DMHC Health Equity and Quality Committee

March 24, 2022

Housekeeping

- Questions and comments will be taken after each agenda item.
- For the attendees on the phone, if you would like to ask a question or make a comment, please dial *9 (star 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 a comment.

Housekeeping

- All questions and comments will be taken in order of “Raised hands.”
- As a reminder, the Committee is subject to the Bagley-Keene Open Meeting Act which requires the Committee meetings to be open to the public.
- Due to Bagley-Keene Open Meeting Act, Committee members should avoid using the Zoom chat.

Agenda

1. Opening Remarks
2. Department of Managed Health Care (DMHC) Remarks
3. Data Quality Expert Panel: Current and Future Initiatives
4. Guiding Principles for Measure Selection and Focus Areas
5. Preliminary Discussion on Measures
6. Public Comment
7. Closing Remarks

DMHC Attendees

1. Mary Watanabe, Director
2. Nathan Nau, Deputy Director, Office of Plan Monitoring
3. Chris Jaeger, Chief Medical Officer
4. Anna Wright, Equity Officer
5. 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 Attendees

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. Nancy Kohler, Quality SME
8. Janel Myers, Quality SME

Questions

DMHC Remarks

Nathan Nau, Deputy Director, Office of Plan Monitoring

Health Equity and Quality Key Dates and Enforcement Approach

March 24, 2022

Nathan Nau, Deputy Director, Office of Plan Monitoring

DMHC Mission Statement

The California Department of Managed Health Care protects consumers' health care rights and ensures a stable health care delivery system.

Key Dates

- September 30, 2022: Final Committee recommendations due to DMHC
- Measurement Year (MY) 2023:
  - Measures and benchmarks take effect
  - DMHC administrative authority begins
- 2024: Health plans submit MY 2023 data to the DMHC
- 2025: First annual report published

Key Dates

- MY 2025: DMHC enforcement authority to address performance deficiencies begins
- Measures Sunset:
  - At most every five years
  - Must be discussed in at least one Committee meeting before changes occur

Enforcement Approach

Measurement Year 2023 and 2024:

- The DMHC may assess administrative penalties for violations relating to health plan data collection, reporting, and corrective action implementation or monitoring requirements.

Enforcement Approach

Measurement Year 2025 and beyond:

- The DMHC may begin assessing administrative penalties for failure to meet the health equity and quality benchmarks.
- It is anticipated that the measures and benchmarks will be codified in regulation by 2026.

Questions

Data Quality Expert Panel: Current and Future Initiatives

Kristine Toppe, National Committee for Quality Assurance (NCQA)

Anna Lee Amarnath, Integrated Healthcare Association (IHA)

Cheryl Damberg, RAND

Kristine Toppe, NCQA
Rachel Harrington, NCQA
Liz Ryder, NCQA

What is NCQA

DMHC Health Equity and Quality Committee: March 24, 2022

NCQA: What We Do and Why

OUR MISSION

To improve the quality of health care

OUR METHOD

Measurement

We can't improve what we don't measure

Transparency

We show how we measure so measurement will be accepted

Accountability

Once we measure, we can expect and track progress

California Aligning on NCQA Quality and Equity Tools

Regulators and Public Purchasers focus on Quality/Health Equity

Agency/ Entity	NCQA Health Plan Accreditation	Health Equity Focus	Timeline
DMHC (HMO licensing body)	AB 133 requires commercial plans to be NCQA accredited	(Convening Health Equity Committee to recommend measures)	January 2026

California Aligning on NCQA Quality and Equity Tools

Agency/ Entity	NCQA HPA	Health Equity Focus	Timeline
DHCS (Medicaid)	2024 contracts	NCQA Health Equity Accreditation (HEA)	January 2026
Covered CA	2022 contracts	NCQA HEA	2022-2023
CalPERS	Existing contracts	Exploring Options	Continuous

Key NCQA Evaluation Tools

Accreditation Standards and Performance Measures

Health Plan Accreditation (HPA)

Provides a rigorous and comprehensive framework for essential quality improvement and measurement

HEDIS

HEDIS data allows the Health Plan Accreditation to effectively measure care and service performance. This focuses attention on activities that keep members healthy.

Key NCQA Evaluation Tools

Accreditation Standards and Performance Measures

Health Equity Accreditation (HEA)

A roadmap to improve health equity through formalized structures, processes and goals for identifying and addressing health disparities.

HEA+

Building on HEA, it focuses on evolving & strengthening community and cross-sector partnerships in health equity and on the roles of social drivers of health.

