STATE OF CALIFORNIA

DEPARTMENT OF MANAGED HEALTH CARE

HEALTH EQUITY AND QUALITY

COMMITTEE MEETING

HYBRID IN-PERSON/ONLINE/TELECONFERENCE MEETING

DEPARTMENT OF MANAGED HEALTH CARE

980 9th STREET, 2nd FLOOR

SACRAMENTO, CALIFORNIA

WEDNESDAY, JUNE 22, 2022

12:00 P.M.

Reported by: John Cota

APPEARANCES

Voting Committee Members

Anna Lee Amarnath

Bill Barcellona

Dannie Ceseña

Cheryl Damberg

Diana Douglas

Tiffany Huyenh-Cho

Edward Juhn

Jeffrey Reynoso

Bihu Sandhir

Kiran Savage-Sangwan

Rhonda Smith

Kristine Toppe

Doreena Wong

Silvia Yee

Ex Officio Committee Members

Palav Babaria

Alice Huan-mei Chen, represented by Margareta Brandt

Stesha Hodges

Julia Logan

Robyn Strong, represented by Starla Ledbetter

APPEARANCES

DMHC Attendees

Mary Watanabe, Director

Nathan Nau, Deputy Director, Office of Plan Monitoring

Chris Jaeger, Chief Medical Officer

Sara Durston, Senior Attorney

Shaini Rodrigo, Staff Services Analyst

Sellers Dorsey Attendees

Sarah Brooks, Project Director - Facilitator

Alex Kanemaru, Project Manager

Andy Baskin, Quality SME, MD

Ignatius Bau, Health Equity SME

Mari Cantwell, California Health Care SME

Meredith Wurden, Health Plan SME

Janel Myers, Quality SME

Other Presenters/Speakers

Marc Elliott
Julie Brown
RAND Corporation

Reverend Mac Shorty
Community Repower Movement

Irma Muñoz
Mujeres de la Tierra

David Lown, MD
California Health Care Safety Net Institute/California Association of Public Hospitals and Health Systems

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1 PROCEEDINGS

2 12:04 p.m.

3 MS. BROOKS: Good afternoon and welcome to the sixth
4 Department of Managed Health Care Health Equity and Quality Committee. My
5 name is Sarah Brooks. I am a director with Sellers Dorsey, a consulting firm
6 which is supporting the DMHC throughout this effort.

7 AB 133, the budget bill from last year, or I guess two years ago
8 now, charges this committee with making recommendations to the DMHC
9 specifically on health equity and quality measures and benchmarks that should
10 be utilized for oversight of managed care plans overseen by the DMHC.

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

14 During last month's meeting we heard from John Ohanian and Rim
15 Cothren at CalHHS' data exchange framework. From the Committee that more
16 information on CAHPS measures is needed. And we also continued our
17 discussion on candidate measures by focus area.

18 During today's meeting we will go from reviewing 31 candidate
19 measures to about 10 to 12 measures or less.

20 As we prepare to vote for the final measure set we do encourage
21 you to consider your top 12 to 14 measures that will create a meaningful set with
22 consideration of the knowledge and expertise that you yourself bring to the
23 Committee.

24 As a reminder, this process is highly iterative and Committee
25 feedback and discussion will support this development.

1 Our last meeting was very fruitful. There was lots of discussion, as
2 has been the case at every meeting, and so just want to continue. My thanks to
3 you all for your contributions to our discussion.
4 So with that, we have a very packed agenda as we have at every
5 single meeting and we are excited about it so we are going to go ahead and get
6 started relatively quickly here. I am going to go ahead and hand things over to
7 my colleague, Janel Myers, who will discuss housekeeping.
8 MS. MYERS: Thanks, Sarah. Hi everyone. This meeting is being
9 conducted in a hybrid format with the opportunity for public participation in-
10 person or virtually through video conference or teleconference.
11 Please note the following items for those joining us in-person
12 today: There is a sanitation station located in the back of the room where you
13 will find masks and hand sanitizer. Masks are strongly encouraged.
14 The women's restroom is located at the end of this corridor to the
15 left. The men's bathroom is located just beyond the women's restroom on the
16 other side of the catwalk. The entryway is near Suite 200. Both men and
17 women restrooms can be accessed using code 5314. This code is also posted
18 on the conference room doors.
19 Please remember to silence your cell phones.
20 For our Committee members there in-person please do not join the
21 Zoom meeting with your computer audio. To ensure that you are heard online
22 and in the room please use the microphone in front of you and push the button
23 on your microphone to turn it on or off. The green light will indicate that it is on,
24 red will indicate that it is off. Please remember to turn off your microphone when
25 you have finished. Please speak directly into the microphone and move it closer

1 to you if necessary to ensure that everyone can hear you.

