DMHC Health Equity and Quality Committee

June 22, 2022

Housekeeping

For those attending in-person and virtually:

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

Housekeeping

For those attending in-person:

- A sanitation station is 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 this corridor to the left; the men's bathroom is located just beyond the women's restroom on the other side of the catwalk. The entry way is near suite 200.

Housekeeping

For those attending in-person:

- Please do not join the Zoom meeting with your computer audio. Use the microphone in front of you and push the button on your microphone to turn it on or off.
- 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.

Housekeeping

For those attending virtually or by phone:

- For attendees participating through Zoom with microphone capabilities, you may use the “Raise Hand” feature and you will be unmuted to ask your question or leave a comment.

Housekeeping

For all Committee members:

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

Housekeeping

For all Committee members:

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

Housekeeping

For all members of the public:

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

Agenda

1. Welcome and Introductions
2. Review June 8, 2022 Meeting Summary
3. DMHC's Cultural and Linguistic Access Requirements
4. Discussion on the Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey
5. Focus Area Measures
6. Complete Narrowing Measures to Final Set

Agenda

7. Break
8. Benchmarking
9. Measure Stratification
10. Public Comment
11. Closing Remarks

DMHC Attendees

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

Voting Committee Members

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

Voting Committee Members

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

Voting Committee Members

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

Ex Officio Committee Members

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

Sellers Dorsey Team

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

Meeting Materials

1. Candidate Measures Workbook
2. References and Resources Handout
3. Epidemiologic and Performance Data Handout

Committee Meeting Timeline

- Committee Meeting #7 – July 13
  - Benchmarking
- Committee Meeting #8 – August 17
  - Review Draft Report of Committee Recommendations

Questions

Review June 8, 2022 Meeting Summary

Sarah Brooks, Project Director

Questions

DMHC's Cultural and Linguistic Access Requirements

Nathan Nau, Deputy Director, Office of Plan Monitoring

Cultural and Linguistic Access Requirements

- In 2003, SB 853 was passed to improve health care access for Limited English Proficient individuals enrolled in California health plans
- Health and Safety Code section 1367.04 directed DMHC to promogulated regulations no later than January 1, 2006
- DMHC reports to the Legislature on Language Assistance compliance on a biannual Basis

Language Assistance Requirements

Language Assistance Requirements:

- Assess the linguistic needs of enrollees
- Provide translation and interpretation services to enrollees
- Train staff in effectively providing language services to enrollees
- Provide oversight to ensure compliance

Oversight Processes

Oversight Processes:

- Health plan Survey's
- Timely access to care
- The DMHC Help Center

Requirements

Requirements:

- Annual Notice
  - Inform enrollees of right to receive appointments within established appointment wait times and the ability to receive interpreter services at the time of the appointment
- Enrollee Experience Surveys
  - Evaluate the experience of limited English proficient enrollees in obtaining interpreter services by obtaining the enrollee's perspectives and concerns

Requirements

Requirements (continued):

- Provider Satisfaction Survey's
  - Shall evaluate provider perspectives and concerns with the plan's language assistance program

Questions

Discussion on the Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey

Cheryl Damberg, RAND Corporation
Marc Elliott, RAND Corporation
Julie Brown, RAND Corporation

Overview of CAHPS Surveys

- Overseen by the Agency for Healthcare Research and Quality (AHRQ), the CAHPS Health Plan Survey asks enrollees about:
  - Recent experiences with health plans
  - Services received across different settings
- Public reporting of CAHPS results are intended to:
  - Incentivize health plans to improve the overall quality of member experiences
  - Promote accountability and increase overall transparency

CAHPS Background

- Standardization is critical to valid comparisons across health care settings and sponsors to:
  - Compare and assess performance across similar organizations
  - Evaluate the effectiveness of interventions to improve targeted aspects of patient experiences
- CAHPS is the most extensively tested, validated, and used measure of patient experience

CAHPS Background

- Patient experience is distinct from patient satisfaction
  - Focuses on aspects of care that are medically relevant, rather than on amenities or conveniences
  - Focuses on aspects of care for which patients are the best or only source of information
  - Asks patients to report on what happened, not to reflect on their satisfaction about what happened

