a lot of them that are, you know, individual surveys or are used by one organization, other organizations use a different survey. The CAHPS survey, obviously, is very universally used by health plans today. It is a requirement to report on that through, for NCQA accreditation.

The survey, however, is what you can see here. There are composites of several questions within the survey and then there is the individual questions in the survey and you are certainly welcome to choose any, mix and match any which way you want. I don't know whether you -- did we send actually around the survey? I know I have a copy of the survey. Does everyone has a copy of the survey that they see the questions? You can look at them. I know there's been some comments made about coordination of care and things and I

don't think the questions are as pinpointed as perhaps one would hope they would be for what at least has been mentioned here.

But I will open it up. Anyone that needs additional information about a specific question that is in the survey just ask if you don't remember seeing it or you can't find it.

MS. BROOKS: Thank you, Andy.

DR. BASKIN: I did want to say one thing, just a technical thing. Understanding that today health plans do not survey all their members with a CAHPS survey. So those of you who aren't in the measurement business have to understand that this is a sample survey. Health plans may sample several hundred. It is usually in the 400 or something range, if I am not mistaken, in a particular state or a particular plan. And I can tell you from experience that the return rate is in the 25 to 35% range on those surveys, so think about that when you are talking about then stratifying results, if that is even possible.

Now understand that the health plan does not know which members actually return the surveys, so stratification actually would be a really major problem because I don't know that technically that can be done. They are not allowed to see the individual names of who returned the surveys. So just pointing that out. It is a big problem. Now, that is not to say you couldn't require a CAHPS survey to go to everybody but I am just saying that is not what happens today.

MS. BROOKS: Thank you, Andy. All right, I see Cheryl has her hand up.

MEMBER DAMBERG: There are several points I'd like to make. So the last comment that Andy made related to the sample size, it is true that

these are samples. However, nationally in Medicare Advantage CMS has, is moving towards stratified reporting. And the way they are able to get to reliable estimates at the strata level is by pooling information across two years. So I do think, particularly in the patient experience space, that is something that would need to be done but you can get reliable estimates for subgroups. And you can see those results already today on the Office of Minority Health for CMS' website if you care to take a look at the health plans nationally.

But I guess, you know, as I stare at the list here, I think these are not the right subset of CAHPS items, composites that you want to select, for several reasons.

So first let me start with the ones at the bottom, the 0-10 ratings. Different subgroups use that 0-10 rating scale differently, which makes them not comparable across subgroups. And that is by race, ethnicity, national origin, education and other characteristics. And if you look at how CMS has used those measures, they tend to down-weight those in, say, value-based payment applications. So I would definitely recommend to the Department of Managed Care to stay away from the 0-10 items.

I do think that there are better measures, for the purposes of equity, on the CAHPS survey, specifically around getting needed access to care, you know, getting care that you need in a timely way, getting it quickly. And as well as the care coordination measures that are on the survey and those composites that are based on several measures within each of those buckets, which will help in getting to a reliable estimate. Those are areas where plans tend to vary more on performance. And it would be expected that they would vary more and we are seeing this in the Medicare data along those dimensions

by subgroup.

I would not be spending time on customer service. You know, it is possible that getting necessary information or help could be useful but oftentimes this is related to what I call plan customer service kinds of operations rather than getting clinical information.

So with that, I would strike all the measures on this particular slide and, you know, pivot to other CAHPS patient experience items and composite measures.

MS. BROOKS: Thank you. Do you have recommendations on which ones we should pivot to? Do they reflect the ones we have kind of talked already about during this meeting so far?

MEMBER DAMBERG: So there are existing composites. So there is one called Getting Needed Care. There is also one called Getting Care Quickly. There is one called Care Coordination. So those comprise a number of different survey items. And then per earlier points, I would look at the specialty access item because, again, that is an area of lower performance. And undoubtedly there is going to be variation In terms of subgroups because we know certain subpopulations who, you know, live in certain geographic areas have poor access to specialty care in their communities.

MS. BROOKS: Thank you. Dannie.

MEMBER CESEÑA: Hi, Dannie from the California LGBTQ Health and Human Services Network. Yeah, I also have concerns with these experience measures. And thank you for giving the rates on how many survey results are returned, 25 to 30%. That number actually doesn't shock me just knowing that -- and not even just from an LGBTQ perspective but just from a

patient perspective.

If I have a horrible experience with my provider and I am going to my insurance plan and filing a complaint and then they investigate and the doctor says, no, everything is fine, this didn't happen, duh-duh-duh, and then when I see that doctor again I am retaliated against. When I get a survey like this I am just going to say like why should I take this when I have tried to complain before and instead I was retaliated against and now I don't feel comfortable going back to that provider. What change is this survey actually going to make when my voice wasn't even listened to?

So that is my biggest concern with these measures. And even using a type of survey that there is a low response rate for because people just don't trust it.

MS. BROOKS: Thank you, Dannie. Ed.

MEMBER JUHN: Hi, Ed, Inland Empire Health Plan. Maybe just adding to what Andy had shared earlier. My question is just more around the CAHPS survey itself. Because right now it is a blinded survey that sort of limits the ability to report, you know, rates stratified, you know, by health equity variables like race and ethnicity. So I guess for me the question is, if this member level data is not currently available to us as a health plan, would we potentially change the collection and reporting requirements for CAHPS in a way then the information that would be required to fulfill the state's needs would then be made available to plans? So that is the first question.

And I guess the second question is, maybe this is more for the experts in the room, but CAHPS, from my understanding, relies more on a sampling method, it doesn't really assess the entire population. So is this

sampling method something that either this Committee or the experts on this committee would provide us guidance on? Again, especially if we are trying to address some of the vulnerabilities that this survey may be able to help bring so that we can improve?

MS. BROOKS: So I think we certainly could provide some additional information perhaps. I mean, there is, there is a lot of knowledge in the room and on the -- and I see Kristine has her hand up so I might just see what she has got to say next. And not taking your questions away, sorry, Kristine. But if you have any comments on Ed's response on CAHPS or anything of that sort?

MEMBER TOPPE: I do. But I was going to actually defer to Cheryl because she is our resident survey methodologist, I think, in the room.

But I did want to, if I may, just reinforce the points that she made, which I think are really productive and useful as it relates to what plans -- you know, what you are getting today with CAHPS. And in several of the measures she referenced, getting needed care, getting care quickly, and the coordination of care, are all things that are -- NCQA includes in our health plan ratings, so it is a required part of the plans who are accredited. You know, that is how we score them in health plan ratings, on those three specifically that she mentioned. And I agree with the, you know, use kind of the, the refocusing away from this set toward those would be a productive use given everything that has already been discussed today.

And so I am going to defer that question about kind of the flexibility around sampling to Cheryl.

MEMBER DAMBERG: So do you want me to chime in now?

MS. BROOKS: Yes.

MEMBER DAMBERG: Okay.

MS. BROOKS: Go ahead, please. Thank you.

MEMBER DAMBERG: So right now it is a random sample and the number of people sampled is designed to generate representative estimates for that particular plan. And obviously if, you know, the various stakeholders in the state wanted to collect, you know, more information. So for example, Native Americans tend to be a very small subgroup just in terms of their presence in the population. So let's say you wanted to beef up the number of respondents in that community. One could potentially choose to over-sample and that could be sort of an add-on to the existing CAHPS framework if you wanted to, you know, get more respondents of particular subgroups or categories.

One thing -- I want to touch on two other comments that have been made in the course of this discussion, one right at the outset. The CAHPS results are case mix adjusted. So it is accounting for differences in response tendencies by different subgroups as well as differences in responses to different, by different subgroups to the questions. So it is adjusted for things like race, ethnicity, education and so on.

And then lastly, I think the question was, would data in an unblinded way be shared back with the plan? I think that that would largely be untenable because I don't think the consumers would be willing to respond on a identified basis. Now, it may be that, you know, the plan would like to get back some information in terms of information by subgroups and I do think that that may be something that could be explored in terms of the results. I know, at least for the Medicare Advantage plans, we actually share back information that allows

them to kind of parse their data by different subgroups.

MS. BROOKS: Thank you, Cheryl. And hopefully that was helpful for those in the room and on the computer. Diana.

MEMBER DOUGLAS: Thank you, Diana Douglas with Health Access California. Appreciate all the conversation here. From the consumer advocate perspective I think often we are a little bit wary of some of the patient experience measures insofar as we don't always feel that they are capturing exactly what we think or hope that they are capturing.

I think looking at the initial, the first measure on customer service. That I would have concerns that that is really just capturing the subset of folks who are interacting with customer service and I think we wouldn't necessarily know enough about why those interactions were taking place or what, what exactly they were sort of rating.

And the enrollees' ratings composite. I also agree with others who have flagged that this might not be the best measure, even among the patient experience measures. Which again overall I think we are a little bit wary of, but I think particularly looking at ratings of health plans. What exactly is that measuring? Are enrollees aware of what, of how health plan should be functioning and what they should be providing enough to be able to adequately comment on how good of a job the plan is doing or how satisfied they are?

I appreciate Cheryl's flagging some of the other potential measurements and some of the issues with these. I do think, just in like a very cursory glance, that something such as getting needed care might get a little bit more to the heart of what I would hope that this Committee would, would settle on as far as measurements in terms of our people feeling that they're getting the

necessary tests and treatments or getting access to specialists as quickly.

