DMHC Health Equity and Quality Committee

February 24, 2022

Agenda

1. Opening Remarks
2. Overview of the Department of Managed Health Care (DMHC)
3. Overview of Bagley-Keene Open Meeting Act Requirements
4. Committee Introductions, Goals, and Timeline
5. California and National Trends

Agenda (cont.)

6. Consumer Representatives Panel
7. Purchaser Overview of Current Activities
8. Public Comment
9. Closing Remarks

DMHC Attendees

1. Mary Watanabe, Director
2. Nathan Nau, Deputy Director, Office of Plan Monitoring
3. Chris Jaeger, MD, MBA 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

Opening Remarks

Mary Watanabe, Director

Questions

Overview of the Department of Managed Health Care

Mary Watanabe, Director

DMHC Mission Statement

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

Our Accomplishments

20 YEARS of Consumer Protection

2.5 MILLION CONSUMERS ASSISTED

The DMHC Help Center educates consumers about their rights, resolves consumer complaints, helps consumers navigate and understand their coverage, and ensures access to health care services.

$36.1 MILLION

dollars recovered from health plans on behalf of consumers

132 LICENSED HEALTH PLANS

87 FULL SERVICE

45 SPECIALIZED

27.7 MILLION CALIFORNIANS' HEALTH CARE RIGHTS ARE PROTECTED BY THE DMHC

95% of state-regulated commercial and public health plan enrollment is regulated by the DMHC

$296.1 MILLION

dollars saved on Health Plan Premiums through the Rate Review Program since 2011

$40.3 MILLION in 2020

INDEPENDENT MEDICAL REVIEW (IMR)

Approximately **68%** of consumer appeals (IMRs) to the DMHC resulted in the consumer receiving the requested service or treatment from their health plan.

$165.1 MILLION

dollars in payments recovered to physicians and hospitals

$83.6 MILLION

dollars assessed against health plans that violated the law

June 2021

What is the DMHC?

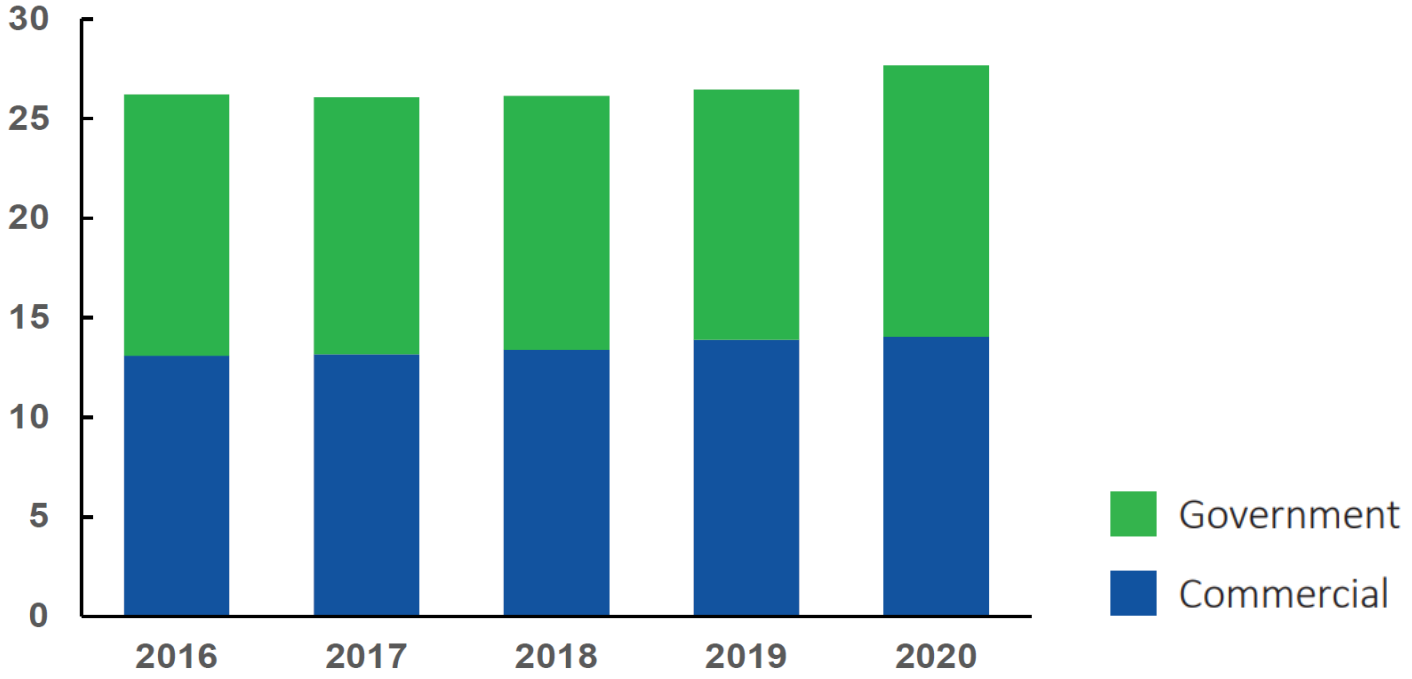
Regulator of full service and specialized health plans

- All HMO and some PPO/EPO products
- Some large group and most small group & individual products
- Most Medi-Cal Managed Care plans
- Dental, vision, behavioral health, chiropractic and prescription drug plans
- Medicare Advantage (for financial solvency only)

DMHC Enrollment Over Time

20 YEARS of Consumer Protection

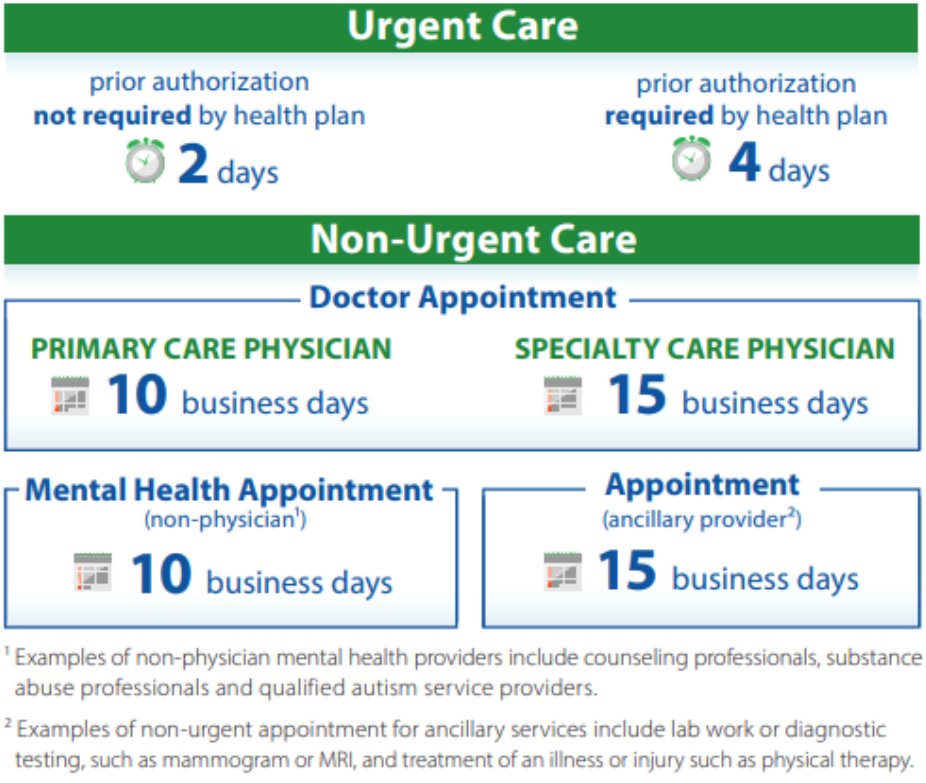
Full Service Enrollment (In Millions)



How Does the DMHC Regulate Plans?

- License plans and approve products
- Analyze provider networks
- Ensure basic health care services and mandated benefits are provided
- Monitor financial health
- Evaluate plan policies and procedures
- Resolve grievances and appeals
- Track enrollee complaints
- Enforce the law

Timely Access To Care



DMHC Help Center

- The DMHC's Help Center has helped more than 2.5 million Californians resolve complaints and issues with their health plan.
- Services are fast, free and confidential.
- If your health plan denies, delays or modifies your request for care you can apply for an Independent Medical Review (IMR).
- Approximately 68% of IMR requests result in the consumer receiving the requested service.

DMHC Help Center

1-888-466-2219

HealthHelp.ca.gov

Questions

Overview of Bagley-Keene Open Meeting Act Requirements

Scott Ostermiller, Attorney

Purpose and General Rule

- To allow the public to participate in government and have an opportunity to participate in the decision-making process of state bodies
- The public is allowed to monitor and participate in all meetings of state bodies, unless there is a specific reason to exclude the public. Three general requirements:
  - Public Notice
  - Opportunity to Comment
  - Public Access

What Bodies are Covered?

- Any multimember body created by statute
- Health Equity and Quality Committee specifically subject to Bagley-Keene under Health and Safety Code Section 1399.870

What Constitutes a Meeting?

A physical meeting: “Any congregation of a majority of the members of a state body at the same time and place to hear, discuss, or deliberate upon any item that is within the subject matter jurisdiction of the state body to which it pertains.”