CAHPS Background

- CAHPS contains global ratings items and multi-item composites that summarize more specific reports in related domains
  - Getting Needed Care and Getting Care Quickly are important access composites

CAHPS: Health Equity Applications

- CAHPS measures used for health equity research with respect to race and ethnicity and other factors for more than 20 years
  - See (Stratified Reporting | CMS) for examples of such reports by CMS' Office of Minority Health

CAHPS: Health Equity Applications

- For 14 years, experiments and other research have established that the 0-10 ratings items are unsuitable for health equity research
  - 0-10 response scales are not used in the same way by patients of different races, ethnicities, and national origins
  - Such measures are excluded from existing health equity CAHPS applications
  - Approaches such as HESS, HEI, and stratified reporting efforts focus on more comparable composite measures

Sample Sizes for Assessing Health Equity using CAHPS Surveys

- Sample sizes of at least 30 with reliability of at least 0.7 (which in practice often requires sample sizes of 50-100) are needed for each group reported within each plan for adequate reliability
- Pooling data over two years, as for HESS and HEI, can support this effort
- Even with large samples, it may not be possible to report reliably for groups that make up a small proportion of a given plan

Challenges of CAHPS Survey

Challenges with the CAHPS survey include:

- Declining response rates for all surveys, including CAHPS surveys, especially for some groups with historically lower response rates
- Requiring mixed mode and appropriate language use increase response rate and representativeness; new Web-first modes can help also
- Reliability and precision of plan scores is a function of the sample size, not the proportion of the population sampled
- Direct measures of discrimination only available as supplemental items

Additional References

- Broad description of the use of CAHPS as a standardized measure of patient experiences
  - Anhang Price R, Elliott MN, Cleary PD, Zaslavsky AM, Hays RD (2015) “Should Health Care Providers be Accountable for Patients’ Care Experiences?” Journal of General Internal Medicine 30(2): 253–6. DOI: https://doi.org/10.1007/s11606-014-3111-7

Additional References

- Why 0-10 response scale is inappropriate for comparisons by race/ethnicity
  - Weech-Maldonado RW, Elliott MN, Oluwole T, Schiller C, Hays RD. (2008). “Survey Response Style and Differential Use of CAHPS® Rating Scales by Hispanics.” Medical Care, 46(9): 963-968.

Additional References

- Why 0-10 response scale is inappropriate for comparisons by race/ethnicity
  - Weinick R, Elliott MN, Volandes AE, Lopez L, Burkhart Q, Schlesinger M. (2011) “Using Standardized Encounters to Understand Reported Racial/Ethnic Disparities in Patient Experiences with Care.” Health Services Research 46(2):491-509. DOI: https://doi.org/10.1111/j.1475-6773.2010.01214.x

CAHPS Measures

During the June 8 meeting, the following CAHPS measure was discussed:

1. Getting Needed Care
    a) Q9. Easy for respondent to get necessary care, tests, or treatment
    b) Q18. Respondent got appointment with specialists as soon as needed

CAHPS Measures

During the June 8 meeting, the following CAHPS measure was discussed:

2. Getting Care Quickly
    a) Q4. Respondent got care for illness/injury as soon as needed
    b) Q6. Respondent got non-urgent appointment as soon as needed

Questions

Vote

Focus Area Measures

Sarah Brooks, Project Director

Most Common Focus Areas

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

Adult Prevention Measures

During the April 20 meeting, there was Committee consensus for the following measures:

1. Cervical Cancer Screening [NQF Disparities-Sensitive]^
2. Breast Cancer Screening [NQF Disparities-Sensitive] ^**
3. Colorectal Cancer Screening [NQF Disparities-Sensitive] ^*

^Performance data is currently available

**NCQA Stratification by Race/Ethnicity and included in Health Equity Accreditation*

***Candidate for NCQA Stratification by Race/Ethnicity*

Chronic Conditions Measures

During the May 18 meeting, there was Committee consensus for the following measures:

1. Hemoglobin A1c Control for Patients with Diabetes [NQF Disparities-Sensitive]^*
2. Controlling High Blood Pressure [NQF Disparities-Sensitive]^*
3. Asthma Medication Ratio ^**