But again, I think we need to think carefully, as we have talked about, about whether the stratification, the lack of stratification, signals that maybe we should step away from these sorts of measurements and just go into it knowing the limits here on stratification.

I appreciate hearing that CAHPS takes into account sort of risk response bias. And I might be saying this wrong. Response bias and differences in how people respond to and whether they respond to surveys. But I think without being able to capture, without being able to stratify by racial and ethnic data, let alone the SOGI data and other data points, I think this is not as useful as we would hope it might be.

MS. BROOKS: Thank you, Diana. Doreena.

MEMBER WONG: Doreena Wong, ARI. Yeah, I just have a lot of questions about what the CAHPS survey does, does capture. I am assuming that the CAHPS survey is just for the English speakers and not in different languages and so maybe --

MS. BROOKS: It is in English and Spanish. There are other translations but those are the standardized languages that are used nationally.

MEMBER WONG: Right. So I think the reason I like some of the questions just about the customer service. And I think that they are, I can't, I have to look now. But I want to get to whether or not they were able to talk in their language or get interpreter services or get, or have some of their language access assistance that they needed. And so to the extent that, of course, if this is only in English then that wouldn't be as helpful because, obviously, if they spoke a different language, they couldn't participate in this survey so that could

be a problem.

But I did appreciate Cheryl's recommendations to get to smaller subpopulations by over-sampling or using more than one year of data. Because I think that that is how we could get to the getting disaggregated data that we need.

Anyway, in the communication question, I am not sure. Maybe we could even ask, did you need help with an interpreter? Because some people have a limited ability to speak English. They still need an interpreter. So I guess so if we are going to include a question about being able to communicate with the customer service then I would like to include some questions around the language access issues. And I guess some of this could be in the equity area as well. I think that there's some questions around, that we could include around a language access plan and some other ways to address the language access barriers, but this could be also one of the areas.

MS. BROOKS: Thank you, Doreena. I see you have your hand raised, Tiffany.

MEMBER HUYENH-CHO: Hi, Tiffany Huyenh-Cho from Justice in Aging. I appreciate everyone's comments that have been made, I think there were some very valid points. I agree that some of these measures that were selected seem kind of broad and might not get out some of the points that we are looking for. I especially agree with eliminating the customer service questions in favor of others that would be more relevant, such as the ones that Cheryl mentioned with getting needed care or care coordination.

I don't have a copy of the CAHPS survey but for the number 2 with the enrollees' ratings composite for rating of a personal doctor or a specialist or

of the health plan itself, I am curious about how these questions are framed in the survey. Are they, you know, just like a star rating or do they ask detailed questions? Because I think with just a broad question or a broad rating it doesn't necessarily get at maybe some of the concerns that individuals would have with a personal doctor or with their specialist.

I did like in the Excel spreadsheet there was another question about how well doctors communicate. Which what I liked about it was that it had more detailed questions like, does your, did you feel that your doctor showed respect for what you had to say or if they listened carefully to you? But I think learning that the CAHPS surveys are not necessarily or are available in English and Spanish and you have to ask for translations of others. I think that caused concern about whether or not that other measure that I mentioned on how well doctors communicate, if that is also reaching, you know, those with limited English or other language needs as well.

MEMBER DAMBERG: Can I jump in?

MS. BROOKS: Thank you, Tiffany. Ignatius, I see -- can I -- okay, go ahead, Cheryl.

MEMBER DAMBERG: Yeah, I just kind of wanted to comment on a couple of the issues that people have flagged. So I do think maybe it is worth staff going offline, you know, whether it is with me or others, to kind of maybe flesh out this space a bit more. Because I think that, you know, people aren't necessarily familiar with the survey and don't have all the information to kind of fully make a decision here.

You know, many plans as well as physician practices we will do supplemental surveying to get at what I call much more specific issues.

But I do think that the CAHPS survey covers sort of a range of issues that are critical to patients in terms of getting access to care and getting it in a timely fashion. And what is good about the CAHPS survey is it is asking about care you received in the last year. I is not tied to a specific encounter but it is like, on average, you know, what has been your experience, you know, interacting with the health system under this plan over the past year. So I think there is advantages to that.

I would also note that there are, that the CAHPS consortium has developed to a whole host of supplemental items and it may be worth taking a look at those. That may get out some of these issues about language and making, you know, interpreters available, and some of the issues that may be of greater interest of California stakeholders.

MS. BROOKS: Thank you, Cheryl. I think what I have been thinking in advance was that I believe it would be helpful to provide -- I know we have provided some information on the CAHPS survey to you all, but to probably provide that information. Maybe have an opportunity for you all to review that in between now and the next meeting, think about the different measures, rank them with respect to kind of which ones seem to be at the top of the list for you, and then we can have a discussion about that at the next meeting and kind of vote on which of those measures make the most sense.

What I was thinking with respect to kind of CAHPS in general, just because there seems to be a lot of interest but a lot of questions as well and I don't know if we are going to get through those. It sounds like you might have a comment, Ignatius.

MR. BAU: This is Ignatius Bau following up on Cheryl's comments.

So all those supplemental measures that might be most relevant, so relating to language access and interpreter, experience with interpreters relating to disabilities, and access for people with disabilities, and relating to health literacy, which is not a topic that we have discussed, are in the health equity workbook so folks can look at those measures.

I also think the other point is that we are toggling a little bit. A lot of this discussion is about people's experience with their providers and there are two separate CAHPS surveys. One is really about the health plan and the experience of the health plan and a lot of these questions are really in the provider survey. And so this is -- because the charge of this committee is to look at measures that are relevant to a health plan it wouldn't be fair to apply measures that are really at the provider level, to the health plans.

MEMBER SANDHIR: Bihu Sandhir from AltaMed. I actually completely agree with what you just said. I do first of all, I think we need to have patient experience as an absolute part of our measures. That is, it is quadruple, I think, weighted right now with Medicare and it is not going to be less. And I think we just need to state that, that this has to be part of it.

But I agree that I think we need some guidance here on the measures, the questions taking into account. And I do agree that there should be a health plan component to that. It is not just the provider, I do think the health plan part is important here as well. And we need, we need some help with understanding what those questions are and some guidance.

MS. BROOKS: So what I am going to suggest is that -- I see three hands up. I am going to suggest we take those three hands and take any public comment and then we kind of move on but we will, as I said, come back to this

and provide additional information. Appreciate everyone's input and comments here. Silvia, it looks like you have your hand up.

MEMBER YEE: Silvia from DREDF. I think I am probably just going on from what Ignatius and others have said. Because I look at this and I, yes, absolutely agree, patient experience is core, it needs to be included. These questions seem very much oriented towards thinking of the patient as an individual who may or may not complain, particularly complaining about a provider, and not necessarily getting at the patient's experience of systemic barriers. Which I think is what we are trying to get at with the health equity, recognizing that there are systemic barriers.

I can be happy with my specialist but it took me four months to get there. I can be quite, I can actually not be thinking, I get along pretty well with my primary care provider, I don't want to complain about them, they always want to see me in my chair, or they are really, really, really reluctant to get a sign language interpreter for our appointments. Or they are always talking to me instead of to my son who I accompany and my son has a developmental disability.

And it is sort of the range of systemic problems. Or, you know, they always refer to me by the wrong gender. These are all these sort of systemic things that are not caught here that are all really relevant to health equity. Yeah, maybe it is just the wrong survey questions that are here but something to keep in mind, even though CAHPS is such, so core to so much of health measures.

MS. BROOKS: Thank you. Thank you, Silvia. Kristine.

MEMBER TOPPE: Yeah, just a quick point of clarification. There

is an additional language, Chinese, that the CAHPS survey is translated into but apparently it is not quite used as often or consistently by plans. And so that is really -- it is still only English, Spanish and Chinese.

MS. BROOKS: All right. And Cheryl.

MEMBER DAMBERG: So on a number of these points. A part of the challenge the plans have had about using the other languages the CAHPS has been translated into is they don't necessarily know which of their members speak which languages. So I think there would be greater use of those surveys in other languages, you know, if plans knew that.

Now, we have done work for CMS where we can predict the probability that someone is Spanish speaking, and have done double stuff mailings of the survey, both in English and a Spanish version. And that has bumped up response rates considerably because it does really get at some of the people who may otherwise face a language barrier that the plan would not have identified if they were just sending out an English language version. So I do think that there are things that could be done vis-à-vis the implementation of the survey to try to address some of these concerns.

I would also note, per Silvia's comment. I agree that, you know, it may not get at some of the granularity of some of the issues that may be critical for certain subgroups. However, I do think that for things like, you know, specialty access, and so this kind of takes me back to, I think we are kind of short on access measures. It does address that particular issue. And that particular issue, you know, for decades now has been a critical problem for all populations, to be able to access specialty care.

And then I think the last thing that I would note is that, you know,

the survey is designed to be fielded among a random sample of members from the plan. And it asks about both plan-specific issues or areas such as customer service and getting needed help and information, but it also asks about the care they receive from that plan's contracted providers. So I hope people will keep in mind that I think we want both aspects covered because the plans are ultimately accountable for the provider networks that they contract with.

MS. BROOKS: Thank you, Cheryl. Shaini, do we have any hands for public comments?