Serial and Spoke Meetings

- A quorum of members may not discuss any matter within the committee's subject matter jurisdiction in a series of meetings (A talks to B, then to C)
- A quorum of members may not discuss a matter within the committee's subject matter jurisdiction through representatives (A, B, and C each talk to a third, non-member party)
- What a quorum may not do as a group it may not do through a series of meetings or through representatives

Exceptions to Meeting Rule

- Separate communications with a member of a legislative body such as the legislature or a committee, as long as no communication about another committee member's position
- Individual contacts between committee members and members of the public
- Conferences that are open to the public and involve discussion of issues of general interest to the public (as long as no private communication between a quorum of committee members)

Exceptions (continued)

- Social gatherings (but no discussion of matters within the committee's subject matter jurisdiction)
- Open meetings of standing committees
- Open meetings of other state bodies or of local agencies

Teleconference Meetings

- Meetings by teleconference are permissible
- The primary physical meeting locations must be designated in the meeting notice, and members of the public must be permitted to attend and participate in the meeting at the primary location.
- All votes by rollcall, all other provisions apply

Notice and Agenda

- Notice of upcoming meetings must be provided to persons who request it and on the agency website at least 10 calendar days before the meeting
- Time and place of meeting, name and contact information for a person who can provide information
- Include a specific agenda with a brief (20-word) description of each item
- Agenda includes closed-session items, and statutory basis for holding closed session
- Make available in alternative formats under ADA

Public Access and Participation

- Committee may not impose conditions on public attendance at a meeting
- Any sign-in sheet at meetings must be accompanied with a notice that it is voluntary
- Members of the public may record and broadcast meetings unless doing so would constitute a persistent disruption

Public Access and Participation (continued)

- Public must have the opportunity to speak either before or during consideration of each agenda item
- No discrimination of attendance based on race, national origin, etc.; no entrance fee
- Meeting facilities must be accessible to disabled

Access to Records

- Any written materials provided to a majority of the committee are disclosable public records
- Must be made available in alternative formats to disabled individuals who request them
- Subject to exemptions under Public Records Act (e.g., attorney-client privileged documents are not public records subject to disclosure)

Remedies for Violations

- Invalidation of action taken in violation
- Costs and attorneys' fees may be recovered from the body
- Misdemeanor penalties if a member attends a meeting with intent to deprive the public of information he/she knows or should know the public is entitled to

Questions

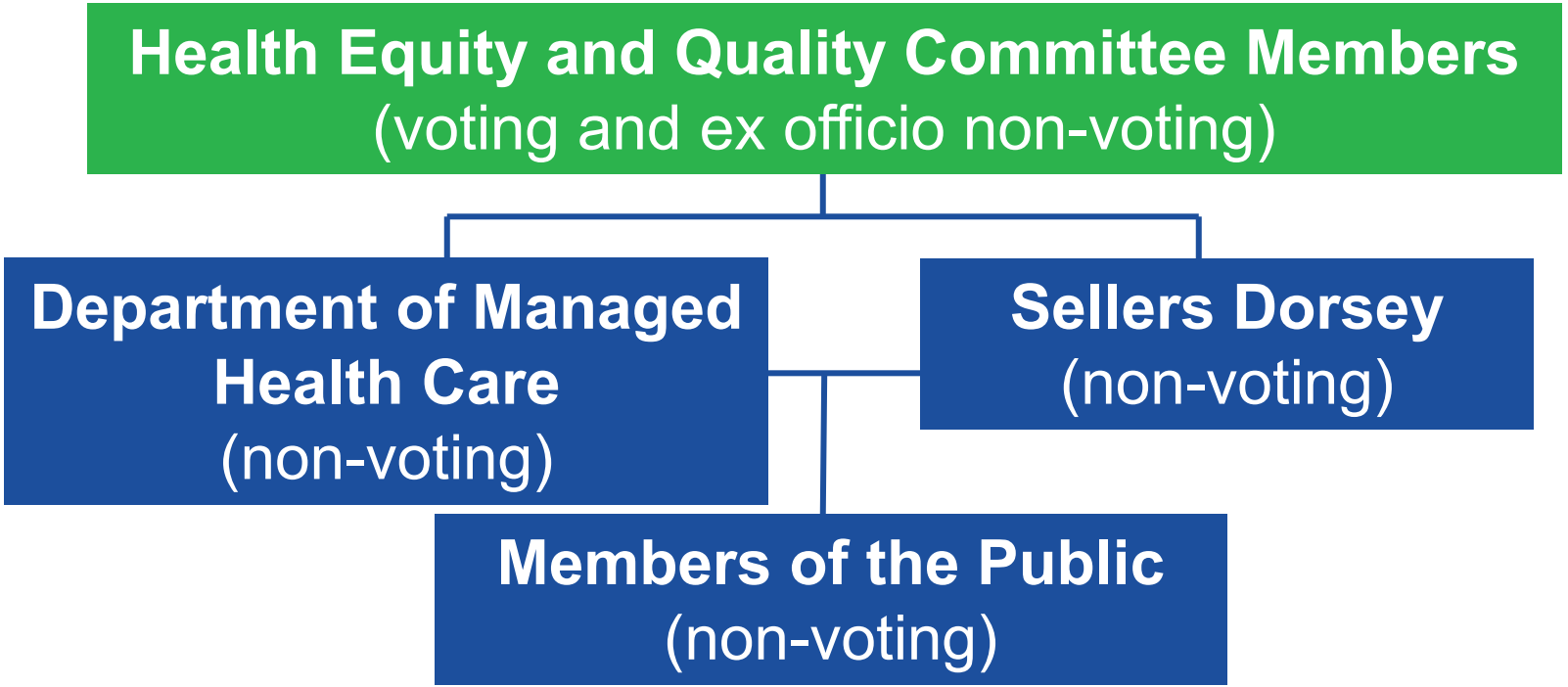
Committee Introductions, Goals, and Timeline

Sarah Brooks, Project Director

Committee Goal

The goal of the Health Equity and Quality Committee is to make recommendations to the DMHC for standard health equity and quality measures, including annual benchmark standards for assessing equity and quality in health care delivery.

Committee Structure



Committee & Attendee Roles

Voting Health Equity and Quality Committee Members

- Review all materials in advance of Committee meetings.
- Present on particular topics as subject matter experts.
- Attend all Committee meetings.
- Participate in forming recommendations to the DMHC Director on or before September 30, 2022.

Committee & Attendee Roles

Ex Officio Non-Voting State Department Members

- In addition to the prior responsibilities listed, State department representatives will provide overviews of the current and future activities of their respective departments and inform Committee discussions.

Committee & Attendee Roles

The DMHC

- The DMHC will consider recommendations brought forth by the Health Equity and Quality Committee in the final Report.
- The DMHC does not act as a voting member of the Committee but will participate in the discussions.

Committee & Attendee Roles

Sellers Dorsey

- Sellers Dorsey will provide health equity, quality, and health care subject matter expertise as well as facilitate and manage Committee meetings.
- Recommendations made by the Committee will be included in the Report submitted to the DMHC by Sellers Dorsey.
- The Sellers Dorsey team will not act as a voting member of the Committee.

Committee Voting Guidelines

- Items that are voted on are subject to a 60% majority.
- If an item meets the “pass” criteria, the item will be included in the Health Equity and Quality Report for consideration by the DMHC.
- Committee members will have an opportunity to submit dissenting comments to Sellers Dorsey for inclusion in the Health Equity and Quality Report .
- A quorum must be present for voting to occur (at least 9 voting members of the Committee).

Committee Timeline

Activity	Date
Committee Meeting #1	February 24
Committee Meeting #2	Week of March 21
Committee Meeting #3	Week of April 18
Committee Meeting #4	Week of May 16
Committee Meeting #5	Week of June 6

Committee Timeline

Activity	Date
Committee Meeting #6	Week of June 20
Committee Meeting #7	Week of July 11
Receive/Review Proposed Report	No Later than July 15
Committee Meeting #8	Week of August 15
Committee to Share Final Comments	No Later than August 26

Questions

California & National Trends

Andy Baskin, Quality SME, MD
Ignatius Bau, Health Equity SME, JD

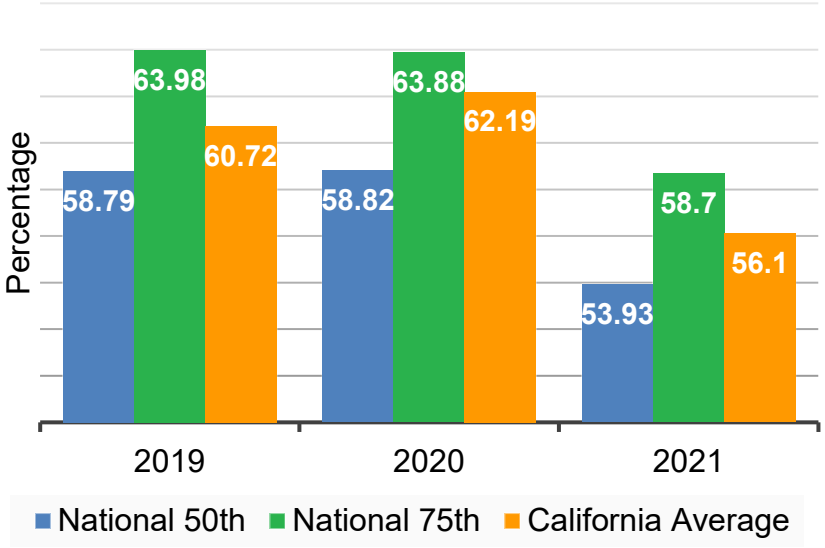
Assembly Bill 133, Article 11.9

The [Health Equity and Quality] committee shall provide initial recommendations, as well as recommendations on updating and revising **standard health equity and quality measures** and annual benchmark standards, consistent with this article.

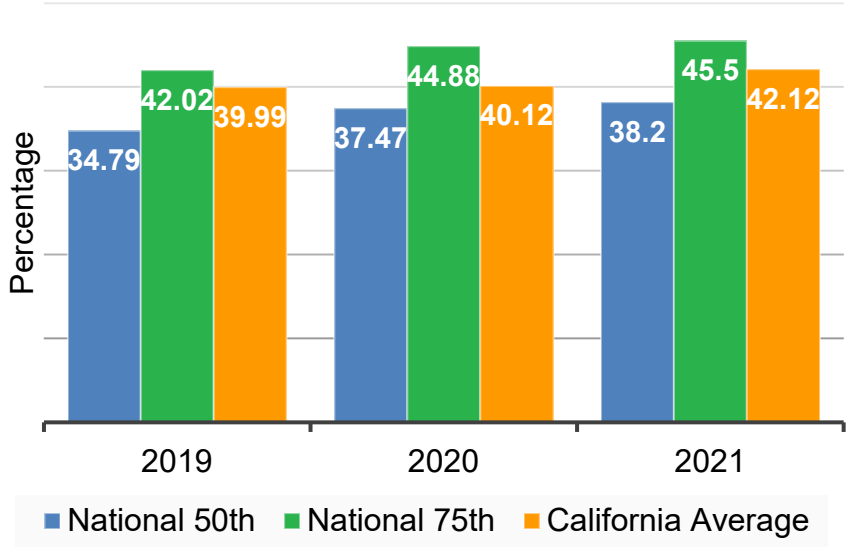
These recommendations shall consider the interaction of multiple characteristics in determining where disparate outcomes exist, including but not limited to, race, ethnicity, gender, sexual orientation, language, age, income, and disability.