^Performance data is currently available

**NCQA Stratification by Race/Ethnicity and included in Health Equity Accreditation*

***Candidate for NCQA Stratification by Race/Ethnicity*

Mental Health Measures

During the May 18 meeting, there was Committee consensus for the following measures:

1. Depression Screening and Follow-Up for Adolescents and Adults [NQF Disparities-Sensitive]**
2. Follow-Up After Hospitalization for Mental Illness^
3. Follow-Up After Emergency Department Visit for Mental Illness^

^Performance data is currently available

***Candidate for NCQA Stratification by Race/Ethnicity*

Substance Use Measures

During the May 18 meeting, there was Committee consensus for the following measures:

1. Pharmacotherapy for Opioid Use Disorder^**
2. Unhealthy Alcohol Use Screening and Follow-Up

^Performance data is currently available

***Candidate for NCQA Stratification by Race/Ethnicity*

Birthing Persons & Children Measures

During the May 18 meeting, there was Committee consensus for the following measures:

1. Cesarean Rate for Nulliparous Singleton Vertex
2. Prenatal & Postpartum Care [NQF Disparities-Sensitive] ^*
3. Contraceptive Care – All Women
4. Childhood Immunization Status (Combo 10)^

^Performance data is currently available

**NCQA Stratification by Race/Ethnicity and included in Health Equity Accreditation*

Birthing Persons & Children Measures

During the May 18 meeting, there was Committee consensus for the following measures:

5. Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents^
6. Topical Fluoride Varnish for Children
7. Well-Child Visits in the First 30 Months of Life^
8. Child and Adolescent Well-Care Visits^*

^Performance data is currently available

**NCQA Stratification by Race/Ethnicity and included in Health Equity Accreditation*

Utilization Measures

During the June 8 meeting, there was Committee consensus for the following measure:

1. Avoidable Emergency Room Visits

Appropriateness of Care Measures

During the June 8 meeting, there was Committee consensus for the following measures:

1. Plan All-Cause Readmissions (PCR)^
2. Transitions of Care: Medication Reconciliation Post-Discharge
3. Timely Follow-Up After Acute Exacerbations of Chronic Conditions

^Performance data is currently available

Population Health Measures

During the June 8 meeting, there was Committee consensus for the following measures:

1. Adult Immunization Status**
2. Body Mass Index (BMI) Screening and Follow-Up Plan [NQF Disparities-Sensitive]
3. Obesity Prediabetes and Diabetes A1c Control

***Candidate for NCQA Stratification by Race/Ethnicity*

Health Equity Measures

During the June 8 meeting, there was Committee consensus for the following measures:

1. Meaningful Access to Health Care Services for Persons with Limited English Proficiency
2. Patients Receiving Language Services Supported by Qualified Language Services Providers [NQF Disparities-Sensitive]
3. Cultural Competency Implementation Subdomain: Quality Improvement

Questions

Complete Narrowing Measures to Final Set

Sarah Brooks, Project Director

Process to Narrow Measures to Final Set

Now that the list of candidate measures is established, the following steps will take place:

1. For each candidate measure, voting members of the Committee will vote “yes” or “no” for each measure (denominator = 17).
   a) If a measure receives a “yes” vote from 60% or more of the Committee, it will be considered for the final measure set. Requires ≥11 “yes” votes.

Process to Narrow Measures to Final Set

b) If a measure receives a 40-59% “yes” vote, it will be included on a list of measures for further Committee discussion. Requires between 7-10 “yes” votes.

c) If a measure receives ≤39% “yes” vote, it will be removed from the list of measures being considered. Requires ≤ 6 “yes” votes.

Process to Narrow Measures to Final Set

For measures that receive a 40-59% “yes” vote further Committee discussion is required. Once Committee discussion for these measures ends another vote will occur.

1. If a measure receives a “yes” vote from 60% or more of the Committee, it will be considered for the final measure set.
2. If a measure receives less than 60% of the “yes” vote in this round, it will be removed for consideration from the final measure set.