I don't see any public comment in the room at this time. So we are going to go ahead, I am sure people will be happy, and take a quick break. It is 2:40, sorry. So why don't we come back at, it is a little bit after 2:40. Why don't we come back at 2:55 and we will see you all and continue conversations then. Thank you.

(Off the record at 2:41 p.m.)

(On the record at 2:56 p.m.)

MS. BROOKS: All right, we are going to go ahead and get started and talk about population health disparities. We have two focus areas remaining, both very important areas, and so want to get into some discussion on those. I am going to turn it over to Ignatius who is going to take us through population health disparities.

MR. BAU: Sure. The focus area here is, you know, trying to take this even beyond prevention and talking about health. And so we know that there are higher rates of obesity among Black, Latinx and American Indian and Alaska Native Californians; that there are lower rates of receiving flu shots and pneumonia vaccines among Black and Latinx Californians; and a higher rate of

adults who smoke among Black, American Indian and Alaska Native Californians. So some of the measures are going to try to address some of those potential issues.

DR. BASKIN: Thank you. It's Andy Baskin again.

As you can see we have three measures that, green measure criteria we use in the current programs. Let me just point out a couple of things to you. The first one is it is Adult Body Mass Index Assessment. This simply means what is done. It has nothing in this particular measure about any follow-up, it is just did a body mass index assessment occur. And if I am not mistaken this measure is being retired. I will get back to that in just a second.

The second one is flu vaccinations in adults, for adults. And this is the measure, it has been out for a while, which is based on the CAHPS survey. This is actually how adults answered the question, did you get a flu vaccine in this year.

The third one is immunization status, which is actually a measure that is a not done through surveys, it is done through the usual process of getting data through claims and however else of immunizations of four different vaccines that are appropriate for adults. The influenza vaccine or flu vaccine; the tetanus-diphtheria vaccine or tetanus alone; the shingles or the herpes zoster vaccine; and the pneumococcal vaccine. All these are recommended for adults. And if I am not mistaken, they are all, they can be reported as a group but they are all reported separately as well and you could work with that if you think that that is appropriate to do that.

Now getting back to the obesity or adult BMI assessment. I just want to be careful here because we have expressed an interest in adult obesity-

related measures in other meetings. And while none of those other measures are being used in the current programs in California there are some other measures that we should be aware of. There are some Minnesota Community Measurement measures you will see in your, in your workbook. Those are new measures, however. They were just really developed within the past year and have not actually been completed measurement yet. And they are very specific measures, they are not just necessarily general. There is not necessarily a general measure of doing body mass index. And then a follow-up plan.

There is a measure that is used by CMS which is adult body mass index screening and a follow-up plan. So there is some documentation that something did occur in the encounter that says you have been referred or, you know, something, some action has been taken beyond just measuring the BMI. Sort of an acknowledgment with the patient that the BMI is elevated and something should be done about it.

That particular one is used in the MIPS program today but it is not used, currently reported by health plans; it generally is reported by physicians because that is what the MIPS program is. So it is a physician level measure and it has not necessarily been tested or, or the specifications adjusted as needed to use in the health plan level. But it is such a measure that exists.

It would sort of be the equivalent to the child and adolescent measure that we already spoke about and put on our candidate list but that is only an age 3-17 measure and this is -- it is children and adolescents, I forget what it is, 17 to 21. But this would be an adult equivalent to it. But once again, not (indiscernible) but I wanted to make people aware of it so that they know what is out there if they want to include that in a discussion. Thank you.

MS. BROOKS: Thank you, Andy and Ignatius. We will open it up for comment and I see Kristine has her hand up to start.

MEMBER TOPPE: Hi. And I apologize because I thought I had gone through and done a thorough review. It looks like we have proposed flu vaccinations for adults. I think this is what you proposed from the CAHPS, as a CAHPS measure. That we proposed that the 18-64, 65 and older and pneumococcal vaccination status for adults, as CAHPS measures be required. And they are modifying the adult immunization status measure to reflect the, kind of the capture of that data through, through a traditional HEDIS measure. And the rationale being that it is kind of a better source of data versus a patient recalling it. I apologize that I did not catch that before. And it is -- that would have gone out for public comment in February. I will know by next Wednesday of the decisions -- everything is being proposed and sent to the board on next Wednesday.

MS. BROOKS: Thank you, Kristine, that is helpful information and context, thank you. Kiran.

MEMBER SAVAGE-SANGWAN: I will apologize in advance for not having thoroughly reviewed the materials. But I thought we already discussed the immunization status and included it in prevention or something like that. Like these, these look really familiar to something we have already discussed in another section so I just want to check on that.

And then my second question is whether the flu vaccination is included, is it part of adult immunization status?

MS. BROOKS: For question number one I can answer. Yes. So you are not having false recollection, Kiran, we did talk about this previously.

And actually, it was just raised in a conversation that we should talk about it later, which is why we included it in a later, or in this focus area here. So there was some minimal discussion but we hadn't landed on anything specifically.

With respect to your question on flu vaccinations for adults I am going to turn to my clinical friends and see if they.

DR. BASKIN: Yes. So I am not sure that -- maybe I didn't make it clear or perhaps you can be more specific with your question. This is Andy Baskin. So there, there are currently two potential flu vaccinations, vaccines. One is through the survey, which is the one that has been done through the CAHPS survey for years. But the newer one is the adult immunization status. And as Kristine pointed out, that is one that is done on administrative data. It is actual data. Did someone actually get a claim for the vaccine? It is included in the immunization status of one of the four vaccines. But it can be reported individually as just the flu vaccine or who received all four vaccines or who received any one of the individual wants. I am not sure I am answering your question. Is that helpful?

MEMBER TOPPE: The flu one is, this was actually included in the materials they sent out yesterday and a link to the proposed public comment and it is under proposed changes to existing measures. I put it in the Chat but I know that that is not the protocol. But I can read it if that is helpful.

MS. BROOKS: Sure.

MEMBER TOPPE: It assesses whether adults are up to date on routine immunizations for influenza, tetanus, diphtheria, a cellular pertussis, excuse me, and/or tetanus and diphtheria, zoster and pneumococcal disease. NCQA proposes updating the pneumococcal indicator to include two new

vaccines and expanding the age range for reporting across commercial Medicaid and Medicare plans in accordance with vaccination guidelines; 18 and older for influenza and DTaP, 50 and older for zoster, and 65 and older for pneumococcal.

MEMBER SAVAGE-SANGWAN: I think that answers the question, thanks, Kristine.

MEMBER TOPPE: Sure thing.

MS. BROOKS: Thank you both. Alice.

MEMBER ALICE CHEN: Hi, Alice Chen from Covered California. Apologies, I just got back on after being off for another call, to see the slide about BMI being used for Covered California, so just wanted to ask about that because it is not in our QRS Measure Set and we haven't been prioritizing it in any way in terms of our quality programs.

MS. BROOKS: So this is a good point you are making, Alice. We will go back and double check where we found that information but thank you for clarifying that. And we do appreciate it and apologize if there was any confusion on it. I think it was in -- okay.

MEMBER ALICE CHEN: Oh, no worries, no need to apologize, just wanted to clarify. Thanks.

MS. BROOKS: Thank you, Alice. Other comments or questions on these measures in the room or from the Committee Members?

MS. BROOKS: Shaini, do we have any public comment online?

Do we have any public comment in the room on any of the population health measures? I see, Ed, you raised your hand.

MEMBER JUHN: Ed from Inland Empire Health Plan. Just for

going back to the flu vaccine. It might be helpful to clarify how we are addressing this. If it is just capturing flu vaccination for adults. Because the flu vaccine is available at retail stores or virtually any other sort of location where they can offer it, getting this information back to the plan to then stratify and then report back on might be something we'd have to consider when we think about benchmarking.

MS. BROOKS: Silvia.

MEMBER YEE: The adult body mass index, just the obtaining of it, it is not stratified information? Really? It just seems like such a -- I have always kind of wondered. It just seems like such a basic thing to me and it should be -- you think it could be retired. Except that I have also, also, always been acutely aware that people with mobility disabilities tend not to get their body mass index. And in terms of stratification, I mean, this does seem like one that should, that we should have stratified information for. It is just not available?

MS. BROOKS: Well, I think, and Ignatius, I would look to you, but I think that today the measure is not stratified, at least in California, specifically. Sorry.

MR. BAU: And I think part of the issue is, yes, it should apply to enough people that it should be stratified. But I think people are moving away from simply the assessment measure and wanting a more complicated measure that is about assessment intervention or assessment and referral to appropriate treatment or something else. And that is the place where we should be looking for stratification.

MS. BROOKS: Does that answer your question, Silvia? We are not trying to play musical mics, I promise.

MEMBER YEE: Yes, I mean, it does. So those, those other ones, something, something related to getting body mass index, and, and follow-up. But that is not here as a recommendation.

MR. BAU: So again, if folks go to the workbooks.

MEMBER YEE: Yes.

MR. BAU: The ones that we are presenting are ones that are currently used in California programs or nationally used. But in the second tab in each workbook it says All Population Health Measures are the measures that Andy referred to, some developed by Minnesota, some being -- a new one developed by CMS, which does have the body mass index screening and follow-up. And the committee is welcome to pull those measures up for consideration.

MEMBER YEE: Right. Okay. I would be interested in having something like that, something as basic as a body mass index and some kind of follow-up that can be stratified. That is what I would be interested in here.

MS. BROOKS: Diana.