NCQA HPA 2022: Standards Categories

Accreditation:

A comprehensive review of functions critical to delivering high quality care

HPA Categories
Quality Improvement (QI)
Population Health Management (PHM)
Network Management (NET)
Utilization Management (UM)
Credentialing (CR)
Member Rights and Responsibilities (RR)
Member Connections (ME)

NCQA HPA 2022: Standards Categories

Interim	18 months Orgs new to accreditation; review of policies and procedures
First/Renewal	36 months All standards apply; review of policies, procedures and evidence of implementation; **annual reporting of audited HEDIS & CAHPS required**

NCQA's Health Equity Strategy

DMHC Health Equity and Quality Committee: March 24, 2022

The BIG Idea

Quality care is equitable care

No quality without equity

Build equity into all programs

NCQA Health Equity Standards & Quality Measures

Health Equity Accreditation Plus

National health equity standards to support health plan and community partnerships
(The California Endowment)

Equity in HEDIS

Race/Ethnicity Stratification, Social Need Screening and Intervention, Gender-Affirming Measurement

NCQA Health Equity Standards & Quality Measures

Health Equity Accountability

Recommend common set of health equity measures for use in Medicaid program accountability (California Health Care Foundation)

Improving Race and Ethnicity Data

Recommendations for policymakers on improving R/E data for use in health programs (The Commonwealth Fund)

Health Equity Journey

Standards and Measures Evolving Together

Programs

Since 2010
Multicultural Healthcare Distinction

→

Launched Sept. 30, 2021
HEA

AND

Planned for March 2022
HEA+

Ongoing Discovery

Measures

MY 2022

5 HEDIS Stratified Measures R/E

MY 2023

Annually: Minimum of 5 additional HEDIS measures stratified by R/E

New measure to address unmet social needs

Making HEDIS more inclusive on SO/GI

Public reporting of R/E stratified HEDIS rates

MY 2024 and Beyond

Ongoing Discovery

Health Equity Accreditation Supports Data Collection

(New standard)
Organizational Readiness

(New requirements added to existing standard)
Race/Ethnicity, Language, Gender Identity and Sexual Orientation Data

(Existing standard)
Access and Availability of Language Services

(Existing standard)
Practitioner Network Responsiveness

(Existing standard)
Cultural and Linguistically Appropriate Services Programs

(New requirements added to existing standard)
Reducing Health Care Disparities

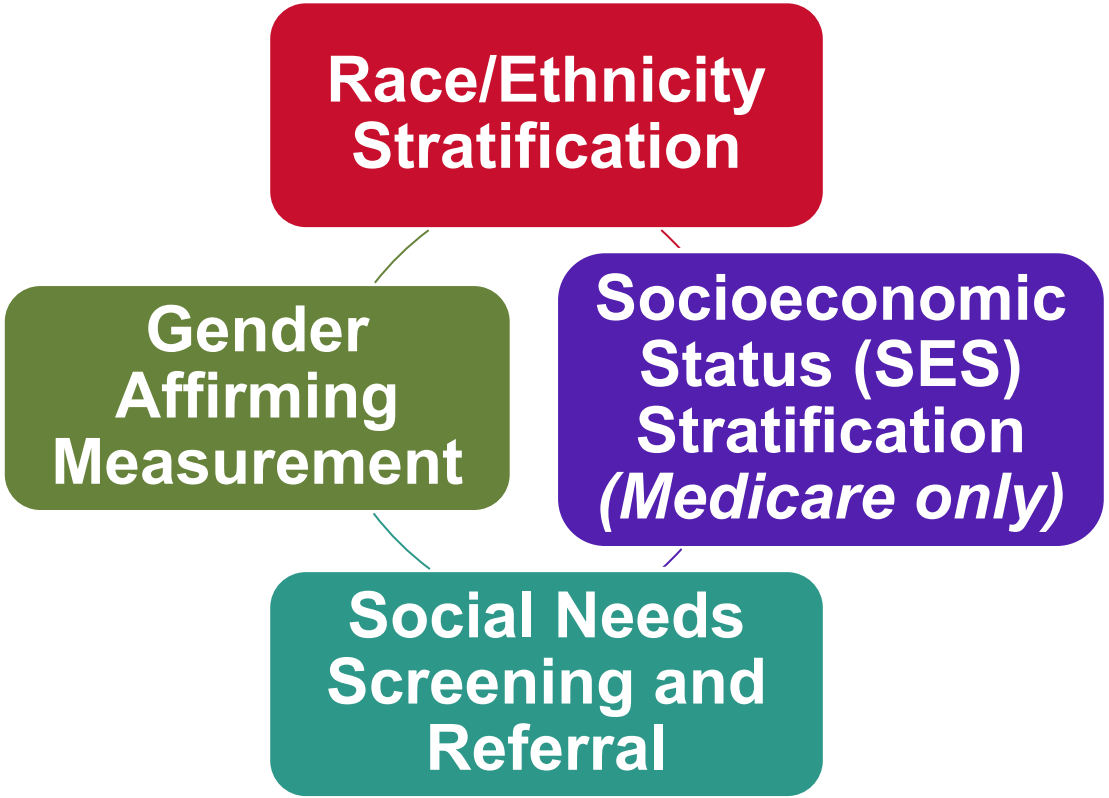
Added new requirements for data system capabilities and gender identity and sexual orientation data collection.