California & National Trends: Medicaid

Breast Cancer Screening

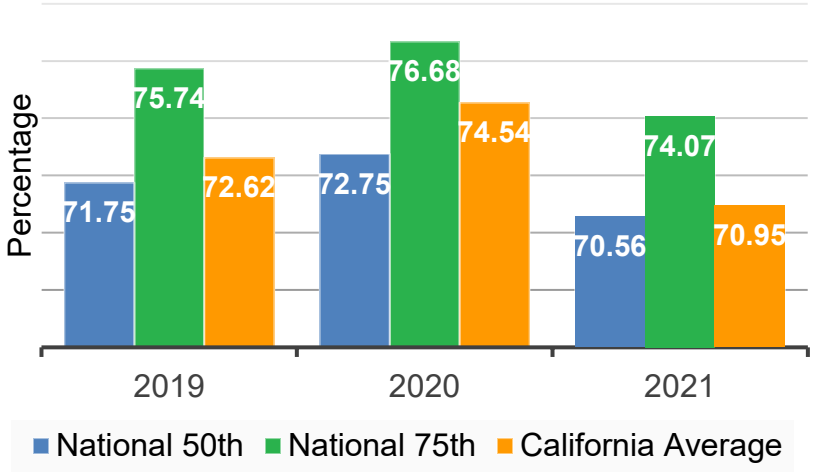


Childhood Immunization Status – Combo 10

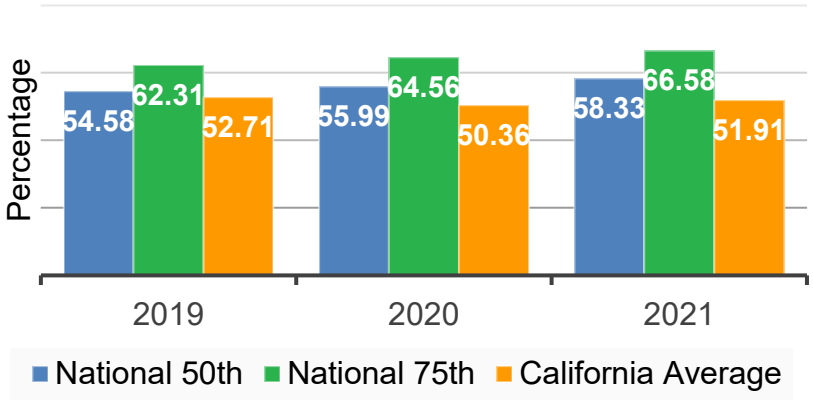


California & National Trends: Commercial

Breast Cancer Screening



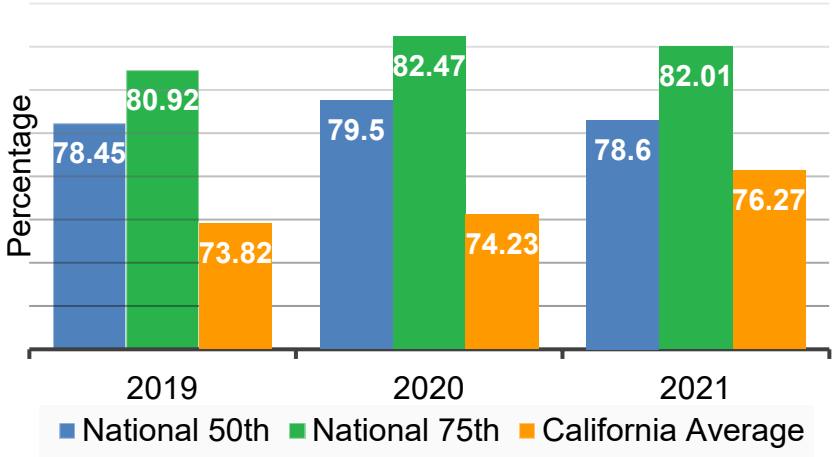
Childhood Immunization Status – Combo 10



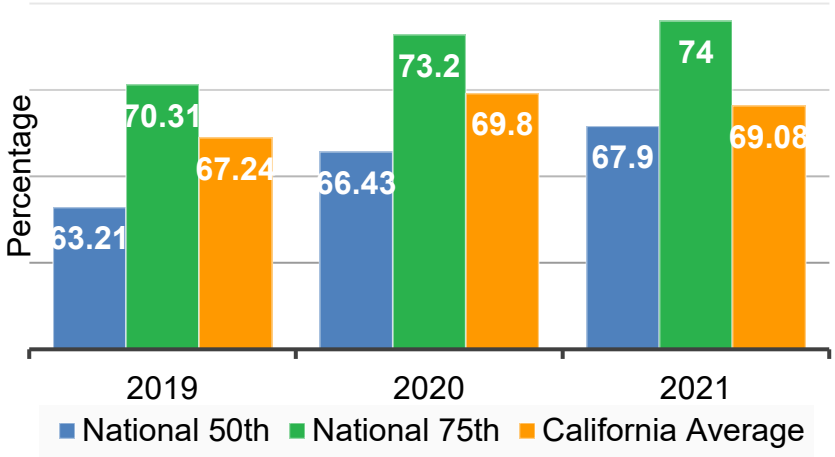
California & National Trends

Adult Survey - Rating of Health Plan

The result displayed is the percentage of members who answered this question with 8, 9, or 10.



Medicaid



Commercial

Health Plan Report Card

HMO and PPO	Quality of Medical Care	Patients Rate Overall Experience
Aetna – PPO	FAIR ★★	GOOD ★★★
Aetna Health of California – HMO	GOOD ★★★	FAIR ★★
Blue Shield of California – HMO	GOOD ★★★	GOOD ★★★
CIGNA – HMO	GOOD ★★★	GOOD ★★★
CIGNA – PPO	GOOD ★★★	FAIR ★★

Health Plan Report Card

HMO and PPO	Quality of Medical Care	Patients Rate Overall Experience
Health Net Life Insurance – PPO	GOOD ★★★	POOR ★
Health Net - HMO	GOOD ★★★	GOOD ★★★
Kaiser Permanente – N CA – HMO	VERY GOOD ★★★★	FAIR ★★
Kaiser Permanente – S CA – HMO	EXCELLENT ★★★★★	GOOD ★★★
Sharp Health Plan - HMO	VERY GOOD ★★★★	VERY GOOD ★★★★
UnitedHealthcare Insurance Co., Inc. - PPO	GOOD ★★★	POOR ★
UnitedHealthcare of CA - HMO	FAIR ★★	GOOD ★★★

NCQA Stratification

5 Measures in MY2022
Colorectal Cancer Screening
Controlling High Blood Pressure
Prenatal and Postpartum Care
Child and Adolescent Well Care Visits (WCV)
Hemoglobin A1c Control for Patients With Diabetes
≥ 10 Measures in MY2023
≥ 15 Measures in MY2024

NCQA Stratification

Categories for Race:

- 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 (missing)

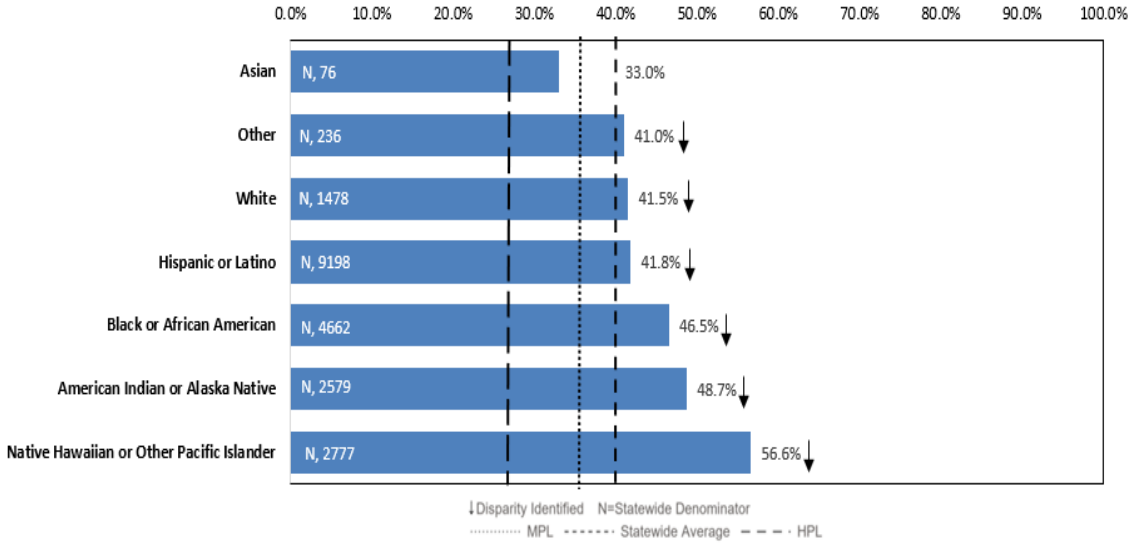
NCQA Stratification

Categories for Ethnicity:

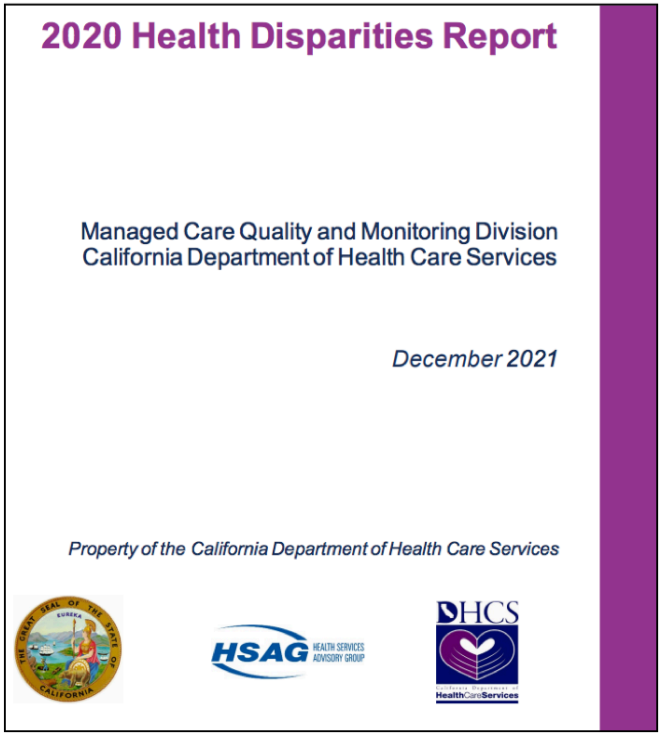
- Hispanic/Latino
- Not Hispanic/Latino
- Asked but not answered
- Unknown (missing)

Medi-Cal Managed Care Plans: Example

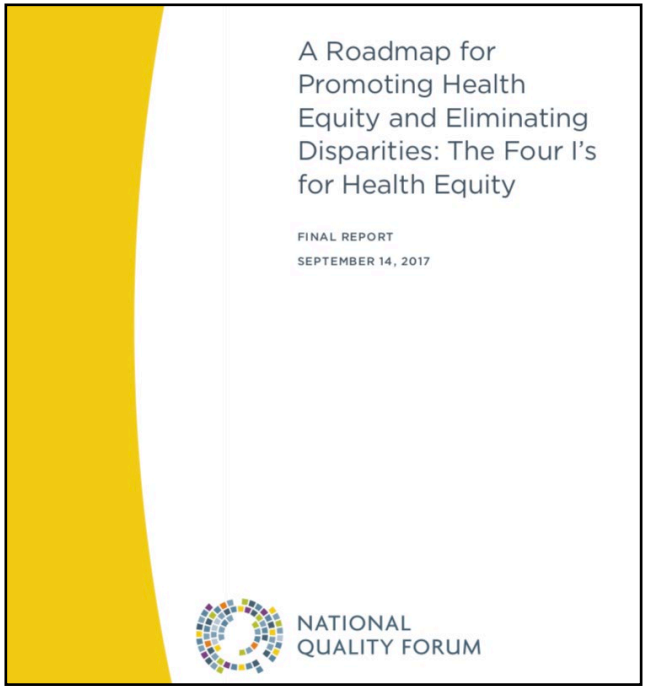
Comprehensive Diabetes Care – HbA1c Poor Control (>9%) where a lower rate is better.

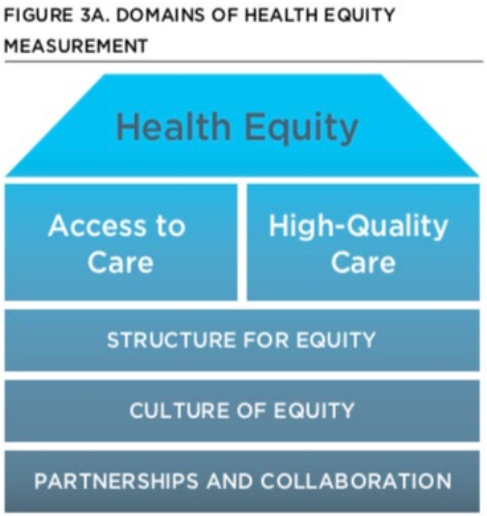


California Landscape: Health Equity



National Quality Forum (NQF)





NATIONAL QUALITY FORUM

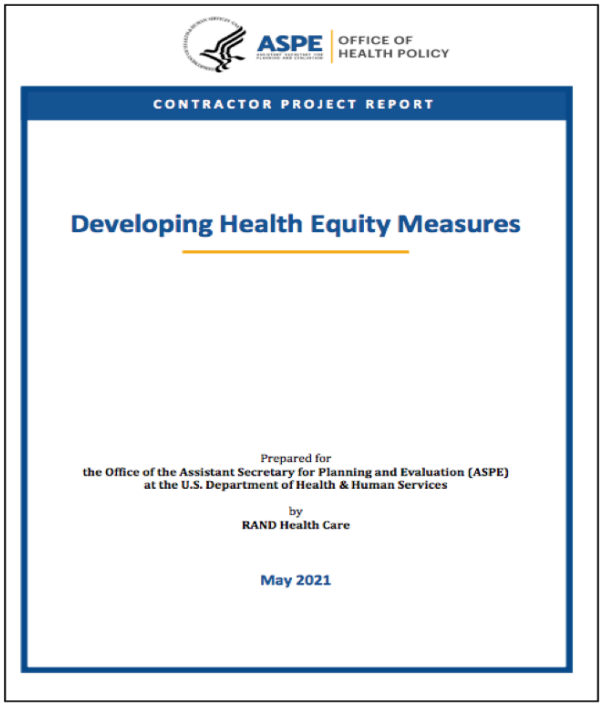
NQF: Disparities-Sensitive Measures

1. **Prevalence —** How prevalent is the condition among populations with social risk factors? What is the impact of the condition on the health of populations with social risk factors?
2. **Size of the disparity —** How large is the gap in quality, access, and/or health outcome between the group with social risk factors and the group with the highest quality ratings for the measure?

NQF: Disparities-Sensitive Measures

3. **Strength of the evidence** — How strong is the evidence linking improvement in performance on the measure to improved outcomes in the population with social risk factors?
4. **Ease and feasibility of improvement (actionable)** — Is the measure actionable (e.g. by providers/clinicians/health plans, etc.) among the population with social risk factors?

Developing Health Equity Measures


ASPE | OFFICE OF HEALTH POLICY

CONTRACTOR PROJECT REPORT

Developing Health Equity Measures

Prepared for
the Office of the Assistant Secretary for Planning and Evaluation (ASPE)
at the U.S. Department of Health & Human Services

by
RAND Health Care

May 2021

Appendix B. Measures Identified as Disparities-Sensitive According to the NQF Disparities-Sensitive Measure Assessment

Examples:

Utilization/Appropriateness of Use

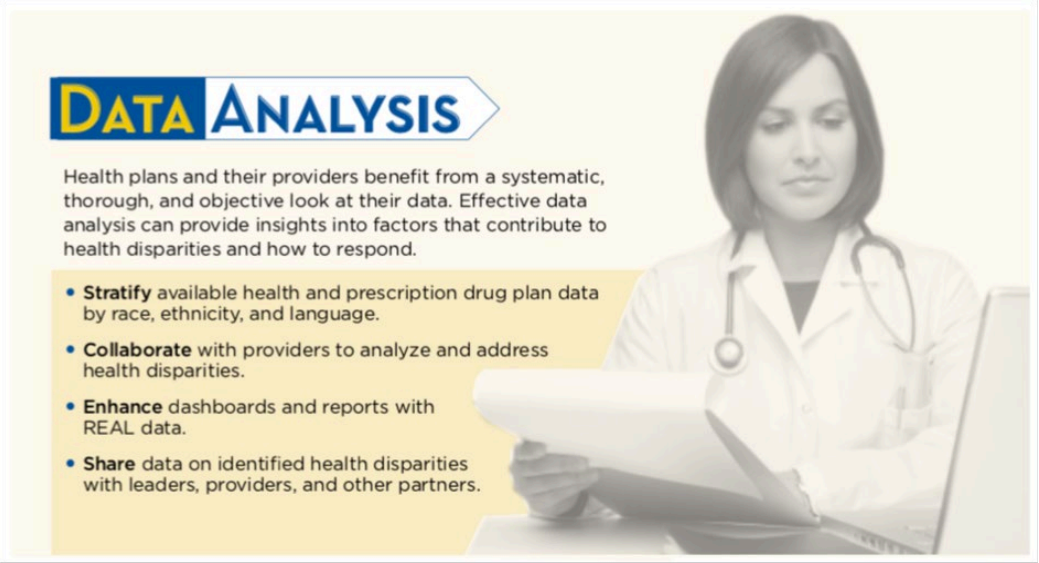
- Relative Resource Use for People with Asthma
- Relative Resource Use for People with COPD
- Relative Resource Use for People with Diabetes
- Relative Resource Use for People with Cardiovascular Conditions
- Asthma Emergency Department Visits

Measures Identified Through Second-Tier Review (Communication/Care Coordination)

Clinician/Group Health Literacy Practices Based on CAHPS Item Set for Addressing Health Literacy
Clinician/Group's Cultural Competence Based on the CAHPS Cultural Competence Item Set
Patients Receiving Language Services Supported by Qualified Language Services Providers
Screening for Preferred Spoken Language for Health Care
Experience of Care and Health Outcomes (ECHO) Survey

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES
go.cms.gov/omh

National Trends



National Trends

Figure 1. CMS Innovation Center Vision and 5 **Strategic Objectives** for Advancing System Transformation.