MEMBER DOUGLAS: Thank you; Diana Douglas with Health Access. And not to be repetitive but that was actually what I wanted to flag was looking at the second tab in the Excel Population Health Measures and seeing the obesity blood pressure control, for example, which I see is one of the Minnesota measures. And just apologies if I, if I missed this, but just you know, what would be entailed in -- is that the only reason that that wasn't included in the list of green measures, because it is not currently in use in California and what would be entailed in pulling that up and potentially using it for our purposes? I am just not sure how, you know, feasible or involved that would be but it seems like something like the obesity, blood pressure control might be a

little bit more nuanced than just the BMI measure.

And then my second comment was just looking at the flu vaccinations versus adult immunization status. Since adult immunization seems to encompass flu vaccinations, it seems --and is at least a candidate for stratification that seems like it would be a more useful overall measure.

MS. BROOKS: Thank you. And I think just to respond to you, the reason that it wasn't included was simply because it didn't fall under kind of the different assumptions kind of that it is not being used in California, it is a newer measure, for those reasons. But I have taken note that you --

MS. MYERS: Sarah, Sarah, this is Janel Myers. I just wanted to add, part of the reason is those Minnesota measures are using, they have specific data collection and it was just we found it difficult for the MCOs in California to report on those measures when there is just different expectations. Because the obesity measures are built out of the Minnesota Community Measurement Program so there's just different reporting requirements as part of it as well.

MS. BROOKS: Thank you for clarifying that, Janel. Doreena has her hand up.

MEMBER WONG: Yes, thanks, Doreena from ARI. I guess I would support Silvia's recommendation, you know, to, to look at the other version of this that looks to not just the adult body mass assessment but to the treatment and to stratify that. Because if we are trying to get to outcomes and addressing health disparities we have to, whenever we can, I think I have said this before, try to stratify as much as we can by race and ethnicity, to be able to address the disparities, so to even identify the disparities and then try to address them. So I

would support that, her suggestion to do that.

And then I did have just a question in the adult immunization status. I know that these are what have been used. What has been included has been what is used in the past. But is there any way to kind of adjust things? Because I think, you know, looking at even COVID-19 vaccinations would be useful to look at as well just to keep it up to date with what is really happening in terms of public health in our state. Thank you.

MS. BROOKS: Thank you, Doreena. Cheryl.

MEMBER DAMBERG: I just wanted to make a comment on the body mass index measure. One of the things now that there are electronic health records in most practices, you know, that is part and parcel of the collection of height and weight information so it pretty much gets populated automatically at each visit. So I think you might be hard pressed to see much differentiation, either across plans or possibly by subgroups, because, you know, it is a kind of standard first step. So, you know, in an ideal world we'd, you know, either focus our attention elsewhere or to the earlier point, you know, on what is being done, you know, once you identify somebody who has a high BMI.

MS. BROOKS: Thank you, Cheryl. I am not seeing any other hands. I am just going to check to see if there's hands raised online for public comment.

Do we have any public comment in the room?

I am going to summarize, then, kind of what I have heard from you all. There is an interest in making a recommendation around a BMI with follow-up measure in the report.

There is an interest, I heard, in moving forward with the adult

immunization status measure.

And that there is some interest in looking into a little bit more the obesity, blood pressure control measure that Minnesota is utilizing and seeing if it would be possible to utilize in California.

Am I misrepresenting anything here?

DR. BASKIN: It's Andy Baskin. No, you're not misrepresenting. But I just wanted to remind everybody because I think Kristine said it on the phone that NCQA is actually, that obesity with follow-up measure that they are going to be voting on in the very near future.

MS. BROOKS: Yes.

DR. BASKIN: Would, I believe, be equivalent to the measure that is in the book here that is being used under MIPS. But if that does happen you may find the NCQA measure will be a much easier one to utilize because we will be doing it by their specifications. So we shouldn't throw that out. We should just remember that that would also solve what I think the Committee has been asking for.

MS. BROOKS: Perfect. Thank you for flagging that. And I believe Silvia has a comment.

All right. So we are going to move on to health equity. Ignatius.

MR. BAU: So in health equity we had to slightly modify the green measure criteria because there are no health equity specific measures being used in any program. That there are increasing requirements to stratify the data by race and ethnicity at least but not necessarily to address health equity more broadly. So what we are suggesting by looking at a number of measures, there are some ways that we can get at health equity from more of a structural and

organizational level, while we think the Committee might also consider, as it has throughout this discussion, which measures could be stratified by race, ethnicity and other demographic data. So I will turn to Andy to discuss the four measures that we identified.

DR. BASKIN: Well, yeah, I mean. You may be the better one for this one. The only one I am aware of is the --

MR. BAU: So a lot of, there's been a lot of attention on screening for health-related social needs and NCQA has a proposed measure. As Kristine mentioned, there are a number of measures being proposed for next measurement year.

There is also the Health Equity Summary Score that Cheryl referred to in her presentation at the first meeting.

And then there are these two HEDIS measures, which simply are a numerical count, that show what the race/ethnicity, diversity of health plan membership is.

And what the language diversity of health plan measures.

So again, it is not necessarily going to move you to improve quality but at least you will have a baseline if those measures are included.

MS. BROOKS: Thank you, Ignatius. All right, I see, Cheryl, you have your hand up.

MEMBER DAMBERG: Thanks. So one measure, and I think it was still sort of in the early stage when I was describing the HESS measure. So CMS is going to move forward with another measure that we helped them construct, which is the Health Equity Index Measure, and it is quite adaptable to include whatever social risk factors you want to include. But it essentially is

measuring how well any plan does with its subgroups.

So it is not comparing, say, Black patients to white patients or Hispanic patients to white patients. It is basically saying, let's say for example, among disabled patients, how well do you do in serving those patients across the different performance measures? So you look at how well you are doing immunization or cancer screening for disabled patients and you create a essentially a composite measure of these individual measures. And you could, and I know we are going to get to the conversation about a benchmark. But you could compare this against some benchmark and, you know, classify plans into, you know, different categories based on, you know, how well they perform relative to that benchmark.

So I would like to offer a friendly amendment here for the Health Equity Index Measure and I could supply the staff with information on that measure. It has been published in the CMS regulations so there is some information out on the street about it.

MS. BROOKS: Thank you, Cheryl; we will definitely follow-up with you. Alice.

MEMBER ALICE CHEN: Alice Chen from Covered California. So a few thoughts. One is this is obviously a critical and foundational area for health care, for DMHC, for California, for this Committee.

I would say a couple of things. One is social needs screening is, I think, really important. There is a lot of work ongoing in this area. CMS has out for comments a measure that was approved by the -- off the Measures Under Consideration list. Right now for the inpatient program, is also proposing it for the MIPS program. NCQA has a slightly different measure. There are other

groups that are pursuing other slightly different approaches.

As important as this is, I think it is really important that we not contribute to the kind of 1,000 flowers blooming and that we really try to stay within the confines of things that are established. Particularly given that DMHC, its tools are more regulatory and are a little less nimble than what typically is ideal in a quality improvement setting.

And so what I would say is, I don't know enough about the RDM and the LDM. If they are solely counts and you can't actually use that data to stratify by race, ethnicity, and language the clinical or utilization or access measures themselves, then I am not sure how much utility there is.

My personal recommendation, given what we have been through at Covered California, again, in partnership with DHCS and CalPERS, is to focus on a, you know, discrete parsimonious set of measures and then look at it through the lens. And make sure the measures are disparity sensitive and are large enough so that you can actually stratify by race, ethnicity and language, and then really target and address those disparities.

And so it doesn't, you know. It is kind of starting in a place where we can really provide focus and direction and as a state hope to see changeable change. So I would actually veer away from this approach and move more towards applying an equity lens across all the other measures that we have been talking about.

MS. BROOKS: Thank you, Alice. Kristine.

MEMBER TOPPE: Did you say, Kristine? Okay.

MS. BROOKS: Yes, thank you.

MEMBER TOPPE: Okay, thanks. I would second Alice's

comments.

The social needs screening and intervention measure, just given the timeline, this is a new measure. We are expecting it to be cleared and approved by our board next week but it won't have -- and the first year of data, it is, you know, it is for measurement Year 2023, it would be reported in 2024, evaluated and not really kind of ready for implementation for any kind of a, I think, probably a meaningful evaluation until 2025. And I know that is the first year that the reports will be expected to be generated. But I just kind of put that in with the caveat that, you know, it is a new space. And there is a lot of kind of data and interoperability issues that go along with reporting that measure as well.

And it was great that we have the data exchange framework folks on to kind of talk about the intersection of all these different data sources that are going to be necessary to come together to report things like this. But I would just, I think that for the purposes of what we are trying to get done here, it might be a bit early.

I just wanted to also add with measures 3 and 4, the RDM and LDM measures, those are things that we have kind of had longstanding in HEDIS. They are, you know, very much just kind of, how are they doing at collecting this data. They are required as part of the existing accreditation requirements that are at play in California. By virtue of the NCQA requirement so you are getting that regardless, I would say, from the standpoint of that mandate being more or less across the board for California plans.

And I think that, you know, Alice's point about the fact that in addition, in addition to all of that, because the plans will have to report the five measures that NCQA chose last year, which are colorectal cancer screening,

high blood pressure, hemoglobin A1c, prenatal and postpartum care and child and adolescent well-care. So those are all slated for stratified reporting for NCQA. So all the plans will have to do that by virtue of those mandates that already exist.