Process to Narrow Measures to Final Set

In the case more than 10-12 measures are voted “yes” for the final set of measures, we will have each Committee member rank their top 12 measure choices.

- The 12 measures with the lowest total will be included in the report as the final measure set.

Questions

Vote

Break

Benchmarking

Sarah Brooks, Project Director

Andy Baskin, Quality SME, MD

Ignatius Bau, Health Equity SME

Benchmark Considerations

As we review core practices for benchmarking, consider the following:

- Which approach(es) will fit the goals of this initiative best?
- How do we set benchmarks that are attainable yet motivating for all health plans?
- Will benchmarks change each year or remain fixed?
- For measures without current benchmarking data, consider using first year results as a benchmark for future years.
- Set statewide benchmark for all MCOs (no separate benchmarks by lines of business)?

Potential Benchmark Sources

- Benchmarks are value(s) to assess performance standards
- External benchmark sources
  - Quality Compass (e.g., National 75th percentiles)
  - National surveys and surveillance systems
  - Other (e.g., NQF, Healthy People 2030)
- Internal benchmark sources
  - Electronic health records, claims data
  - Annual reports
  - Other data-generating activities

Benchmark Approaches

- **Absolute:** sets the benchmark as a specific value of performance for all entities
- **Relative:** sets the benchmark based on performance of similar entities or performance within industry
- **Improvement based:** sets the benchmark as a specific change (percentage or absolute value) in performance to achieve
- **Disparity reduction:** sets the benchmark to reduce gap between the performance of a disparity subpopulation(s) and the performance of the general population or the highest performing subpopulation

Absolute Benchmark

Example

- Baseline performance is 50%
- Achieve performance of 60% in Measurement Year 1
- Achieve performance of 65% in Measurement Year 2
- Achieve performance of 70% in Measurement Year 3
- Achieve performance of 75% in Measurement Year 4
- Achieve performance of 80% in Measurement Year 5

Absolute Benchmark

Considerations

- Commonly applied to measures where:
  - Achieving a specific value is desired
  - Performance across participating organizations varies a little
- The benchmark should be a goal that is feasible and informed by performance
- Could be adjusted each measurement period to meet an ultimate, long-term goal
- Could be the same across payors

Relative Benchmark

Example

- Meet or maintain the Quality Compass National Medicaid or Commercial 50th percentile benchmark for Measurement Year 2
- Meet or maintain the Quality Compass National Medicaid or Commercial 50th percentile benchmark for Measurement Year 3
- Meet or maintain Quality Compass National Medicaid or Commercial 50th percentile benchmark for Measurement Year 4
- Meet or maintain the Quality Compass National Medicaid or Commercial 50th percentile benchmark for Measurement Year 5

Relative Benchmark

Considerations

- Commonly applied to measures where:
  - Performance should be maintained at or above a standard (e.g., national average).
  - Allows the benchmark to fluctuate from year to year based on external mitigating factors (e.g., a pandemic).
  - If the benchmark is a statewide standard, then there is heightened competition. Some plans will exceed, and others will not meet the benchmark in any given year.

Improvement Based Benchmark

Example

- Using the data provided in Year 1, the plans will improve on Year 1 (baseline) data by X% for Measurement Year 2
- Based on results of Year 2, the plans will improve by X% for Measurement Year 3
- Based on results of Year 3, the plans will improve by X% for Measurement Year 4
- Based on results of Year 4, the plans will improve by X% for Measurement Year 5

Improvement Based Benchmark

Example

- Plans are not expected to meet a benchmark each year but rather to make improvement *toward* the benchmark
- Year 2-4: Require improvement of at least 5% between the plan's prior year performance and benchmark
- By Year 5: Achieve Quality Compass National Medicaid or Commercial 50th percentile benchmark

Improvement Based Benchmark

Considerations

- Commonly applied to measures where:
  - Continuous improvement is possible and desired
  - Baseline performance among participants varies greatly
- Requires data be available to determine baseline performance
- If baseline performance is already high, future improvements could be negligible or small

Disparity Reduction Benchmark

Disparity reduction goals may be set for disparity subpopulation(s)

Absolute Example

- Disparity between X individuals compared to Y individuals should be no larger than 2 percentage points.