Measure Applications Partnership

Health Equity Advisory Group

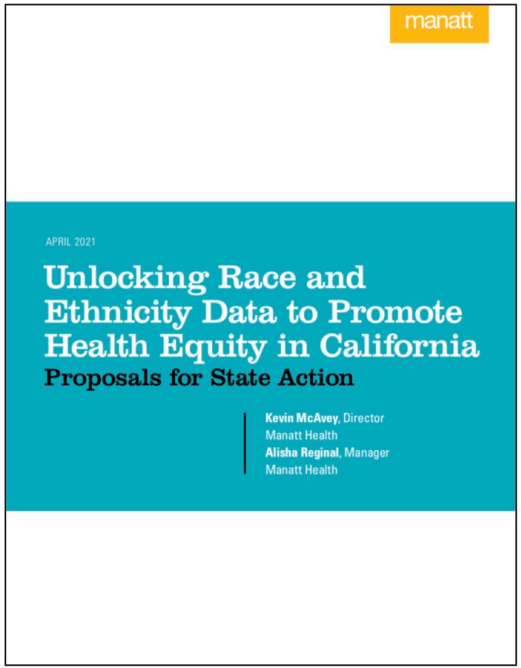
The Advisory Group takes a poll on the potential impact on health disparities if the measure is included within a specific program; the poll scores range from 1-5, or from negative impact/increasing disparities to positive impact/reducing disparities.

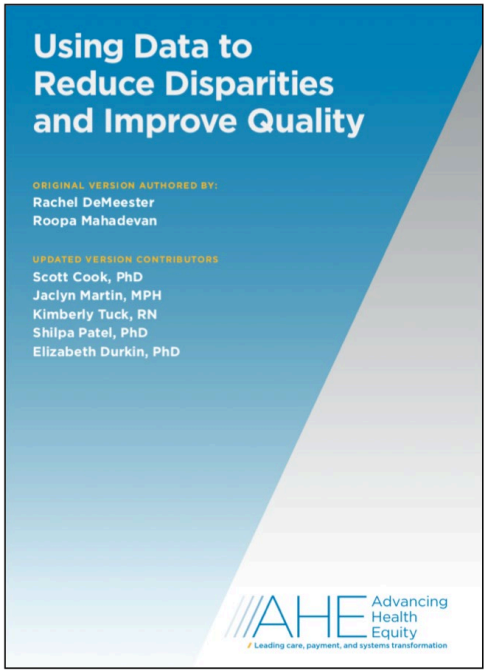
Suggested discussion questions for the Advisory Group:

1. What aspects of health equity do you see this measure advancing (culture, access, outcomes, etc.)?
2. What social determinants of health should be considered related to this measure?

3. If the measure includes stratification or risk adjustment, are there any concerns about how the measure is stratified or risk adjusted from a health equity lens? What additional information would be beneficial to include? If the measure does not include stratification or risk adjustment, what information would be beneficial to include?

Leveraging Data to Improve Health Equity and Quality



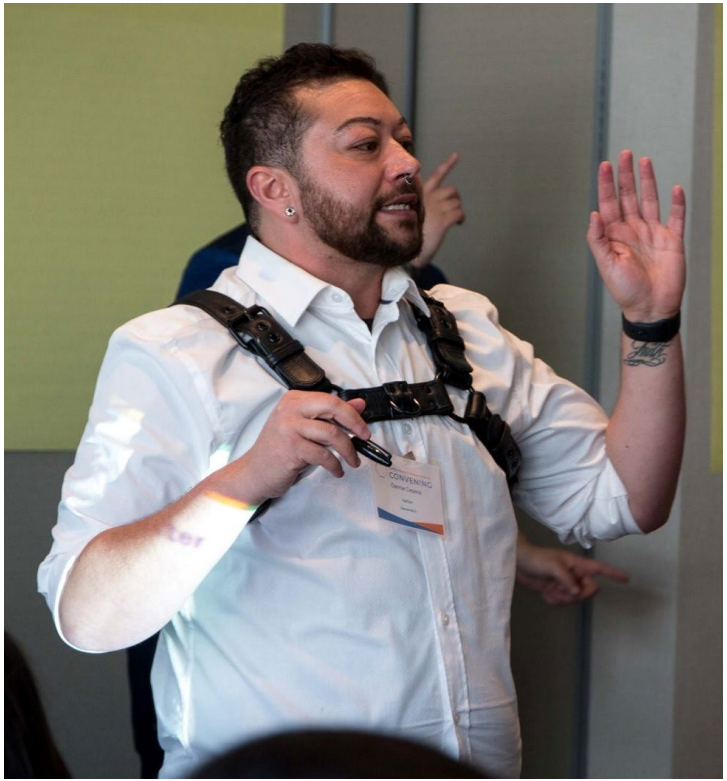


Questions

Consumer Representatives Panel

Dannie Cesena, California LGBTQ Health and Human Services Network

Introductions



Dannie Cesena, MPH *(he/they)*

Two-Spirit, Latinx, trans activist, husbear, escape room nerd, Disneyland fanatic

CALIFORNIA LGBTQ HEALTH AND HUMAN SERVICES NETWORK

The Network

Founded in 2007, The CA LGBTQ Health and Human Services Network brings together more than 60 non-profit providers, community centers, and researchers to advocate collectively for state level policies and resources that will advance LGBTQ health. The Network provides coordinated leadership about LGBTQ health policy in a proactive, responsive manner that promotes health and well-being as part of the movement for LGBTQ equality, and ensures that there is a distinct LGBTQ voice in health policy decision-making venues.

What would an equitable health system look like?

- Removing barriers to care such as discrimination and eliminating gatekeeping (patient satisfaction as a key measure)
- Gender affirming preventative care
- Affordable health system/elimination of high-cost deductibles and prescription costs that makes health care inaccessible to marginalized communities
- Holistic care including addressing social determinants of health

What are the biggest challenges or barriers to reducing health disparities?

- Lack of streamlined data collection
- Lack of affirming and competent providers and insurance agencies
- Distrust of medical system
- Holistic care including addressing social determinants of health
- Gender affirming and inclusive preventative care

What should be considered when establishing health equity and quality measures?

- Access to mental health services for depression, anxiety, PTSD, etc.
- STI screenings
- Are people filling their prescriptions? If not, why? Are people utilizing their insurance, paying cash, or purchasing via back alley/internet?
- Are preventative services and screenings gender inclusive?
- Do consumers need to advocate for their own care while educating their provider?

Diana Douglas, Health Access California

Lishaun Francis, Children Now

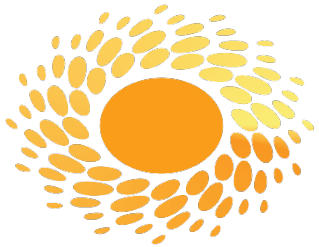
Tiffany Huyenh-Cho, Justice in Aging

JUSTICE IN AGING

FIGHTING SENIOR POVERTY THROUGH LAW

Jeffrey Reynoso, Latino Coalition for a Healthy California

Kiran Savage-Sangwan, California Pan-Ethnic Health Network



California Pan-Ethnic
HEALTH NETWORK

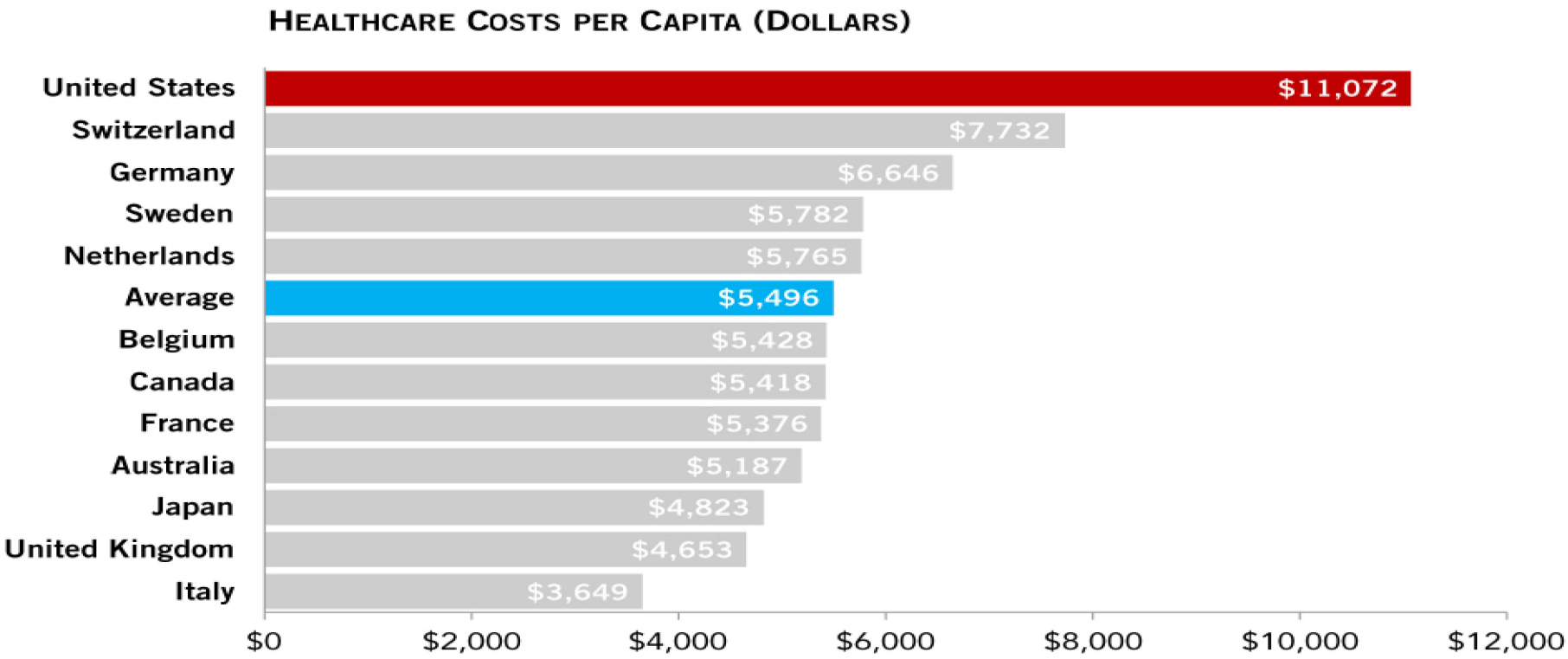
Rhonda Smith, California Black Health Network

