Health Equity and Quality Committee Meeting
March 24, 2022
Meeting Summary

Health Equity and Quality Committee Members in Attendance:
Dr. Anna Lee Amarnath, Integrated Healthcare Association
Dr. Palav Babaria, California Department of Health Care Services
Bill Barcellona, America's Physician Groups
Dannie Ceseña, California LGBTQ Health and Human Services Network
Dr. Alex Chen, Health Net
Stesha Hodges, California Department of Insurance
Dr. Alice Huan-mei Chen, Covered California
Dr. Cheryl Damberg, RAND Corporation
Diana Douglas, Health Access California
Lishaun Francis, Children Now
Tiffany Huyenh-Cho, Justice in Aging
Dr. Edward Juhn, Inland Empire Health Plan
Dr. Jeffrey Reynoso, Latino Coalition for a Healthy California
Dr. Richard Riggs, Cedars-Sinai Health System
Dr. Bihu Sandhir, AltaMed
Kiran Savage-Sangwan, California Pan-Ethnic Health Network
Rhonda Smith, California Black Health Network
Robyn Strong, California Department of Healthcare Access and Information
Kristine Toppe, National Committee for Quality Assurance
Doreena Wong, Asian Resources, Inc.
Silvia Yee, Disability Rights Education and Defense Fund

Department of Managed Health Care (DMHC) Staff in Attendance:
Mary Watanabe, Director
Nathan Nau, Deputy Director, Office of Plan Monitoring
Dr. Chris Jaeger, Chief Medical Officer
Anna Wright, Equity Officer
Sara Durston, Senior Attorney

Sellers Dorsey Staff in Attendance:
Sarah Brooks, Project Director
Alex Kanemaru, Project Manager
Dr. Andy Baskin, Quality Subject Matter Expert (SME), MD
Ignatius Bau, Health Equity SME
Mari Cantwell, California Health Care SME
Meredith Wurden, Health Plan SME
Nancy Kohler, Quality SME
Janel Myers, Quality SME

Agenda Item 1 – Opening Remarks (Transcript, P. 5-11)

Sarah Brooks called the meeting to order, conducted a roll call, gave an overview of the first Committee meeting, and walked through the agenda. Janel Myers reviewed housekeeping notes for Committee members and members of the public.

Agenda Item 2 – Department of Managed Health Care (DMHC) Remarks
(Transcript, P. 11-18)

Nathan Nau provided the Committee and members of the public with an overview of the key dates for the Committee's recommendations and the DMHC's enforcement approach for measurement year (MY) 2023 and beyond.

Dr. Richard Riggs asked for clarification on the timeline. For example, if the recommendations are not shared until September 2022, there is infrastructure required to implement for MY 2023. If penalties are enforced in MY 2025 does the DMHC plan to facilitate organizational readiness?
Mr. Nau responded the DMHC is tracking what is discussed in the Committee and will release an All Plan Letter that outlines the identified measures and benchmarks prior to 2023.

Bill Barcellona asked for clarification on if measures would have to be in place for five years and if the measures and benchmarks can only be replaced by reconvening the Committee. This process is strict and there may be learnings about some measures that need to be continuously revisited and modified. Mr. Barcellona also asked if this is bound by statute. Mr. Nau responded this interpretation is correct. Director Mary Watanabe added the DMHC had envisioned ten to twelve core measures that are already collected while adding a health equity benchmark. She reiterated that in order for the Department to take enforcement action, the measures would need to be codified in regulation as well.

Dr. Bihu Sandhir echoed Dr. Riggs' concerns regarding the timeline for measures and benchmark implementation. Dr. Sandhir added it takes time to set targets and infrastructure to make actionable changes moving forward. Dr. Sandhir noted it will be important to consider the timeline as the Committee selects measures and to consider measures where the data already exists and that are actionable.

Kristine Toppe added the clarification around timelines, benchmarks, and inclusion of measures in regulation was helpful. Ms. Toppe added measures and specifications evolve over time. Additionally, there might need to be flexibility between state and national benchmarks. Mr. Nau commented the DMHC does not have contracts with the health plans. The DMHC's contracts are the law which is why the measures need to be codified in statute.

Dr. Edward Juhn asked if there is an opportunity to select data elements that are already in existence and if there's an opportunity to work on improving the data quality

of some fields, such as those in an 834, before requiring plans to build the infrastructure to capture new measures. Mr. Nau responded the DMHC wants to report out on measures in a way that makes sense, so currently available data is something the Committee will want to discuss.

Doreena Wong asked how long this Committee will be in existence for and if there is an opportunity to provide feedback on this timeline after September 2022. Mr. Nau responded the Committee runs through September when the recommendations are due, but the DMHC is always open to collaborating and getting additional feedback.

Agenda Item 3 – Data Quality Expert Panel: Current and Future Initiatives
(Transcript, P. 18-66)

Ms. Toppe and Dr. Rachel Harrington from the National Committee for Quality Assurance (NCQA), Dr. Anna Lee Amarnath from the Integrated Healthcare Association (IHA), and Dr. Cheryl Damberg from RAND Corporation presented on their organizations' current approach to advancing health care quality in California and how their organizations address health equity.