And I do think it gets at this issue of health equity in the way that the Committee is, is really trying to kind of tackle it, which is -- and the points I think Cheryl made earlier around, you know, you are getting at disparities across different kind of categories of care. So just wanted to make those points. Thank you.

MS. BROOKS: Thank you, Kristine, very helpful information. Doreena.

MEMBER WONG: Yes, Doreena Wong, ARI. I think I have a slightly different perspective about, you know, what we should, how we should move forward with relation to these health equity measures. I think this is an opportunity for California to be leading rather than waiting. You know, although I agree that some of the measures that we will be looking at, and if they are stratified by race and ethnicity we will get to some of the health equity issues.

But I think that the referrals, the social determinants of health screening and referrals, I thought was a really good measure, actually, to try to use. I think we can, you know, start to collect that data and we should be starting to collect that data because we have recognized, especially with this recent public health emergency, the need, in particular. I mean, we have kind of recognized this need for years but finally, I think we have got some real tension on this as a result of the pandemic.

Then in relation to the other, the other measures. This is when I

am -- to I think this is our opportunity to get to some of the language access issues that I was mentioning before. Rather than the, the question, the RDM question about the diversity of language by the plans, I think that there, there are a couple of other, the language diversity of membership.

I think there are two other measures, at least two other measures that are better that I saw. The meaningful access to health care services for persons with limited English proficiency or even the, I think it was the what is the -- what is it? The patient is receiving language services supported by qualified language services providers? I think we are still hearing issues around people getting language services, including interpreters so I would like us to be able to measure that or to try to see how the plans are doing with that. So those would be my particular suggestions around these two measures.

Oh, and I also liked the other measure that was not selected around the cultural competency implementation. Because again, I think we are starting then to get to really some of the health equity issues and the health disparities that we are trying to get to as a committee.

MS. BROOKS: Thank you, Doreena, just taking notes. Also checking on. All right, I see Dannie has.

MEMBER CESEÑA: Hi, this is Dannie from the California LGBTQ Health and Human Services Network. A measure I just kind of wanted to bring up, especially as we are talking about health equity and ensuring that the LGBTQ community doesn't get left behind.

The Human Rights Campaign every year releases their Health Care Equity Index and it is a national LGBTQ benchmarking tool that evaluates health care facilities' policies and practices related to the equity and inclusion of

their LGBTQ+ patients, visitors and employees. And you can even break down the report right down to your local facility because over 2,200 health care providers and agencies participate in this report every single year. So I am going to go ahead and drop the link in the Chat for review and for this to even be considered to pull some of their measures.

MS. BROOKS: We will, we will email you and get that information from you, no worries about putting it in the Chat. Oh, it is on. Ignatius has a comment. Is it in our resources?

MR. BAU: Dannie, it is actually in the specialty focus area measures. And the challenge with that is the index currently is really structured for hospitals and health systems and so if we were to -- the Committee were to recommend it you'd have to look at the measure and see how it might apply to health plans.

MS. BROOKS: Kiran.

MEMBER SAVAGE-SANGWAN: Yeah, thanks. I think a couple points to sort of denote what other folks have said. One is that I do agree with Doreena, this would be an important place to actually look at language access and access to interpreter services and appropriately translated materials. And it did look like there were a couple of measures not necessarily widely used but options in the workbook that we can look at.

The other thing is, you know, while I appreciate the importance of social needs screening and intervention, I don't want us to conflate that with health equity because doing that screening on its own is not health equity. And I am not clear if that is a measure that is proposed for stratification by NCQA or not, but if not, it definitely you know, for me wouldn't fall in this particular

category, while, again, I think it is important.

The third thing is I am wondering, you know, I know this might be a little bit outside the scope of the Committee, but as opposed to trying to pick a couple of measures for this could we advance our recommendation that health plans be required to obtain the NCQA health equity accreditation? And I don't know if Kristine could just say a little bit more about which of these issues are covered in that accreditation, because to me that just feels like a more meaningful and also cleaner way of addressing the health equity measures, most of which are process measures anyway.

MEMBER TOPPE: I am happy to answer that if it is appropriate?

MS. BROOKS: Yes, please, go ahead.

MEMBER TOPPE: Okay. Thanks, Kiran. You were reading my mind because I failed to mention that as another kind of facet of this conversation. Both Covered California and Medi-Cal have requirements as part of their accreditation requirements that the health plans go through not only health plan accreditation with NCQA but what is current, what is as of June 8 our Multicultural Health Care Distinction but which is evolving into health equity, accreditation.

And much of what we are talking about here in terms of cultural competency and being able to really like look at, look at your population, understand who you are serving and what you need to do to serve them in, you know, in a diverse way that is equitable and inclusive, that is the intent of this accreditation.

And so I think that, you know, it is certainly something. Across the country we are seeing state agencies, both on the Medicaid side, Covered

California, the Exchange, the DC Exchange is considering it, we are seeing departments of insurance in different parts of the country consider it. The NAIC is considering it as part of recommendations from -- at the federal level for qualified health plans.

So there is a lot of interest in that as an approach. And it is not a measure, per se, but it does include that kind of bigger evaluation of does the organization have the structures and processes in place to really get at those issues that are, that we are all talking about today in terms of not only data collection but actually taking action to address disparities.

MS. BROOKS: Thank you, Kristine, for that follow-up information. Bihu.

MEMBER SANDHIR: I actually have a question; it was for Cheryl, I think. I just wanted to understand about the Health Equity Index a little bit more. You know, what is CMS requiring? Because I think that is something, is that something that we may be able to adopt? I just wanted to understand if it is possible to share some of that?

MEMBER DAMBERG: Sure. I can send you the text that is in the regulation where they describe what they are doing. So CMS has sort of expanded its effort, particularly in the Medicare Advantage space. First and foremost around stratified reporting of performance scores and doing that for a much broader set of measures than, say, the initial five, I think it is, that NCQA indicated that they were proposing to do starting in, is that measurement Year 2023? But anyway, so they are going to be doing the stratification of each individual measure.

But in addition to that, they have been working to construct an

overall kind of summary score, a health equity score, that would be used as part of their star ratings incentive program. And it would include both the clinical measures such as the HEDIS measures or the Pharmacy Quality Alliance measures as well as the CAHPS measure. And as I noted, each contract would be scored.

The performance on each of those individual measures for each of the different social risk factor groups would be computed and then would be summarized. They are applying weights similar to the weights they currently apply to different types of measures in the program. So, for example, we said historically patient experience measures have been given like a weight of 1.5 or 2 and outcome measures given a weight of 3, and so they will combine this.

The difference between the Health Equity Index and the HESS score, and I know it was a long time ago that we talked about the HESS, is the Health Equity Score focuses just on performance for those with social risk factors. And it is this composite measure and you can choose to, you know, weight the measures equally or you could weight them differentially based on, you know, differential importance of the measures.

The HESS score combines both absolute performance as well as improvement so they have, you know, slightly different constructions and there is nothing to preclude, you know, possibly implementing both. But I am happy to share with staff, you know, what was published in the CMS draft regulations so that people could see a little more information on the Health Equity Index.

MS. BROOKS: Thank you, Cheryl. Alice.

MEMBER ALICE CHEN: Alice Chen from Covered California, again. You know, I, you know, in listening to this discussion I just did want to

step back and kind of go back to the organizing principles in terms of our charge to land on a parsimonious set of measures to really drive improvements in health and reduce disparities. And to that end think that choosing proven, established, available measures that build on existing efforts, like those of NCQA, will give us the fastest glide path to achieving something that we can measure.

And so I would say, you know, referring back to, to Kristine's comments around NCQA already requiring, it is in flight already that certain HEDIS measures that are disparity-sensitive have to be stratified by race/ethnicity is something we should think of as part of this health equity, even if it is not a specific measure. It squarely belongs here in terms of how we are thinking about health equity.

And then, in terms of, you know, I would veer away from measures that are process versus outcome. And to that end, I think that looking at a requirement around NCQA health accreditation, health equity accreditation, is something we could look at and recommend, even if it isn't a measure, per se.

And if it is helpful, Covered California did engage HMA to do an analysis of the benefits. Because again, we are very cognizant that we don't want to increase administrative burden on health plans and providers and really we are very deliberate about whether to require that of our health plans. And based on the report that HMA did for us, did decide that this would be an important lever to advance the health equity agenda. So happy to share that if that is helpful.

Just two other thoughts. Doreena, you know I have been working in this area for a long time and I think part of where I come from is, I have been on the bleeding edge in the past. It is good to be on the cutting edge, it is not

good to be on the bleeding edge, because then you end up having to backtrack when the national standards coalesce. And so I just want to warn us against going down a path where we are -- as a recommendation to DMHC in particular, which again, regulatory agency, a lot of this will be baked in for many years to come, things that are not proven and vetted and well established already.

And then lastly, just to address -- I am trying to remember who -- Diana about the social needs. I can't agree with you more that there is some confusion right now around social needs and equity. But I will say, in the end when you step back, health related social needs are about poverty and how much poverty has been racialized in this country and I do think it is a both and -- and I don't think it is ready for prime time. But I do think it deserves to be in the mix in terms of ongoing discussions around health equity, particularly given not at this level, at a statewide level.