Added new requirements for HEDIS measures stratified by race/ethnicity to identify disparities.

Surveys begin July 1, 2022

Equity in HEDIS Measurement

Approaches from Multiple Directions



Stratification and transparency into disparities is necessary, but not sufficient, for advancing equity

Race and Ethnicity Stratification

Initial Measures for HEDIS MY 2022

Measure	Product Lines	Domain
Colorectal Cancer Screening (COL; COL-E)	Commercial, Medicare	Effectiveness of Care
Controlling High Blood Pressure (CBP)	Commercial, Medicaid, Medicare	
Hemoglobin A1c Control for Patients With Diabetes (HBD)	Commercial, Medicaid, Medicare	

Race and Ethnicity Stratification

Initial Measures for HEDIS MY 2022 (continued)

Prenatal Postpartum Care (PPC)	Commercial, Medicaid	Access & Availability of Care
Child and dolescent Well Care Visit(WCV)	Commercial, Medicaid	Utilization

Measure Selection Process for Stratification

Exclusion and Prioritization Criteria

Target of minimum 5 additional measures stratified for MY 2023

Criteria for selecting candidate measures:

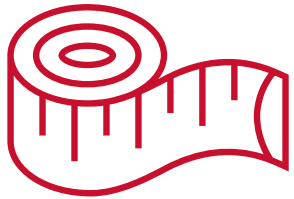
Exclude	Prioritize
• Risk-Adjusted Measures • First Year Measures • Slated for Retirement • Small Denominators	• High priority for disparities • Represent multiple product lines • Digital measures

Measure Selection Process for Stratification

Exclusion and Prioritization Criteria (continued)

14 candidate measures identified for MY 2023

Measures of Behavioral Health, Prevention & Screening, Utilization, Access & Availability, Respiratory Conditions, Care Coordination



Social Need Screening and Intervention (SNS-E)

Draft Measure (MY 2023)

Measure Description

The percentage of members who, during the measurement period, were screened at least once for unmet food, housing and transportation needs using a pre-specified screening instrument and, if screened positive, received a corresponding intervention.

Status:
Field testing completed in Winter 2022
Public comment closed March 11, 2022

Social Need Screening and Intervention (SNS-E)

Draft Measure (MY 2023) (continued)