CALIFORNIA
BLACK HEALTH NETWORK

THE CAMPAIGN FOR
BLACK
HEALTH
EQUITY
HEALTH, HOPE, HUMANITY

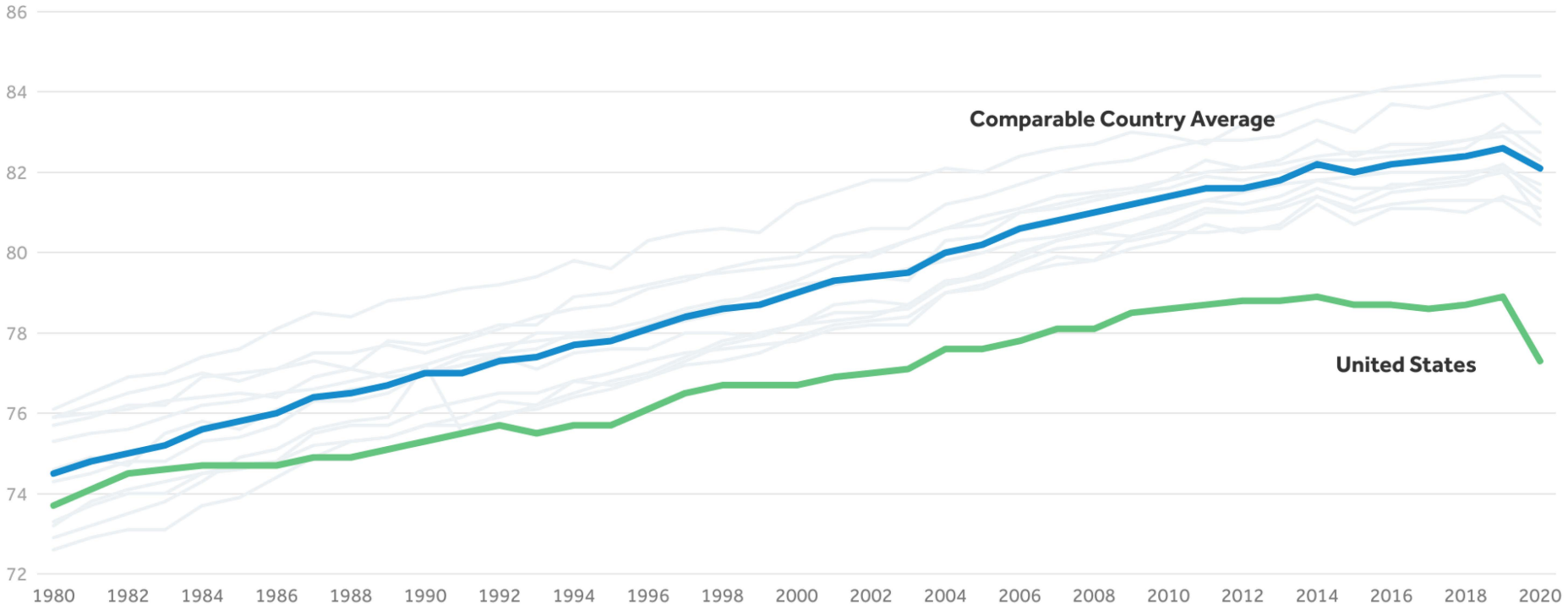
PETER G. PETERSON FOUNDATION

U.S. per capita healthcare spending is almost twice the average of other wealthy countries



SOURCE: Organisation for Economic Co-operation and Development, *OECD Health Statistics 2020*, July 2020.
NOTES: The five countries with the largest economies and those with both an above median GDP and GDP per capita, relative to all OECD countries, were included. Average does not include the U.S. Data are for 2019. Chart uses purchasing power parities to convert data into U.S. dollars.

Life expectancy at birth in years, 1980-2020

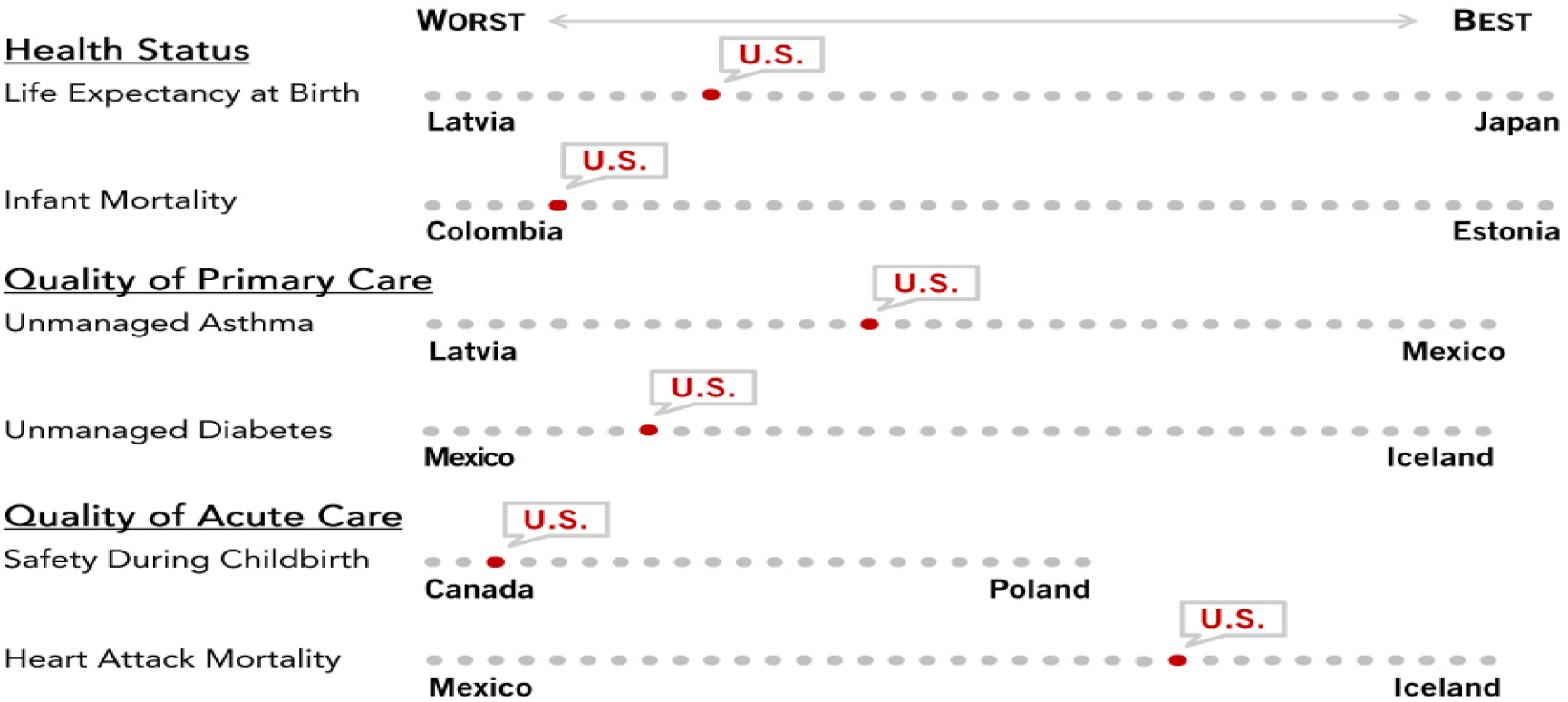


Notes: Data prior to 2020 are from OECD. 2020 data are from CanStat, the CDC, OECD, and Public Health England. 2019 life expectancy values are used for Australia and Japan in 2020. Life expectancy for the United Kingdom in 2020 was calculated by taking the weighted mean of provisional life expectancy values for males and females in England. Break in series for Canada in 1982, Germany in 1991, Switzerland and Belgium in 2011, and France in 2013.

Source: KFF Analysis of CDC, OECD, StatCan, Office for National Stastics, and Public Health England data

PETER G. PETERSON FOUNDATION

Although the United States spends more on healthcare than other developed countries, its health outcomes are generally not any better



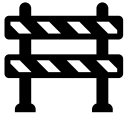
SOURCE: Organisation for Economic Co-operation and Development, *OECD Health Statistics 2020*, July 2020.
NOTES: Data are not available for all countries for all metrics. Data are for 2019 or latest available.

From Reducing Disparities to Achieving Health Equity

Health Disparities

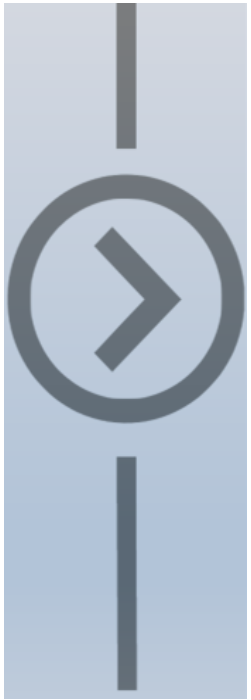
Differences in health outcomes among specific groups such as race/ethnicity, age, disability, socioeconomic status, sexual orientation and education.

Disease Progression & Late Dx



Structural Barriers to Care

High Death Rates



Health Equity

Attainment of the highest level of health for all people, ensuring that everyone has full and equitable access to health opportunities that enable them to lead healthy lives.

Prevention & Early Dx

Access to Quality Equitable Care

Lives Saved

Doreena Wong, Asian Resources, Inc.

Doreena Wong,
Policy Director
Asian Resources, Inc.
dwong@asianresources.org (323) 547-9485

DMHC Health Equity and Quality Committee: Consumer Representative Panel

Asian Resources, Inc

- Asian Resources, Inc. (ARI) is a non-profit community- based organization established in 1980 dedicated to providing multiple social services needed in our community and promoting policy advocacy to empower everyone we serve to become a vital part of our changing, diverse society.

Asian Resources, Inc

- For the last 40 years, Asian Resources has committed itself to serve and respond to the needs of the most vulnerable and diverse community o Asian Americans, Native Hawaiians and Pacific Americans, immigrants, refugees, limited English speakers, and other communities of color.
- With offices in the Sacramento and LA. We lead local CHW collaboratives and statewide advocacy collaboratives.

What would an Equitable Health Care System Look Like

- The diverse population of California would be able to access an affordable, culturally and linguistically competent and quality health care services and programs.
- Equity does not necessarily mean equal but what is needed to level the playing field for all communities in the state.
- The health care system would allow each individual to reach their full potential in life.