But once you kind of drill down to the point of care, some of the levers that are needed to address health disparities really do tie back to knowing about social drivers of health and social risks. And then at a health plan and health system level I think that data on an aggregate level is really important for resource allocation and planning. So some -- sorry that part of it is a little bit adjacent to our conversation about measures but I would really encourage us not to be on the bleeding edge, to be on the cutting edge. Which all of this is, by the way. And then also think about the health equity accreditation.

MS. BROOKS: Thank you, Alice. Ed, I see you have your hand up.

MR. BAU: Hi, this is Ed, Inland Empire Health Plan. I echo Alice's comments. I think potentially having an opportunity to leverage the NCQA health

equity accreditation process from a plan perspective might be a way to fulfill the requirements of the state. If not the entire accreditation at least pieces of what those requirements are as a starting point could be a option.

I also think that what is important about this measure as a collective group is that with the recent APL requirements to have a chief health equity officer in place by 2024. My thinking, again, would be if we had an opportunity to leverage an existing sort of, you know, NCQA accreditation type approach it might also help streamline some of the requirements, you know, from the APL and the duties of the Chief Health Equity officer may or may not need to address moving forward.

MS. BROOKS: Thanks, Ed. Palav.

MEMBER BABARIA: Hi everyone, Palav Babaria, DHCS. Just wanted to double down on some of the comments that Alice made. Similar to Covered California, we at DHCS will be requiring health equity accreditation of all of our managed care plans with the new managed care contracts and the timeline that they specify.

And I think a lot of our rationale was very similar that to do the health equity work well there are a number of process measure considerations. I think just picking one in isolation always felt sort of not sufficient and so what the health equity accreditation, at least for the Medi-Cal program, allows us is a standard foundation that we can guarantee across the state via all of our managed care plans for how this work will be done, at least what the floor looks like, not necessarily the local adaptation and innovation that comes on top of that. So definitely encourage us to think about that. And, you know, at least a good portion of the state will already be doing it between Covered California and

Medi-Cal requirements.

Also, second, that there are clear outcome measures with clear, documented, especially racial and ethnic disparities but other groups as well, that are ripe, I think, to really think about using as a health equity measure. And NCQA has done a good job identifying sort of the highest priority ones, which we in the Medi-Cal program have also adopted as our health equity measures for this year for stratification by race and ethnicity in addition to a few other high-priority measures. So agree with all of those comments.

I think just to deepen Alice's comment about racialized poverty in this country. One thing that we have noticed in the Medi-Cal program is when we look at our data, yes, we have differences within certain subpopulations within the program. But those differences are very small compared to the differences we see when we are comparing the Medi-Cal population, which by its nature of how it is defined is a low-income population living in poverty, with, you know, other populations such as commercially insured populations, or looking at duals as opposed to just Medicare-only populations.

And we have clear, huge health disparity issues across the state by payer and by income level and I would just -- you know, I don't have a solution to this but I think as we are thinking about health equity -- and some of those interventions are obviously beyond the scope of a single plan. But figuring out how we don't lose sight of that and how for all of these measures we can sort of compare and look at where we are as a state across different payer types will be really critical.

MS. BROOKS: Thank you, Palav. Alex.

MEMBER ALEX CHEN: Hi, everyone, Alex Chen, Chief Medical

Officer for HealthNet. I want to provide a little bit of context of some of the suggestions that have just been mentioned, and obviously I am in agreement with them.

We are the first health plan to get the health equity accreditation this year and we are, you know, 90, 95% there, I think. And we also have a Chief Health Equity Officer reporting to me for all three lines of business.

What I can say is that both of these steps, you know, help us structurally to address in a systematic fashion sort of health equity gaps that we would like to address in our membership. So I think these suggestions are, you know, pretty meaningful in the sense that, you know, if we look at Donabedian's model for health care progress and improvement, it really follows the structure, you know, process and outcome approach, right?

So I think health equity accreditation and health equity officer roles are structural implementation that is really helpful to build a foundation at the beginning of this movement. And then as we are developing measures, which is a process to help against the costs, and then eventually we will be able to see a change in outcome in health equity.

So I certainly will support those recommendations. It is just that I am not sure. You know, if we -- these are process -- I mean, these are structural changes that will benefit everyone but it doesn't really distinguish between health plans or other, you know, entities in terms of advancing the movement. But I do think it is a necessary and important fundamental first step.

MS. BROOKS: Thank you so much for your comments, Alex. Diana.

MEMBER DOUGLAS: Thank you, Diana Douglas with Health

Access California. I appreciate the discussion on the potential for inclusion of the NCQA multicultural distinction. I did just -- I would be remiss to not point out here, as Health Access has in other spaces as well, just some of the gaps that can exist between California standards and what California sets out to do versus some of the national standards such as NCQA. And I think if we, if we were to go that route of including the NCQA distinction as part of our measurement, would like to have a discussion to some of the gaps that may be there.

So I appreciate Alice's point on, you know, being at the cutting edge but not, but also using measures that are tried and true and are reliable and, you know, that are going to provide a strong foundation. But from, from my understanding, though, there are some details that could be left out or some measurements that could be left out, particularly around sexual orientation, disability, and other groups that might not be captured there.

So while it is good for some areas, particularly looking at racial and ethnic disparities, it might be something that falls a little bit short of at least where we would aspire to get to. Now whether or not there is a better alternative to that, I don't know. But think that we should try to at least have the standard of addressing some of those gaps and making sure that we are not sort of selling short the ability to find measurements to capture some of these other areas as well.

MS. BROOKS: Great comment, thank you. Kiran.

MEMBER SAVAGE-SANGWAN: Yeah, just quickly because I thought Palav have made a really important point about the disparity between Medi-Cal and non-Medi-Cal and I am wondering if we can sort of put a pin in that for when we talk about benchmarks. And if there would be an opportunity for

plans that do have multiple lines of business, including Medi-Cal, for some of the sort of equity benchmarks to be about that disparity in addition to the racial inequity of racial and ethnic stratification benchmarks.

MS. BROOKS: Taking note of that. Julia.

MEMBER LOGAN: Yeah, hi, Julia Logan, CalPERS. I just wanted to, quick note that while our new five year contract with our health plans is in the works with our RFP process going on right now, so we haven't solidified our requirements yet, but we are looking to align with Covered California and DHCS. Certainly around accreditation and specifically looking into NCQA accreditation and health equity.

MS. BROOKS: Thank you, Julia. Kristine, I see you have your hand up.

MEMBER TOPPE: Sorry about that. Sorry about that. I wanted to just clarify, I think it was Diana had a question or a comment about like the gaps. And I just wanted to note that we do recognize that the disability community isn't necessarily captured fully or completely at all in the way we have currently structured our, the current version of our programs. I would like to -- and that is on -- we are very aware of that. We are very much focused on it as, you know, a priority area for us to explore going forward. The existing program does require SOGI data collection. So I just wanted to kind of clarify that point for the group.

MS. BROOKS: That information, Kristine, very helpful. Silvia. Pass her a mic, yeah.

MEMBER YEE: Thank you. I am sort of going back and forth in my head about some of what Doreena brought up before. And I think that my -- I would really prioritize stratification, stratification. And it seems to me that is

something, that is a strength that DMHC can bring, this kind of, we want plans to stratify. We want you to stratify by race. The information you get by race, ethnicity, by SOGI, by age, gender, disability. Because until you have that evidence of disparity the disparities don't exist. The population doesn't exist as a as a population that is subject to inequity.

And what I have been struggling with thinking about is, does everything have to start at the same place? Thinking about that leading edge and bleeding edge. I think that race, and ethnicity, awareness of those disparities. We have a greater body of knowledge along that. That there is an understanding of, a growing understanding, perhaps advanced beyond what is accepted for disability or other populations of that inequity.

So maybe given that we know this we should be moving towards having measures, health equity measures that look at that, even if we aren't at that place across all population groups. I am just sort of thinking aloud here. And of course there is overlap. Individuals who have different, you know, combine a variety of characteristics and experiences. But beginning somewhere when we have such a gross accumulation of evidence of inequity just seems to make sense, in this state, in this country.

MS. BROOKS: Thank you, Silvia. And I do want to note for everyone that stratification will be a part of our future discussion so that is definitely still on the table and we will be talking more about it. This is an important issue that you have raised so I appreciate it. Jeff.

MEMBER REYNOSO: Great. Jeff, with LCHC. I think, yeah, this is my favorite topic so I think this has been a really fascinating discussion. I think the one kind of population that hasn't been brought up in the conversation that I

think is really critical for us to think about in California is the impact of immigration status on health inequities.

In California nearly one in three Californians are an immigrant or come from an immigrant background; one in two kids live in an immigrant household. And thinking about California being a leader under Medi-Cal and having our state-funded program expansion to that population, there are disparities that, you know, I think, should be uncovered as we think about disaggregation.

So I appreciate the comments around, you know, thinking further than race/ethnicity. We may not be able to get there with this initial 8 to 12 measures that we identify as part of the Committee but I think the report should support us in the pathway of being able to ultimately disaggregate by immigration status and to be able to identify those disparities.

So, you know, I think having some type of conversation, you know, language in the final report that kind of uplifts that immigration stuff, disability status, you know, the SOGI indicators as well, I think would be really, really important.

MS. BROOKS: Thank you, Jeff. And I think I am hearing that theme from many of you so definitely. Just the fact, the importance of including that type of information in the report and that that is coming from the recommendation of the Committee.