Product Lines

- Commercial, Medicaid, Medicare

Data Source

- Electronic Clinical Data Systems

Exclusions

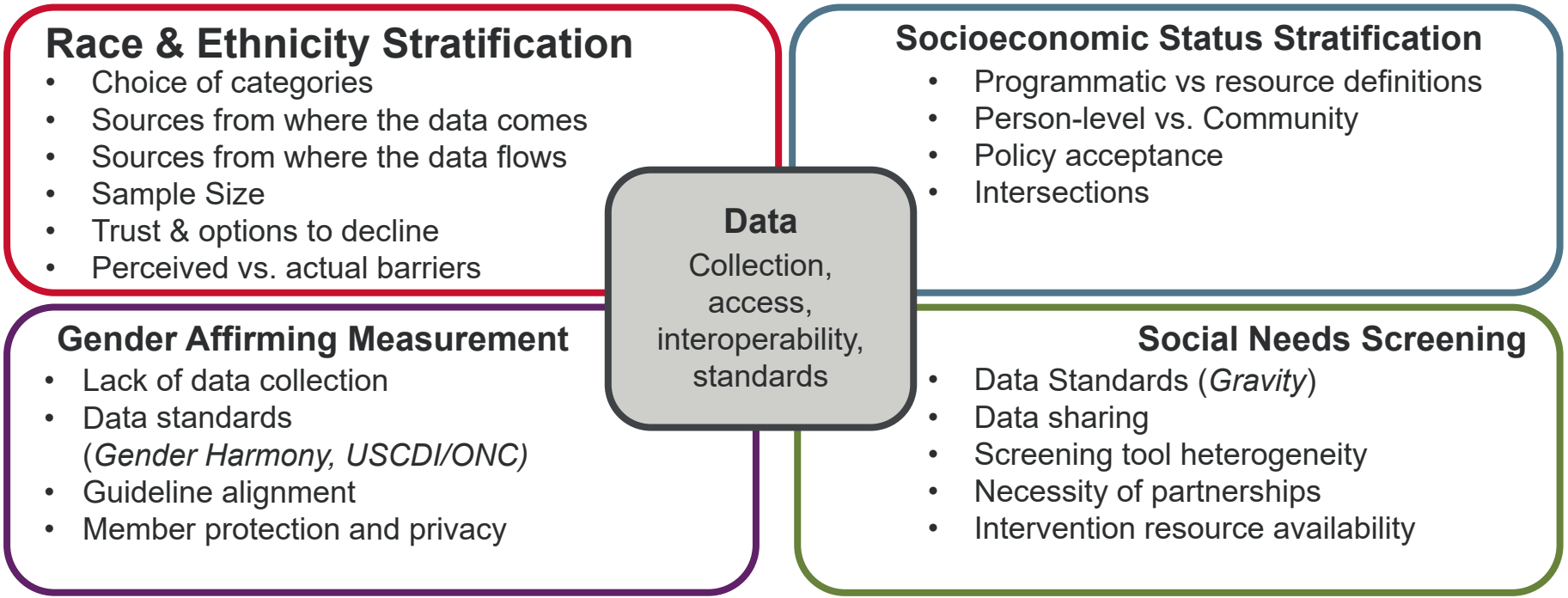
- Hospice
- I-SNP
- LTI

Age Stratification

- ≤17
- 18-64
- 65+

Equity Measurement

Lessons Learned



Anna Lee Amarnath, Integrated Healthcare Association (IHA)

Integrated Healthcare ASSOCIATION

About Integrated Healthcare Association

Performance Measurement: AMP Program, Atlas, EDGE, HPD
Provider Director Management: Symphony

Who we are

- A non-profit business league funded by the healthcare industry to make the system work better for everyone
- Our board of directors includes leaders from across the healthcare industry

IHA

About Integrated Healthcare Association *(continued)*

What we do

- We align healthcare around shared goals and new possibilities
- We use data and insights to help everyone improve
- We build what's needed to drive lasting change

What is Align. Measure. Perform. (AMP)?

AMP is a statewide, value-based healthcare performance improvement measurement program for plans and providers. Since 2003, our single, industry-curated measure set has tracked the quality, resource use, and cost measures that have the biggest impact on care outcomes.

IHA

What is Align. Measure. Perform. (AMP)? (continued)

AMP offers **impartial, validated results and a neutral appeals process** to so that plans and providers can benchmark their cost, quality, and resource use performance against peers and the market, helping them know where to target improvement efforts.

AMP program participants

AMP performance measurement by provider organization: **12.1M Californians represented**

Atlas performance measurement by region, payer and product type, market characteristics: **16M Californians represented**

200+ Medical Groups, IPAs, ACOs, and FQHCs

15 Health Plans

6 Industry Partners

3 Purchasers

IHA

How does the AMP program work?

AMP's four components work together to encourage continuous improvement

Common measure set

Common infrastructure & aligned reporting across 12.1 M lives

Health plan incentive design

Largest non-governmental advanced payment model (APM) in the country

Public reporting

Office of Patient Advocate Report Card available to all Californians

Public recognition

Recognition for provider organizations advancing value

IHA

California Advancing Primary Care Measure Set

Subset of AMP Common Measure Set; Does not include Data Quality Measures

Clinical Quality	Patient Experience (CAHPS)	Appropriate Resource Use	Cost

*(phased approach: screening → monitoring → remission)