Improvement Based Example

- Disparity among X individuals compared to Y individuals should decrease by 5 percentage points compared to the prior performance year.

Disparity Reduction Benchmark

Considerations

- Not all MCOs will have statistically significant data for all disparity subpopulations
- Balance accepting continuing disparities with feasibility and pace of disparities reductions
- Current data limitations may create challenges for identifying meaningful targets
- Demographic data beyond race and ethnicity may depend on implementation of Data Exchange Framework and evolving national standards

Options for Benchmarking

For benchmarking, Committee members will vote “yes” on one of the following Options 1-3 to apply to the final measure set.

- The Option with the most “yes” votes will be included in the final report.

Options for Benchmarking

- **Option 1 – Absolute/Improvement:**
  - For measures that have available benchmark data, apply an improvement based benchmark, capped at the NCQA Medicaid or Commercial 50th or 75th percentile.
  - For measures without available benchmark data, after a baseline is established, determine yearly incremental improvement targets for the remaining program years.

Options for Benchmarking

- **Option 2 – Improvement:**
  - Establish baseline performance for all measures regardless of whether current benchmarks are available.
  - Determine yearly incremental improvement targets for the remaining program years.

Options for Benchmarking

- **Option 3 – Relative/Improvement:**
  - For measures with available benchmark data, determine targets based on a real time benchmark:
    - Year 1-2: Performance targets set at higher of Medicaid and Commercial 50th percentile.
    - Year 3-5: Performance targets set at X% (e.g., 5%) above the 50th percentile.
  - For measures without available benchmarks, after a baseline is established, determine yearly incremental improvement targets for the remaining program years.

Options for Benchmarking *Disparities Reduction*

Additional recommendations for the final report for the Committee's consideration:

- Disparity reduction goals in addition to improvement goals for measures where there will be at least race and ethnicity data.
- As additional stratified data by race and ethnicity and other demographic data becomes available, DMHC should consider including additional disparities reduction approaches and benchmarks.

Questions

Vote

Measure Stratification

Sarah Brooks, Project Director

Andy Baskin, Quality SME, MD

Ignatius Bau, Health Equity SME

Measure Stratification

- To comprehensively identify and address health inequities and eliminate health disparities it is critically important to systematically measure and report on health care disparities in a standardized way.
- Measure stratification provides useful and actionable information for targeted quality improvement initiatives and appropriate health care interventions and strategies.

NCQA Stratification

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

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

NCQA Stratification

Currently, for NCQA stratification, categories for Ethnicity are based on Office of Management and Budget categories:

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

Options for Measure Stratification

For measure stratification, Committee members will vote “yes” on one of the following Options 1-3 to apply to the final measure set.

- The Option with the most “yes” votes will be included in the final report.

Measure Stratification

- **Option 1:**
  - Health plans are required to stratify measures identified by NCQA for Health Equity Accreditation by race and ethnicity.
  - When NCQA announces additional measures for stratification, those measures will automatically be required for stratification by the DMHC.

Measure Stratification

- **Option 2:**
  - Health plans are required to stratify by all measures required for NCQA Health Equity Accreditation **and** the Committee may determine additional measures for stratification by race and ethnicity.
  - When NCQA announces additional measures for stratification, those measures will automatically be required for stratification by the DMHC also.

Measure Stratification

- **Option 3:**
  - Health plans are required to stratify **all** measures identified for the final measure set by race and ethnicity.

Measure Stratification

Additional recommendations for the final report for the Committee's consideration:

- As additional stratification data becomes available for language, sexual orientation and gender identity, disability status, and tribal affiliation DMHC should consider including this information.
- As disaggregated data by race becomes available the DMHC should consider including this information.

Questions

Vote

Public Comment

Public comments may be submitted until 5 p.m. on June 29, 2022, to publiccomments@dmhc.ca.gov

Closing Remarks

Public comments may be submitted until 5 p.m. on June 29, 2022, to publiccomments@dmhc.ca.gov

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

Next Health Equity and Quality Committee meeting will be held in Sacramento on July 13.