Challenges to Reducing Health Disparities

- Cultural and linguistic barriers
  - Diversity of needs
  - Lack of disaggregated demographic data
  - Lack of effective, understandable materials in different language
  - Lack of interpreters at govt. agencies and health care providers

Challenges to Reducing Health Disparities

- Anti-Asian incidents/Anti-immigrants
  - Public charge fears
  - Lack of trust of government agencies and programs
- Health literacy issues
- Technology barriers

Considerations in Establishing Health Equity and Quality Metrics

- Need to require the uniform and standardized collection and reporting of disaggregated race, ethnicity, language, sexual orientation and gender identity, and other demographic data
- Provision of language assistance services, including interpreter and translation services, notice of consumer rights, language access assessment and plans, and monitoring and evaluation of plans

Considerations in Establishing Health Equity and Quality Metrics

- Address health disparities of chronic conditions, including diabetes, heart disease, cancer screening and treatment, and asthma
- Address access to medical, oral and behavioral health services

Silvia Yee, Disability Rights Education and Defense Fund

HEALTH & HEALTHCARE EQUITY FOR PEOPLE WITH DISABLITIES

February 24, 2022

DREDF

Disability Rights Education & Defense Fund

Equitable Healthcare System

Health Equity for People with Disabilities requires having an equal opportunity to achieve and maintain health, which includes not having one's diagnosis dictate one's life opportunities (e.g., housing, education, employment, social interactions, having a family, financial resources, right to vote, and so forth).

Health Barriers for People with Disabilities

- Greater healthcare need/thinner margin of health
- Implicit provider bias
- Inaccessible Examination/Medical Equipment
- Unmodified Office/Medical Policies and Procedures
- Effective Communication barriers
- Lesser Access to Social Determinants of Health (e.g., accessible public transportation or housing, internet access)

Key Needs, Unmet Needs, and Identifying Who Gets What

- Durable Medical Equipment
- Drug therapies
- Rehabilitation and Habilitation Services
- Mental Health Services
- Any other essential health benefit that does not consider accommodation needs for people who have chronic care needs and functional limitations

Health Equity & Benefit Design

Insurance carriers have historically limited services and devices medically needed by disabled persons:

- Visit/quantity limits
- Special co-pays, deductibles & co-insurance
- Medically arbitrary item or service restrictions
- Drug utilization management/cost controls

Questions

Purchaser Overview of Current Activities

Julia Logan, California Public Employees Retirement System

CalPERS Health Benefits Program

1.5 million
Members

1,200
Number of employers that contract for health benefits

$9.7 billion
Spent to purchase health benefits in 2020

Membership by Employer
58% State
28% Public Agency
14% School

Exceptional Health Care

Ensure all members receive **equitable** care

Ensure the care we provide is **affordable**

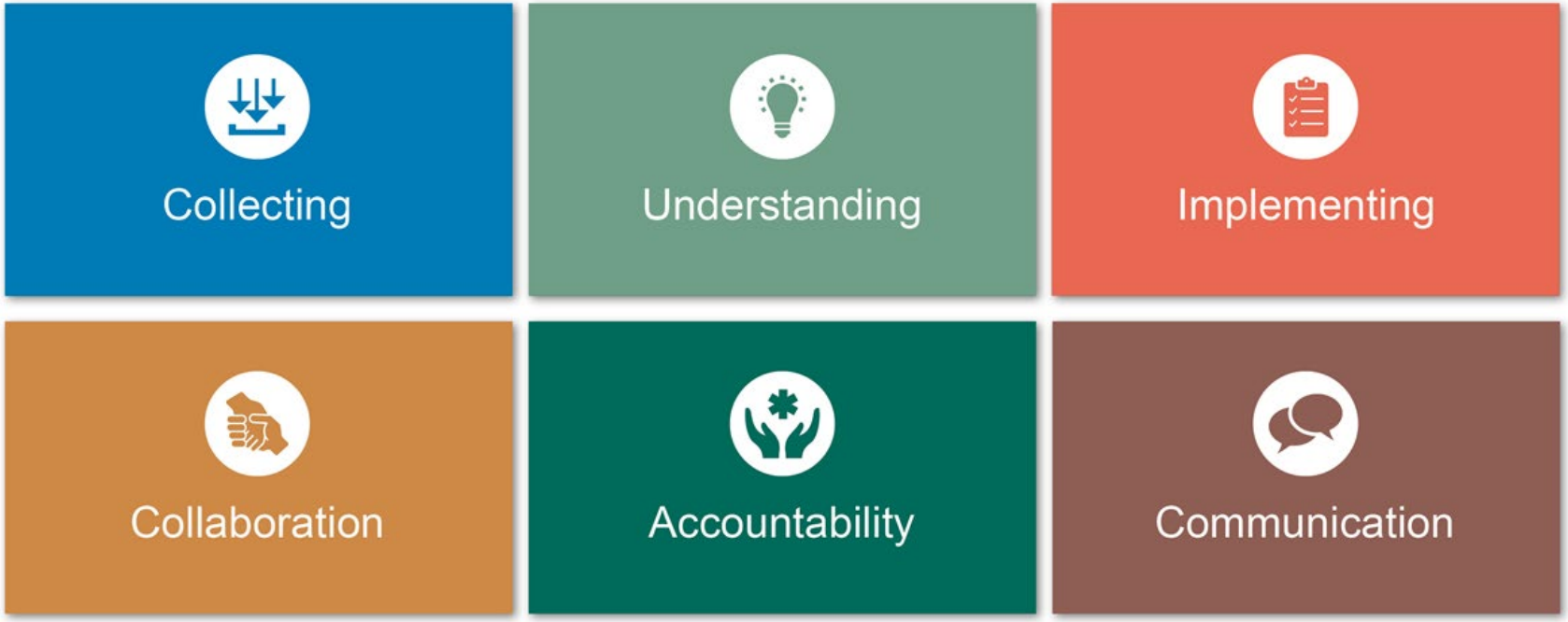
Ensure our members receive high-**quality** care

Ensure our members have **access** to care when and where they need it

Alignment with Other Healthcare Purchasers

Health Demographic Profile in myCalPERS

What We're Doing

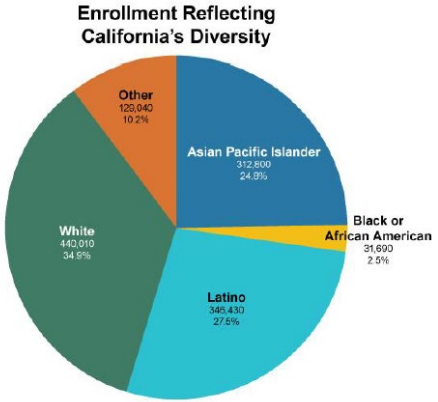


Margareta Brandt, Covered California

COVERED CALIFORNIA

Our vision is to improve the health of all Californians by ensuring their access to affordable, high-quality care.

Our mission is to increase the number of insured Californians, improve health care quality, lower costs, and reduce health disparities through an innovative, competitive marketplace that empowers consumers to choose the health plan and providers that give them the best value.



1.78M Enrolled

MANY MEASURES, LITTLE IMPROVEMENT

CMS' Quality Rating System (QRS): while 83% of enrollees in 2020 were in health plans that received 3 or more stars for "Getting the Right Care" (25 measures), health plan performance has not consistently or substantively improved over time.

Qualified Health Plan Issuer	2021 Enrollees	2016	2017	2018	2019	2020	2021
Anthem HMO	1.9%	3	-	-	-	NA	NA
Anthem PPO	-	2	-	-	-	-	-
Anthem EPO	4.5%	2	NA	3	2	2	2
Blue Shield HMO	7.4%	NA	NA	NA	2	3	3
Blue Shield PPO	20.6%	2	2	3	2	3	3
CCHP HMO	0.3%	3	3	3	3	3	3
Health Net HMO	8.3%	3	3	3	3	3	3
Health Net EPO	0.05%	NA	2	3	2	3	NA
Health Net PPO	2.7%	-	NA	NA	NA	3	2
Kaiser Permanente HMO	36.9%	5	4	5	5	5	4
LA Care HMO	6.1%	1	3	4	3	4	3
Molina Healthcare HMO	3.5%	2	3	3	2	2	2
Oscar Health Plan EPO	4.3%	NA	NA	3	2	2	2
Sharp Health Plan HMO	1.5%	4	4	5	4	4	4
Valley Health Plan HMO	1.4%	3	3	5	4	4	3
Western Health Advantage HMO	0.6%	3	3	3	2	2	3

* 2021 represents measurement year 2020 which may not be representative due to COVID-19

1. Diabetes Care: HbA1c Control < 8.0% (NQF 0575)
2. CBP – Controlling High Blood Pressure (NQF 0018)
3. AMR - Asthma Medication Ratio Ages 5-85
4. Antidepressant Medication Management (Effective Acute Phase Treatment)
5. Antidepressant Medication Management (Effective Continuation Phase Treatment)
6. Admissions for Diabetes Short-term Complications among Members with Diabetes
7. Admissions for Diabetes Long-Term Complications among Members with Diabetes
8. Admissions for Uncontrolled Diabetes among Members with Diabetes
9. Admissions for Lower-Extremity Amputation among Members with Diabetes
10. Admissions for Hypertension among Members with Hypertension
11. Admissions for Heart Failure among Members with Hypertension
12. Admissions for Asthma among Older Adults with Asthma
13. Admissions for Bacterial Pneumonia among Members with Asthma
14. Admissions for Asthma among Children and Younger Adults with Asthma

MANY MEASURES, LITTLE IMPROVEMENT

Disparities Measures: initial set of 14 disparities measures developed in 2017 not actionable due to small population sizes for some measures and incomplete self-reported race/ethnicity data for stratification.