**Will potentially be replaced by new HEDIS measure Hemoglobin A1c Control for Patients With Diabetes (HBD)

IHA

Focusing on the data

Race and ethnicity data is an industry-wide challenge

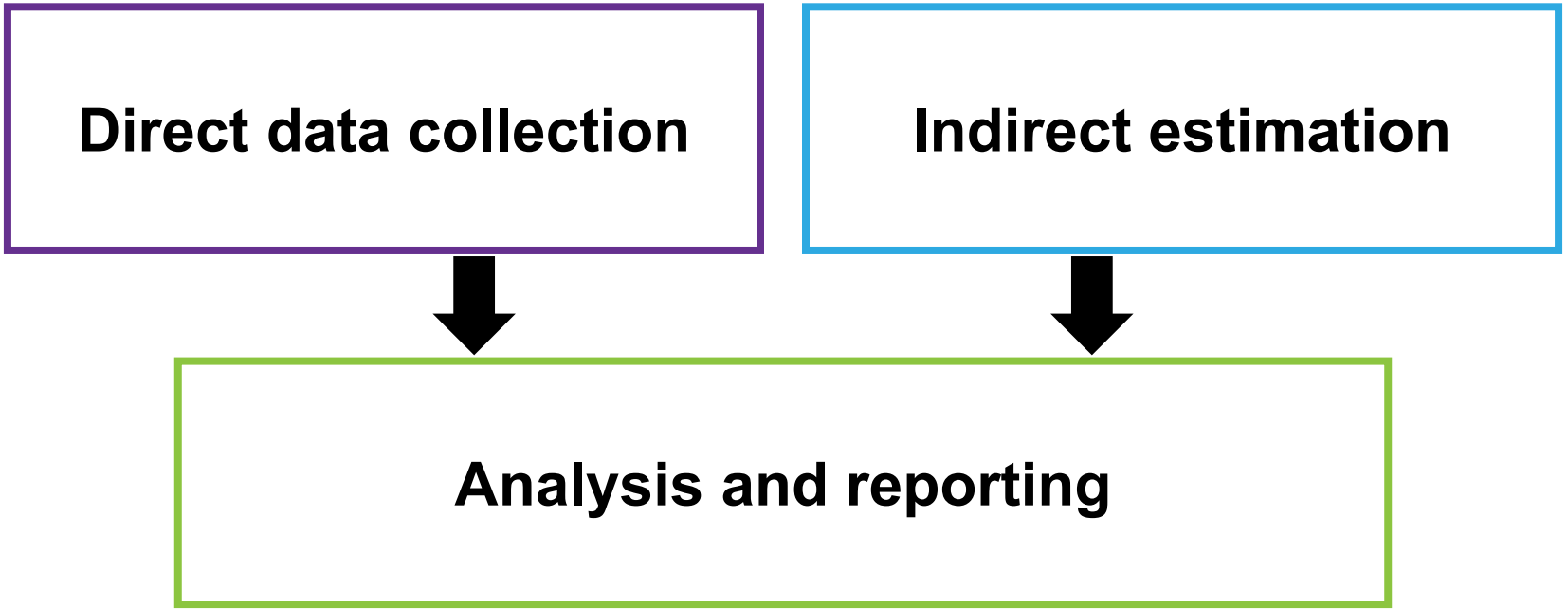
Inconsistent capture and lack of standardization of data

Inability to match data to claims-based information

Lack of consensus on how to use data to improve health equity

IHA

Approaches to improving race/ethnicity data and reporting



IHA

RAND's Bayesian Improved Surname Geocoding (BISG) Method

Indirect estimation method linking a person's surname and residential address to Census data on race/ethnicity to produce a set of probabilities that a given person belongs to one of a set of mutually exclusive racial/ethnic groups:

- Asian/Pacific Islander
- Black
- White
- Hispanic/Latino

RAND's Bayesian Improved Surname Geocoding (BISG) Method

- BISG can measure race/ethnicity with 92-97% accuracy at the group level (which is its intended purpose vs. individual level)
- In proof of concept run by IHA, Onpoint, and RAND, BISG was able to generate estimated race/ethnicity for 98% of members with available surnames and zip codes using MY 2019 data (sample = ~5 million members)
  - Note: *proof of concept results have not yet been validated against self-reported race/ethnicity in IHA claims data*

IHA

Where can IHA have an impact in addressing health disparities?

Focus on improving the data

Find new ways to use existing data

Use the data outside the AMP/Atlas infrastructure

Support state policy and regulatory efforts

IHA

Cheryl Damberg, RAND Corporation

DMHC Health Equity and Quality Committee Meeting

Cheryl L. Damberg

RAND Distinguished Chair in Healthcare Payment Policy

Director, RAND Center of Excellence on Health System Performance

JAMA Health Forum™

Invited Commentary

Opportunities to Address Health Disparities in Performance-Based Accountability and Payment Programs

Cheryl L. Damberg, PhD; Marc N. Elliott, PhD

1) Measure Performance Accurately to Reduce Provider Incentives to Avoid Disadvantaged Patients
2) Make Disparities Visible Through Public Reporting of Stratified Performance
3) Specifically Incentivize Providers and Health Plans to Improve Care for Disadvantaged Patients
4) Modify Performance-Based Payment Systems to Avoid Redistributing Resources Away From Providers Who Care for Disadvantaged Patients

JAMA Health Forum. 2021;2(6):e211143. doi:10.1001/jamahealthforum.2021.1143 June 11, 2021

Reducing Bias in Measurement

- **Measure validity:** Remove bias in scores that does not reflect provider performance, but is instead associated with patient characteristics outside of the control of providers or plans
- Disparities are composed of:
  - **within-provider disparities** (extent to which patients of low SES receive worse care than patients of high SES from the provider) and
  - **between-provider differences** (extent to which all patients of a clinician or health care institution receive worse care)

Reducing Bias in Measurement

- **Adjust for the mean within-provider differences** associated with factors appropriate for adjustment
  - Retains between-provider quality differences
- Case-mix adjustment produces the scores that providers would receive if they all served the same patients