Dr. Alice Chen shared her appreciation for the presentation and NCQA's social needs screening. Covered California has been working to align across Medicaid, Medicare, and the Marketplace. Dr. Chen encouraged NCQA to review the Centers for Medicare and Medicaid Services (CMS) Measures Under Consideration (MUC) list and see if there is a way to align with what is happening at the federal level. The way the measures are constructed around percentage screened and percentage positive is important and we will skip a step if we only look at percentage screened and people who received an intervention Dr. Harrington answered NCQA is aware of the MUC list and is in conversations with CMS and other stakeholders about alignment now versus alignment in the future and why NCQA made certain decisions.

Dr. Riggs commented there is a difference between self-reported and attributed data around sexual orientation and gender identity (SOGI), race, and ethnicity. The data shows the ability to self-attribute is the most accurate. Dr. Riggs asked how the Committee could encourage looking at new types of measures and screening tools, like the Health Equity Summary Score, as it looks towards standards.

Dannie Ceseña commented on the experience of many low socioeconomic status patients. When they visit a provider for care with complaints about their health and symptoms, they are dismissed due to different factors including education status, gender identity, weight gain, etc. Since they are dismissed, they are misdiagnosed, or provider hop until their concerns are acknowledged. Dr. Damberg answered more thought would be needed to answer this question. Historically, measurement has required that a patient be with a provider for some duration to kind of hold that provider accountable. This may require additional data to analyze and understand what is going on.

Dr. Amarnath expressed the importance of having data across providers, payers, and lines of business. This allows for transparency among potentially segmented populations churning between payers or providers. The California Department of Healthcare Access and Information (HCAI) is taking this into account while thinking about the future with the all-payer claims database (APCD). Dr. Damberg emphasized the APCD will track individuals over time and examine the care trajectories.

Dr. Jeffrey Reynoso recommended that at future Committee meetings each presenter pause after their presentation to allow for Committee members to ask questions. Dr. Reynoso commended NCQA for their work on Health Equity Accreditation Plus because it addresses partnerships outside of the health care sector. Dr. Reynoso asked for more details on when a measure becomes a standard and what the process looks like. In addition, Dr. Reynoso asked if there are index measure that provide a more robust picture for a population to advance health equity. Dr. Harrington responded it is important to think of standards and measures as two distinct concepts. Standards have structural requirements and frameworks. Measures are a part of that process and drive quality improvement efforts. NCQA has an iterative vetting, stakeholder engagement, and pilot testing process. Silvia Yee said you can't improve what you can't measure and stratification and transparency into disparities is necessary to advance standards, but it is not sufficient in itself. She also noted the lack of demographic information on disability status. The Office of the National Coordination for Health Information and Technology (ONC) has included three disability elements which is a great initial step in measuring disability. Ms. Yee also asked how RAND's Bayesian Improved Surname Geocoding (BISG) works for people who are mixed race. Dr. Amarnath responded there are many places the BISG has gaps in attributing characteristics of mixed race individuals. The imputation method is intended to aggregate at the physician group, hospital, or health plan level and is not intended for person-by-person analysis. While there are gaps in the BISG method, when compared to what is self-reported, the concordance is very high. Ms. Toppe added NCQA is considering this in all contexts, both on the accreditation standard and how standards are written to evaluate organizations who serve people with disabilities. Robyn Strong commented through HCAI's existing data collection programs work has been done around data completeness, particularly for race and ethnicity.

Agenda Item 4 – Guiding Principles for Measure Selection and Focus Areas
(Transcript, P. 66-102)

Ms. Brooks explained the measures recommended through this process will apply to full-service and behavioral health plans regulated by the DMHC and identified goals of the recommended measure set. Dr. Baskin and Ignatius Bau presented on the guiding principles for measure selection, criteria for measure selection, the measure selection process, and focus areas.

Dr. Palav Babaria commented risk adjustment is impacted by population mix, payer, and health equity focus. The Department of Health Care Services (DHCS) is reviewing health equity between Medi-Cal populations and other payers (e.g., commercial). Dr.

Babaria commented there is a need to focus on the ultimate goal of eliminating disparities between lower income populations in the Medi-Cal program and commercial populations in California. Dr. Babaria also asked how benchmarks fit into the guiding principles for measure selection. Dr. Baskin responded benchmarks are slated for discussion in a future Committee meeting.

Dr. Juhn asked if the Committee should factor in a data completeness threshold and if the Committee should prioritize measures with higher thresholds of available data. Dr. Juhn added there is an opportunity for the Committee to use the Delphi scoring approach to collectively vote. Dr. Baskin responded the Committee will need to factor in what is feasible for measurement. By selecting measures that have been implemented elsewhere, there is evidence these measures can be reported on. The Committee will need to assess if measures can be stratified by race, ethnicity, and any other parameters the Committee recommends. In response to Dr. Juhn's Delphi scoring question, Dr. Baskin responded this process will be iterative and may require multiple votes before selecting ten to twelve measures.