I am not seeing any other hands raised in the room. Let me see if there are any raised online. Hello.

MS. GOLDEN TESTA: Hi.

MS. BROOKS: Sorry. Please go ahead. And if you could state

your name and organization that would be great. Thank you so much.

MS. GOLDEN TESTA: Hi, this is Kristen with the Children's Partnership. Can you hear me?

MS. BROOKS: We are not hearing you, Kristen.

MS. GOLDEN TESTA: You are not hearing me?

MS. BROOKS: It is a little bit staticky. Now we can. Go ahead and try.

MS. GOLDEN TESTA: Is this better?

MS. BROOKS: Yes.

MS. GOLDEN TESTA: Okay. Just two quick points about this. I agree on the comments that have been made about the NCQA health equity accreditation, and I would recommend that it be the health equity plus accreditation that comes after one meets the first stage.

And then second, I saw in your workbook a RAND measure that was emerging, not yet approved or endorsed, but it was on cultural competency of care, as another useful measure to be considered. Thank you.

MS. BROOKS: Thank you, Kristen. Other hands Shaini, online?

Do we have any public comment in the room? Yes, please. There should be a microphone up there.

(Public comment in the meeting room was not broadcast through the microphone.)

MS. BROOKS: Thank you. Oh, sir, I am so sorry to interrupt you. I guess we are having trouble with the mic so we are going to give you a different one. It is very important what you are saying, we want to make sure we hear what you, what you have to say.

REV. SHORTY: So the public deserves what we should have had years ago. People look to California for leadership. We can go round and round with surveys, the RAND Corporation, this corporation, that corporation, but yet people are still dying. People are still dying. As we sit here, 91,741 Californians have died. We, the family members of those people, deserve better. And I come here every month because I have lost family members. And I am obese and I deserve better so that my kids won't have to come in this room and sit before you guys and say, we lost our father to COVID-19 because he was obese. Yes, I have taken all the shots. Yes, I get the flu shot notice. My pharmacist advises me better than my doctor do because he wants to see me live. But other people are not as fortunate as I am.

And it bothers us that we continue to go through the cycle year after year of people who say they care, people who say they want the best, but yet they don't provide it. I come from a community that is 3600 doctors short; 3600 doctors short in South Los Angeles. So South Los Angeles is comprised of Los Angeles, Lynwood, Compton, Southgate, Huntington Park. We deserve much better. Where are we going to find 3600 doctors to come into a community that is already under-served. That Medi-Cal don't want to pay. Yet we sit and we talk about the gas prices.

But we have a budget today to do something. We could sit here and talk about measures all day. But they have to be effective measures because people are dying. Literally, people are dying. The longer we keep waiting, month after month, people are still dying, and they deserve to live. Thank you.

MS. BROOKS: Thank you so much for your comments, sir. I am

not seeing any other hands up at this time for public comment.

I am going to attempt to summarize what I have heard. I think, to start, I have heard that there would like to be a recommendation specific to the NCQA health equity -- is it distinction or accreditation? I am forgetting. It's one or the other.

MEMBER TOPPE: Accreditation.

MS. BROOKS: Accreditation, thank you. Accreditation. But that more broadly we also want to include some language in the report around the fact that there are some gaps potentially. You know, Kristine talked a little bit about disability earlier. We can explore and talk with you all about what else might make sense there. Also, we heard about immigration as well and that that is something key that we need to flag. I also heard from you all that there are some measures on meaningful access and patients receiving language services, appropriate interpreter services and materials. So we will flag those measures as well. And then I know that there was an interest in getting a little more information about the Health Equity Index that Cheryl talked about earlier as well.

Is there anything that I am missing from the conversation that we just had? Thank you very much. Doreena has her hand up. Thank you, thank you for flagging that. Doreena, go ahead.

MEMBER WONG: Yeah. And I do think, I think there was -- Kristen from the Children's Partnership and I think I also kind of raised the other cultural competency measure that was, you know, included, I think it was the RAND Corporation, for us to look at as well.

MS. BROOKS: Great, the RAND measure, okay. We'll add that to the list, thank you. All right.

So here is where we are, I am just going to tell you all. So we have moved through all of the focus areas. Accomplishment. I think we should all pat ourselves on the back or do something, but quite an accomplishment. And really, it is, because there has been a lot of great dialogue and conversation, comments, feedback, input and I just appreciate that so thank you all.

We are going to move on now. We have about an hour left in the meeting. What we will start doing is going through the process to narrow the measures to the final set. What we are going to do is kind of split apart thing. So this is a little bit different than the approach that we had thought we were going to take but there is a lot of interest in the CAHPS survey. A lot of interest in learning more about it, one, and then also just understanding what the questions are and kind of making some decisions about which questions specifically we may want, at least, or you all may want to make as the recommendation to the DMHC.

So we are going to table those to the next meeting. And, Cheryl, I hope that you are available because we are going to try and leverage some of your great expertise there in that area; so we will talk with you a little bit more about that.

And then there are some other areas too that, you know, we likely will not go into today that we talked about earlier. So example, low patient experience is obviously one because there is CAHPS. But the utilization one that we change to appropriateness of care I think we are going to hold off on that. So there are a few that we are going to -- so I guess what I am trying to say is we are not going to go exactly by the slides here. We are going to skip some slides, we are going to move through some things, and so we will be clear about

kind of where we are as we move through those and just welcome the, welcome and appreciate your continued engagement as we move through this information.

All right. We are on slide 74. Thank you. All right. So just a little bit of a reminder so we can go to the next slide, thank you.

Well, actually, so we were going to talk a little bit about voting but we are not going to get to voting today. So as an example of how I am going to bypass some information I am just going to bypass that unless you guys want to just sit and listen to me, but I don't think that is the case. All right.

So we are going to move on to Slide 77 and we are going to start talking about different patient and data that is available specific to those measures that you have chosen and then are included on this list. This is intended to really provide you with additional detail and information. And again, as we go through here -- and I recognize that, you know, we don't have the full list of measures yet because of some of the complexities in terms of the discussions we are having.

I just would recommend that you think about, you know, the 12 measures, the 14 measures that you really think you would vote yes on as we move through this process. And maybe there will be more than that. I am not, I am not saying you have to, I am not directing you, I am not directing you on anything here. But point being that, you know, just wanted to kind of give you, give you some food for thought as you move through this process. All right. So with that I am going to turn it over to Ignatius and we are going to start with adult prevention data. Oh, is it Andy? Did I go? I'm sorry. You guys are figuring that out. I see Ed has his hand up so, Ed, go ahead.

MEMBER JUHN: Hi, Ed from Inland Empire Health Plan. Just a quick question. So as next steps for these measures are we going to just think about the 10 to 14 we like or is it going to go through a rounds of votes to narrow it down to a handful?

MS. BROOKS: So what I would say is that we will see what happens with the process. So the thinking would be that we would have, you know, a vote and we would narrow it down to the number of measures. However, it could be -- so okay, we will go back to the voting that we were going to talk about. So I will just remind you all that essentially we talked about the rules of voting earlier on, I think it was in meeting number one. And that is on Slide 75 if you want to go back a couple of slides.

So just a reminder that if a measure receives a yes vote from 60% or more of the Committee, with the Committee being the denominator, it will be considered for the final set. If the measure receives 40-59% of yes votes it will be included on a list for future discussion. And then if it is 39% are yes, it will not be included moving forward. So my point, Ed, there is that some measures might include in this, end up in this 40-59% group where they didn't make yes and they didn't make no and so we may have another vote on those measures, if that makes sense.

Hopefully -- if there are questions about that please let me know. I'm sure it is crystal clear. Silvia has a question. Please go ahead, Silvia.

MEMBER YEE: I just wanted to clarify maybe that when you say the Committee is the denominator, the Committee that is present for the vote or everyone in Committee? A full Committee, even if some aren't here to form a quorum? We have a quorum but some are missing.

MS. BROOKS: Right. Thank you. To clarify the question. So to ensure consistency across all the meetings the denominator will stay the same so it will be the committee of voting members. So for example, there are some non-voting members on the committee, as you know, from the state department and others, so that they would not be counted in the vote, in the denominator. So to be clear, the denominator is 17. Okay.

Did you have a question, Bihu?

MEMBER SANDHIR: I did. I just wanted to know, is there any set number of measures? Do we have, do we have any guidelines or any thought of how to -- I mean, we could have 20 to 30 measures. So the question is, do we have any thought of how do we, should we consider setting a number, at least some kind of a number so that way we -- that helps us also structure how we move forward.

MS. BROOKS: I mean, I think that is a good question and we could open that up for some discussion if that makes sense. But obviously, we are going off the recommendation of what the Committee provides to us but let's open that up for discussion. Should there be a number that you all want to focus on specifically? Is there any comment or feedback on that?

MEMBER SANDHIR: My recommendation is we should have some set number. We may go over one or two, but it is just that otherwise we -- we have discussed a lot of measures and I think it has to be also doable. That is the part that, you know, I worry about or struggle with. So the question is, you know, what standard? I can't tell you that I know the right number but there may be some recommendations, that would be something to think about. What do we have in the past? Even that would maybe help with some legacy, if there is

some legacy data.

MS. BROOKS: Yes, please go ahead, Mary.