Make Disparities Visible Through Public Reporting of Stratified Performance

- CMS Office of Minority Health as example
  - Stratified reporting of clinical and patient experience measures by **race/ethnicity** and by **gender** for Medicare Advantage plans
  - Pools data over 2 years to accurately differentiate subgroup performance
  - Requires a minimum of 100 cases per subgroup, and enforce minimum reliability standards of 0.6 to report results

https://www.cms.gov/About-CMS/Agency-Information/OMH/research-and-data/statistics-and-data/stratified-reporting#

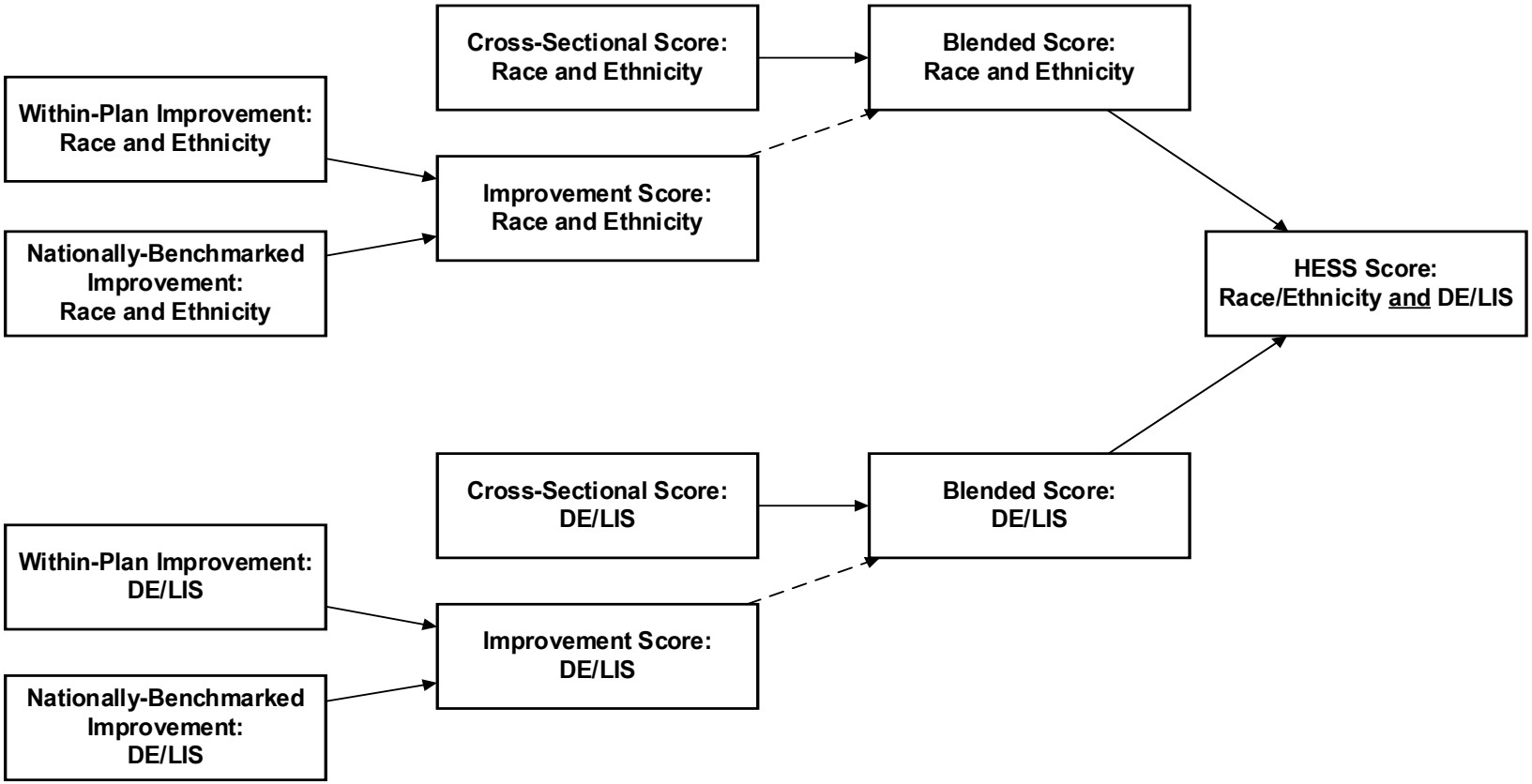
CMS Office of Minority Health's Health Equity Summary Score (HESS)

- To characterize the quality-of-care delivered to Medicare patients with social risk factors (SRFs)
- To create a summary index of health equity, it combines data across:
  - Multiple measures (HEDIS, CAHPS)
  - Multiple social risk factors (e.g., dual/LIS, race/ethnicity