Dr. Amarnath reiterated measures may fit into multiple focus areas. Dr. Amarnath asked if there is an opportunity to discuss the measure selection criteria before discussing the focus areas. Dr. Amarnath also mentioned potential to have a measure selection criteria be around unintended negative consequences of a certain measure. Dr. Baskin responded the intent of the measure selection criteria is not to be limiting. Ignatius Bau commented the universe of measures is vast and given the timeline for establishing recommendations this is the proposed process, however, this process will require a lot of both, and. For example, while reviewing potential health equity measures the Committee may consider established measures but also a stratification strategy. The Committee may also want to address the theme of alignment. This is an opportunity to focus the effort of multiple payers in multiple markets across Medi-Cal and the commercial markets to focus on what can improve in the next five years.

Kiran Savage-Sangwan commented health equity is presented as a stand-alone focus area, but it is primarily describing social needs and the Committee may want to address health equity more broadly. The Committee should not dismiss the possibility of stratification just because it is not currently done. In addition, the statute that created this Committee does call for looking at alternative approaches. She asked for clarification on what health plans this measure set applies to. Dr. Baskin responded that a measure that has not been developed may not meet the needs of the DMHC. Since only ten to twelve measures will be selected there may be gaps in measurement. Mr. Nau commented recommendations are due to the DMHC on September 30, according to statute. These measures would apply to our full-service health plans and behavioral health plans. The DMHC is open to discussing innovative practices or California-specific measures.

Lishaun Francis commented none of the focus areas are specific to outcomes and it is unclear what the Committee is specifically trying to do in terms of equity. There are measures that are informative of what the population is doing and how the system is

performing. Dr. Baskin responded that the measure examples provided are not meant to be restricting and outcome measures will be reviewed throughout this process.

Diana Douglas commented as the Committee identifies focus areas and measurements, one thing to consider is that California's standards often exceed national standards. So as Committee members advocate for alignment and consistency, Ms. Douglas urged Committee members to review measures that capture California's leadership in enacting stronger standards to protect quality of care and access to care. In addition, Ms. Douglas commented stronger demographic data and stratification would be useful.

Ms. Wong commented the behavioral health focus area should include mental health and substance use. In addition, the Committee may want to look beyond what is currently available even if there are feasibility issues with doing so. For health disparities it is important to have the disaggregated race and ethnicity data to identify which populations are suffering from disparities. For example, for some measurements, Asians are combined with Native Hawaiian/Pacific Islanders. Ms. Wong would like to see the disaggregation of available data as a core principle for measure selection.

Dr. Damberg commented the Committee is responsible for identifying measures for different populations and there are focus areas that represent domains and others represent populations. In addition, some of the examples are single measures (e.g., colorectal cancer screening) and some are indices. The Committee may want to consider the use of telehealth services across the different populations. Dr. Damberg also commented that this work tends to be iterative, and review of the data is often necessary. Dr. Damberg asked as the Committee continues with this process, what kind of data is available to help inform measure selection. Understanding this would be useful to identify sub-performing areas in order to arrive at a parsimonious measure set. Dr. Baskin commented if this is something being required of the health plans the Committee should ensure the health plans have access to the data. The Committee should consider additional California data that can be added to health plan data to inform this process. Dr. Damberg responded if the focus of this Committee is to improve health equity the Committee needs the appropriate information to make informed decisions.

Ms. Toppe suggested it would be useful for the Committee to look at the existing requirements for health plans for measure stratification.

Dr. Chen said Covered California is working with the National Quality Forum (NQF) to quantify the impact of the four measures selected for Covered California's Quality Transformation Initiative (QTI) including colorectal cancer screening, blood pressure, diabetes, and childhood immunizations. Dr. Chen asked the Committee at large what the goals are including holding plans accountable and acknowledging improvements need to be made for health and equity in California. Covered California felt if the QTI started with ten to fifteen measures quality improvements would be limited or non-existent. Covered California has already aligned with Medi-Cal and California Public Employees' Retirement System (CalPERS). The DMHC has an opportunity to lean in for

the entire California health care ecosystem. Finally, Dr. Chen commented social needs screening is not disparities. In the QTI, Covered California plans to stratify by race and ethnicity for each measure.

Agenda Item 5 – Preliminary Discussion on Measures (Transcript, P. N/A)

The Committee did not have the opportunity to cover this agenda item.

Agenda Item 6 – Public Comment (Transcript, P. 103)

There was no public comment. Ms. Brooks let the group know members of the public may submit comments until 5 p.m. on March 31, 2022, to publiccomments@dmhc.ca.gov.

Agenda Item 7 – Closing Remarks (Transcript, P. 103)

The meeting adjourned at 12:08 P.M. The next meeting is scheduled for April 20, 2022.