Qualified Health Plan Issuer	2021 Enrollees	2016	2017	2018	2019	2020	2021
Anthem HMO	1.9%	3	-	-	-	NA	NA
Anthem PPO	-	2	-	-	-	-	-
Anthem EPO	4.5%	2	NA	3	2	2	2
Blue Shield HMO	7.4%	NA	NA	NA	2	3	3
Blue Shield PPO	20.6%	2	2	3	2	3	3
CCHP HMO	0.3%	3	3	3	3	3	3
Health Net HMO	8.3%	3	3	3	3	3	3
Health Net EPO	0.05%	NA	2	3	2	3	NA
Health Net PPO	2.7%	-	NA	NA	NA	3	2
Kaiser Permanente HMO	36.9%	5	4	5	5	5	4
LA Care HMO	6.1%	1	3	4	3	4	3
Molina Healthcare HMO	3.5%	2	3	3	2	2	2
Oscar Health Plan EPO	4.3%	NA	NA	3	2	2	2
Sharp Health Plan HMO	1.5%	4	4	5	4	4	4
Valley Health Plan HMO	1.4%	3	3	5	4	4	3
Western Health Advantage HMO	0.6%	3	3	3	2	2	3

* 2021 represents measurement year 2020 which may not be representative due to COVID-19

1. Diabetes Care: HbA1c Control < 8.0% (NQF 0575)
2. CBP – Controlling High Blood Pressure (NQF 0018)
3. AMR - Asthma Medication Ratio Ages 5-85
4. Antidepressant Medication Management (Effective Acute Phase Treatment)
5. Antidepressant Medication Management (Effective Continuation Phase Treatment)
6. Admissions for Diabetes Short-term Complications among Members with Diabetes
7. Admissions for Diabetes Long-Term Complications among Members with Diabetes
8. Admissions for Uncontrolled Diabetes among Members with Diabetes
9. Admissions for Lower-Extremity Amputation among Members with Diabetes
10. Admissions for Hypertension among Members with Hypertension
11. Admissions for Heart Failure among Members with Hypertension
12. Admissions for Asthma among Older Adults with Asthma
13. Admissions for Bacterial Pneumonia among Members with Asthma
14. Admissions for Asthma among Children and Younger Adults with Asthma

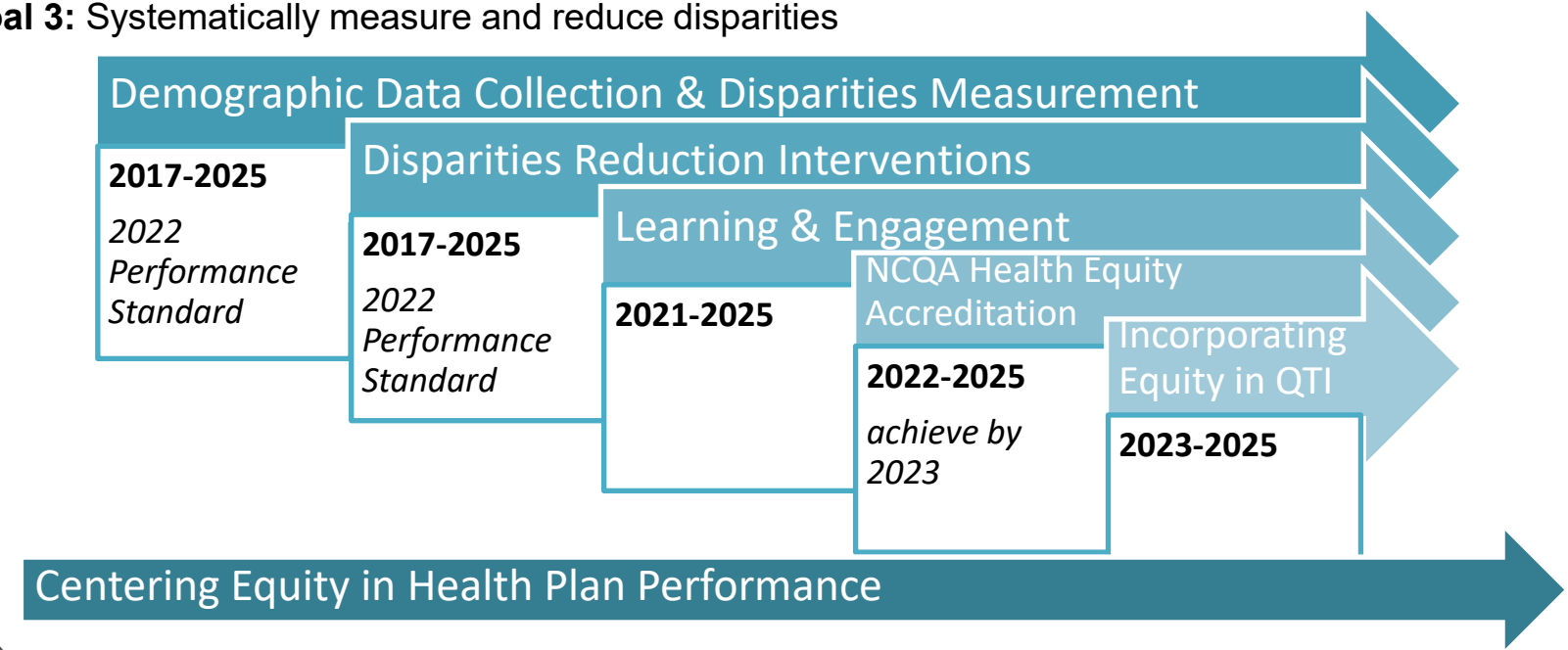
EVOLUTION OF HEALTH DISPARITIES REQUIREMENTS

Covered California's multi-year disparities reduction initiatives have been in place since 2017 and seek to achieve the following goals:

Goal 1: Improve disparity data capture to support measurement, and

Goal 2: Improve structure and rigor for disparities intervention development, in order to

Goal 3: Systematically measure and reduce disparities



CHALLENGES AND LESSONS LEARNED

- Continued gaps in member race and ethnicity data due to voluntary reporting and health plan dependence on imputation methodology
- Best practice of using DHCS Patient Level Data (PLD) file submission process challenged by vendor arrangements
- Small numbers when stratifying by race and ethnicity means some plans need to use two years of data or combine on and off-Exchange for baseline measurement

CHALLENGES AND LESSONS LEARNED

- Limitations in use of administrative data for intervention population identification and measurement can be addressed with data completeness thresholds
- Lack of benchmarks for performance measurement will be addressed with implementation of HEDIS measure stratification
- Plans benefit from technical assistance, though progress remains slow and resource-intensive despite plan engagement and commitment

2023 – 2025 QUALITY TRANSFORMATION INITIATIVE

QTI Core Measures (PLD sourced)	Disparities Monitoring (PLD or HEI sourced)
Controlling High Blood Pressure (NQF #0018)	Prenatal Depression Screening and Follow-up (PND-E)
Hemoglobin A1c (HbA1c) Control (<8.0%) (NQF #0575)	Postnatal Depression Screening and Follow-up (PDS-E)
Colorectal Cancer Screening (NQF #0034)	Comprehensive Diabetes Care (CDC): Hemoglobin A1c (HbA1c) Testing (NQF #0057)
Childhood Immunization Status (Combo 10) (NQF #0038)	Ambulatory Emergency Room (ER) Visits© per 1,000
Depression Screening and Follow-Up for Adolescents and Adults (DSF) (reporting only)	Adult Preventive Visits© per 1,000
Pharmacotherapy for Opioid Use Disorder (POD) (reporting only)	Breast Cancer Screening (BCS) (NQF #2372)
	Proportion of Days Covered: Three Rates by Therapeutic Category (NQF #0541) a) Diabetes All Class (PDC-DR) (NQF #0541) b) RAS Antagonists (PDC-RASA) (NQF #0541) c) Statins (PDC-STA) (NQF #0541)

All QTI measures will be stratified by race/ethnicity for reporting only in initial years. Quality payments tied to reducing health disparities for the QTI measure set will begin in 2025 or 2026.

Dana Durham, Department of Health Care Services

CALIFORNIA DEPARTMENT OF
HEALTH CARE SERVICES

Measuring Quality and Equity in Medi-Cal

Palav Babaria, MD, MHS
Chief Quality Officer

DHCS | Quality and Population Health Management

DHCS's Vision for Quality & Equity

Specific Measures

Infant, child and adolescent well-child visits
Childhood and adolescent vaccinations

Prenatal and postpartum visits
C-section rates

Prenatal and postpartum depression screening
Adolescent depression screening and follow up

Follow up after ED visit for SUD within 30 days
Depression screening and follow up for adults
Initiation and engagement of alcohol and SUD treatment

Infant, child and adolescent well-child visits
Childhood and adolescent vaccinations
Blood lead & developmental screening
Chlamydia screening for adolescents

BOLD GOALS: 50x2025

STATE LEVEL

Close racial/ethnic disparities in well-child visits and immunizations by 50%

Close maternity care disparity for Black and Native American persons by 50%

Improve maternal and adolescent depression screening by 50%

Improve follow up for mental health and substance use disorder by 50%

Ensure all health plans exceed the 50th percentile for all children's preventive care measures

Equity metrics for 2022

- Colorectal cancer*
- Controlling high blood pressure*
- HgbA1c for persons with DM*
- Prenatal and postpartum care*
- Child and adolescent WCV*

*Metrics recommended by NCQA for stratification by race/ethnicity

Equity metrics for 2022

- Childhood immunizations
- Adolescent immunizations
- Follow up after ED visit for mental illness & SUD
- Depression screening and follow up

DHCS Priorities for Quality & Equity Measurement

- Measuring access, utilization and engagement with primary care/preventive services & primary care spending
- Measuring behavioral health access, utilization, and clinical outcomes
- Measuring disparities by race/ethnicity, sexual orientation/gender identity, language, disability & geography
- Measuring disparities between Medi-Cal and other populations (e.g. commercial)

Questions

Public Comment

Public comments may be submitted until 5 p.m. on March 3, 2022 to publiccomments@dmhc.ca.gov

Closing Remarks

Public comments may be submitted until 5 p.m. on March 3, 2022, to publiccomments@dmhc.ca.gov

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