CMS Office of Minority Health's Health Equity Summary Score (HESS)

- Multiple types of comparisons
  - Cross-sectional score: combines 2 most-recent years of data
  - Improvement score: compares performance in 2 most recent years to performance in the 2 years prior
    - Narrowing/widening of within-plan differences
    - Improving quality for those with SRFs relative to national benchmarks (incentive for absolute improvement)

Construction of the HESS



CMS 2023 Advance Notice Health Equity Index (proposed)

- Summarizes MA plan performance among those with SRFs across multiple measures (CAHPS, HEDIS) into a single score
  - Propose initially to include disability and LIS/DE
- Distribution of plan contract performance on each measure for each SRF would be separated into thirds:
  - top third of plans receive 1 point
  - middle third receive 0 points
  - bottom third receive -1 point

CMS 2023 Advance Notice Health Equity Index (proposed)

- Index calculated as the weighted sum of points across all measures in the index using the Star Ratings measure weights divided by the weighted sum of the number of eligible measures to calculate the index.
- Contract performance on the index would vary from -1.0 (performance was in the bottom third for each included measure) to 1.0 (performance was in the top third for each included measure).

CMS 2023 Advance Notice Health Equity Index (proposed)

- CMS is considering replacing the current reward factor in the Star Ratings program.
- Plans with a minimum percentage of enrollees with SRFs, such as half the contract median percentage of enrollees with SRFs, and which meet a minimum score on the index, such as a score greater than zero, could receive a reward factor that could vary with higher index scores receiving a larger reward factor.

Modify Value-Based Payment Systems

- To avoid redistributing resources away from providers who care for disadvantaged patients, need to act on the distribution of the incentive payments
- One approach:
  - Start with standard incentive payment allocation
  - Post adjust provider payments using patient or provider characteristics
  - Hold mean incentive payout constant across subgroups
  - Provides larger incentives for better performers within all subgroups

Modify Value-Based Payment Systems

- This approach:
  - Nearly doubled payments to providers caring for disadvantaged patients
  - Reduced payment differentials across providers according to patients' income, race/ethnicity, and region

Damberg CL, Elliott MN, Ewing BA. Pay-for-performance schemes that use patient and provider categories would reduce payment disparities. Health Aff (Millwood). 2015;34(1):134-142. doi:10.1377/hlthaff.2014.0386

damberg@rand.org

Questions

Guiding Principles for Measure Selection and Focus Areas

Andy Baskin, Quality SME, MD

Ignatius Bau, Health Equity SME, JD

Guiding Principles for Measure Selection Sources

- California Department of Health Care Services (DHCS) Criteria for the Medi-Cal Managed Care External Accountability Set (MCAS)
- National Quality Forum (NQF) Criteria to Assess Measures for Endorsement
- NQF Measure Application Partnership Criteria

Guiding Principles for Measure Selection Sources

- Centers for Medicare and Medicaid Services (CMS) /America's Health Insurance Plans (AHIP) Core Quality Measures Collaborative Measure Selection Principles
- National Academy of Medicine
- State Medicaid Programs

Guiding Principles for Measure Selection Criteria

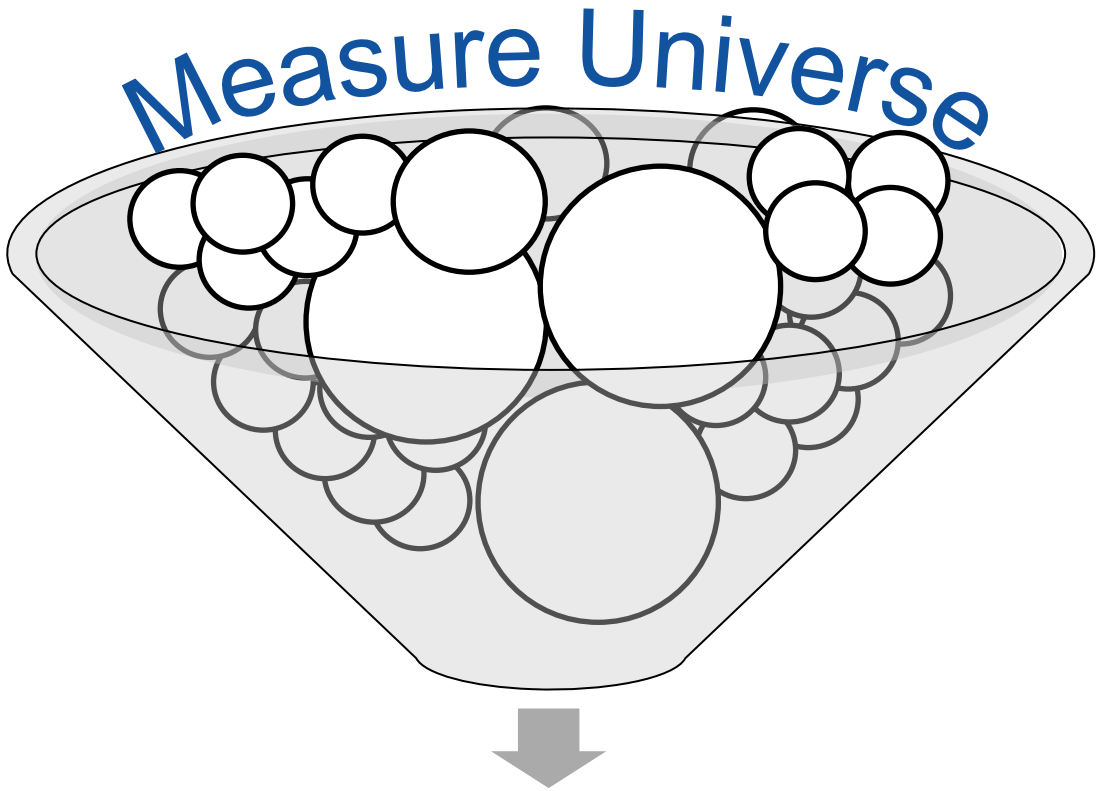
- Important to measure and report to make significant gains in quality and improve outcomes
  - Opportunity for improvement
  - Potential for high population impact
- Feasibility
  - Access and availability of data
  - Minimize burden for data collection and reporting
  - Potential for stratification