MS. WATANABE: Yes, maybe I will just add a little bit of context. As we were, you know, kind of drafting the language and coming up with the idea for this initiative, we met with those that have worked in this space and we kept hearing, don't go more than 10 or 12. Like 10 to 12 was like the breaking point and I think the goal has been really to try to focus the industry on a core set of measures really to move the needle. I think Alice made a comment at an earlier meeting that maybe it should be 5. You have from purchasers that they are narrowing that focus.

So again, we are looking for the Committee to make the recommendation. You all can recommend 30 measures and at some point, I will have to make a decision about what we move forward with. But I would just ask that you are thoughtful about, you know, how do we really focus our energy collectively on a feasible number of measures. And so I think we will be looking for all of you to give your input on what that number is. But that is just some context about what we were thinking about.

MS. BROOKS: Thank you, Mary.

MR. NAU: Sarah, can I add one point?

MS. BROOKS: Yes, please go ahead, Nathan.

MR. NAU: So one of the things that we have talked about internally, Nathan Nau from the DMHC, is we are focusing on, let's just say, 10-12 measures, I will just say that for context. But each purchaser has their own list, which a lot of the measures don't overlap so there is a bigger menu out there and different programs where there's specialized targeted measures for that

program that other folks are working on. Like Mary said, we are looking to come in with a focused set of measures to drive improvement. So that's some of the things that we talked about internally from our perspective.

MS. BROOKS: Ed, I see you have your hand up. Is it in relationship -- Ed, please go ahead.

MEMBER JUHN: Ed, Inland Empire Health Plan. So I guess it depends on how we define what a parsimonious set is, whether it is somewhere between 5-12, for example. Is that something we as a committee should talk about before we vote or is it better to let it organically develop based on how many fall above the 60% threshold and then have a discussion after? It is just more of an opening query on what might work best.

MS. BROOKS: You have a comment, Bihu?

MEMBER SANDHIR: No, I agree with you. I think, you know, we have had a lot of discussion about all the measures and we have had some great ideas and so I think maybe setting at least maybe a maximum goal would be helpful so that way we then are a little bit more thoughtful of how we vote. Because I think that does play into it, of how important is the measure when we are considering it.

MS. BROOKS: So I would ask then, I think, is there a recommendation for a number? I mean, we heard from Mary that 10-12 is usually the --

MEMBER SANDHIR: Twelve.

MS. BROOKS: So we're going -- okay, so I hear the number 12.

MEMBER SANDHIR: I mean, I would go with whatever --

MS. BROOKS: Do anybody have a concern with the number 12?

Doreena has her hand up. Please go ahead, Doreena. Doreena?

MEMBER WONG: Sorry. Doreena from ARI. You know, I completely understand that we can't have 30, we can't have 20, We probably can't even have 15. But I do hesitate to have a maximum number. I am trying to think of what makes sense. Because, because we all have our -- was it Nathan that said -- we all have our own kind of priorities or we have our own constituencies of who we are trying to represent.

And so, you know, I think, I think I would feel more comfortable. We can set a recommended maximum but who, you know. If, if we are coming down to arguing about this particular measure or another particular measure and that would get us like to, let's say we set a maximum of 15 and ended up at 16. I don't want to, you know. I think we should just go with the 16 if it is, if it goes slightly over our maximum, I guess is what I am saying.

MS. BROOKS: Yeah, and I think that is kind of what I am hearing in the room, Doreena. I may be wrong. I am looking around to see if anyone shaking their head no. But just that, you know, we might go with a number but then if there is -- I keep hitting the mic, I'm sorry. If there is some slight -- I use my hands a lot, I guess. If there is some slight fluctuation then, you know, that would obviously be, could be, could be dealt with in some way.

I see Kiran has her hand up, let's see what she has got to say.

MEMBER SAVAGE-SANGWAN: Well, I just think it would be helpful to understand how the Department plans to enforce these to inform that. Like, is it for each measure and each benchmark? If a plan doesn't meet it there would be corrective action or is it sort of a composite score of how they do on all those measures? Because for me that makes a difference in terms of not only

how many individual measures but how many benchmarks might be associated with those measures.

MS. BROOKS: We're getting there, mic technology. You can use this one, Nathan.

MR. NAU: Nathan Nau, DMHC. For the record, Mary can't get it either. (Laughter.)

So Kiran, great question. We are going to have a benchmark discussion and so -- no decisions have been made by DMHC, we want to hear the recommendations of the Committee. But typically, and people can correct me if I am wrong, but there is a benchmark that is going to be established. And usually measures are applied to that benchmark so at a minimum you'd be looking at each measure. But then we are going to stratify, we just don't know how we are going to do that yet. And so part of the recommendation could be at what level you enforce and that could include the different stratification options as well. But not a direct answer but we are looking for your recommendations.

MS. BROOKS: Thank you. I will share the mic with you in the future as well.

Okay, Kiran, did that answer your question?

MEMBER SAVAGE-SANGWAN: Well, so then for clarification, for each measure are we just choosing one benchmark? In other words, are we going to have to choose between whether it is a disparities reduction or like gap closure benchmark or whether it is an absolute value type of benchmark? Like, is it possible there would be multiple sort of goals for a particular measure depending on what it is? Because that, you know, I would think you want the total number of benchmarks rather than a total number of measures.

MS. BROOKS: Kiran, this is Sarah and I think you are asking a great question. I will tell you what we have -- we, meaning Sellers Dorsey has talked about. And just to be clear, we hadn't talked with (laughed). But, you know, the thinking was that we were going to have a discussion with you all about what the approach could be. Because, you know, NCQA, for example, has benchmarks for certain measures, right. But they don't, they don't have benchmarks for all of the measures that are included on the list that we have come up with or with our final list.

And so there could be a different way of benchmarking that could be based off of improvement over baseline or something like that for some measures and use NCQA for other measures, or use the same process or methodology for all measures. So I guess my point is, is that we were going to go through a process and we just didn't get to that today. You will see if you actually look in the PowerPoint, we love to put together PowerPoints that we don't get to, that part of the PowerPoint that we don't get to you will see that there's four different terms in there that really talk about the different ways that benchmarking can be done. And we wanted to talk with you all about what the best approach is too with respect to making a recommendation to the DMHC on how it should be approached.

MEMBER SAVAGE-SANGWAN: Got it. Really helpful. In that case I might just suggest that that discussion come before we start our voting on measures so that we really understand what we are voting on for each measure. Like what it will, what it will really be measuring.

MS. BROOKS: Other comments? I was talking to Nathan and I was saying, you know, given where we are with the time, and also the fact that

we, I think, need to go back and regroup a little based on the discussion today, because you gave us so much thoughtful, informative information. But we need to, I think, restructure the PowerPoint a little bit so that it reflects what you all told us today and that we can move forward and have a dialogue that that is appropriate based off of that.

So I think what we will do is look to see if there is public comment, if that is okay, and then we will just -- I don't think anyone is going to complain if we end a little bit early. No? Okay. So let me just see if there is, Shaini, if there is any public comment online at this time.

All right. So the next meeting is on June 22 and will be held here so we will be here again. And again, we will be, it will be important, we will get to a vote at the next meeting. So it will be important that we have a quorum to do so. So just really appreciate all of you that are participating on in these ongoing dialogues. I know that it is quite a bit and we really appreciate it. We will post where the physical meeting is, obviously, here, downtown, 10 days in advance of the meeting. And then we do ask if you are able to and are comfortable with attending in-person that you do so. And of course, the public is welcome to join us both online and in-person for all meetings and continue to offer the public an opportunity to participate remotely as I said. With that we will end the meeting unless Mary has anything she'd like to say.

MS. WATANABE: I just wanted to take the opportunity to thank the Committee and the public for joining. This is a five hour, it tends to be a five hour meeting. It is a huge commitment. And with the rise in COVID cases just really want to thank everybody. For those of you that came in-person, we really appreciate it.

I will just say that I think there is data in the deck that was responsive to some of the earlier requests for more information and data on where the disparities exist so I would encourage you to maybe just take a look at the deck that you have in advance, that may save us some time.

We knew going into this the benchmark discussion was potentially one of the most complex conversations we needed to have so we will take this back and do some restructuring of the agenda. But that is going to be a really important discussion so I hope you all will join us again. But just wanted to acknowledge, really, really appreciate the great discussion and your participation.

MS. BROOKS: Thank you, Mary, and thanks to everyone. Have a great day. Bye-bye.

(The committee meeting concluded at 4:23 p.m.)

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CERTIFICATE OF REPORTER

I, JOHN COTA, an Electronic Reporter, do hereby certify that I am a disinterested person herein; that I recorded the foregoing California Department of Managed Health Care Health Equity and Quality Committee meeting and that it was thereafter transcribed.

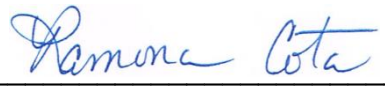
I further certify that I am not of counsel or attorney for any of the parties to said committee meeting, or in any way interested in the outcome of said matter.

IN WITNESS WHEREOF, I have hereunto set my hand this 16th day of June, 2022.

JOHN COTA

CERTIFICATE OF TRANSCRIBER

I, RAMONA COTA, a Certified Electronic Reporter and Transcriber, certify that the foregoing is a correct transcript, to the best of my ability, from the electronic recording of the proceedings in the above-entitled matter.



June 16, 2022

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