Guiding Principles for Measure Selection Criteria

- Usability
  - Proven implementation elsewhere
- Consideration of disparities sensitive measures (e.g., racial, ethnic, etc.)
- California priority area for focus

Guiding Principles for Measure Selection Criteria

- Alignment with other measurement and reporting programs
  - California (e.g., Medi-Cal, IHA, Covered CA), National (e.g., CMS), accreditation programs (e.g., NCQA)
- Harmonize similar measures across programs in California



The final measure set will consist of approximately 10-12 measures, with final decision by DMHC

Measure Selection Process

The measure set will be developed by:

1. Determining what areas to focus on
2. Presenting an initial proposed list of focus areas and having the Committee identify any gaps in focus areas
3. Selecting the top 2-3 measure candidates for each focus area
4. Once we have completed all the focus areas, selecting a final proposed measure set understanding that some focus areas may end up with 0-2 measures

Measure Selection Process

- Throughout the selection process, we will note any recommendations that may not be feasible now, but could be desirable in the future

- Measures may overlap multiple focus areas so exclusion of an area does not necessarily mean there will not be quality measurement

Focus Areas Sources

- CMS Child/Adult Core Set
- NCQA HEDIS Domains
- Agency for Healthcare Research and Quality (AHRQ) Quality Indicators
- California Programs and Organizations (e.g., Medi-Cal and Covered California)
- State Delivery System Reform Incentive Programs (DSRIP) (e.g., New York, Texas)
- Literature Reviews

Most Common Focus Areas

- Health equity
- Access
- Prevention
- Coordination of care
- Mothers and children
- Chronic conditions
- Behavioral health
- Substance use
- Population health
- Specialty
- Utilization
- Patient experience

Discussion of Most Common Focus Areas

- Health equity
- Access
- Prevention
- Coordination of care
- Mothers and children
- Chronic conditions
- Behavioral health
- Substance use
- Population health
- Specialty
- Utilization
- Patient experience

Questions

Vote to Identify and Select Focus Areas

Preliminary Discussion on Measures

Andy Baskin, Quality SME, MD

Ignatius Bau, Health Equity SME, JD

Preliminary Discussion on Measures: Prevention

These measures are NQF-endorsed and reported elsewhere (Medi-Cal Accountability Set, Covered CA, and IHA):

- Cervical Cancer Screening
- Chlamydia Screening
- Breast Cancer Screening
- Colorectal Cancer Screening
- Well-Child Visits in the First 30 months of Life

Preliminary Discussion on Measures: Prevention

These measures are NQF-endorsed and reported elsewhere (Medi-Cal Accountability Set, Covered California, and IHA):

- Child and Adolescent Well-Care Visits
- Childhood Immunization Status
- Immunizations for Adolescents
- Weight Assessment and Counseling for Nutrition and Physical Activity for Children/ Adolescents

Questions

Public Comment

Public comments may be submitted until 5 p.m. on March 31, 2022 to publiccomments@dmhc.ca.gov

Closing Remarks

Public comments may be submitted until 5 p.m. on March 31, 2022, to publiccomments@dmhc.ca.gov

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

Next Health Equity and Quality Committee meeting will be held on April 20, 2022, in Sacramento from 1:00 – 4:00 p.m.