2 Questions and comments will be taken after each agenda item, first

3 from the Committee Members and then from the public. For those who wish to

4 make a comment, please remember to state your name and the organization you

5 are representing. If any Committee member has a question, please use the

6 Raise Hand feature. All questions and comments from Committee Members will

7 be taken in the order in which raised hands appear.

8 Public comment will be taken from individuals attending in-person

9 first. For those making public comment at the podium there in front of the room

10 please be sure to leave your business card or write down your name and title

11 and leave it on the podium so that our transcriber can accurately capture your

12 information. For those making public comment virtually please use the Raise

13 Hand feature.

14 For those joining online or via telephone please note the following:

15 For our Committee Members attending online please remember to unmute

16 yourselves when making a comment and mute yourself when not speaking.

17 Please state your name and organization before speaking.

18 For our Committee Members and the public attending online, as a

19 reminder, you can join the Zoom meeting on your phone should you experience

20 a connection issue.

21 For the attendees on the phone, if you would like to ask a question

22 or make a comment please dial *9 and state your name and the organization you

23 are representing for the record. For attendees participating online with

24 microphone capabilities, you may use the Raise Hand feature and you will be

25 unmuted to ask your question or leave a comment. To raise your hand click on

1 the icon labeled Participants on the bottom of your screen; then click the button
2 labeled Raise Hand. Once you have asked your question or provided a
3 comment please click Lower Hand.
4 Written public comments should be submitted to DMHC using the
5 email address at the end of the presentation. Members of the public should not
6 contact Committee Members directly to provide feedback.
7 As a reminder, the Health Equity and Quality Committee is subject
8 to the Bagley-Keene Open Meeting Act. Operating in compliance with the
9 Bagley-Keene Act can sometimes feel inefficient and frustrating, but it is
10 essential to preserving the public's right to governmental transparency and
11 accountability. Among other things, the Bagley-Keene Act requires the
12 Committee meetings to be open to the public. As such, it is important that
13 Committee Members refrain from emailing, texting, or otherwise communicating
14 with each other off the record during Committee meetings because such
15 communications would not be open to the public and would violate the Act.
16 Likewise, the Bagley-Keene Act prohibits what are sometimes
17 referred to as serial meetings. A serial meeting would occur if a majority of the
18 Committee Members emailed, texted or spoke with each other outside of a
19 public Health Equity and Quality meeting about matters within the Committee's
20 purview. Such communications would be impermissible even if done at the
21 same time such as member one emailing member two, who emails member
22 three. Accordingly, we ask that all members refrain from emailing or
23 communicating with each other about Committee matters outside the confines of
24 a public Committee meeting.
25 MS. BROOKS: All right, thank you, Janel. All right, next slide.

1 There we go. Move on one more slide. Thank you. All right.
2 Slide 9 walks us through today's agenda, which includes a
3 presentation from Nathan Nau to discuss the DMHC's cultural and linguistic
4 access requirements; another presentation from the RAND Corporation on the
5 CAHPS Survey; a review of candidate measures by focus area; and narrowing
6 measures to the final set.
7 If time allows we will also begin the discussion on benchmarking
8 and measure stratification.
9 Once we conclude Agenda Item 4, discussion on the CAHPS
10 survey, we will vote on the Committee's top CAHPS survey measure.
11 During Agenda Item 6, complete narrowing measures to final set, is
12 when we will begin voting on measures for the final set.
13 So just kind of distinguishing between, we will have a vote on
14 CAHPS earlier. Later we will vote on the measures that have been selected by
15 you all during the focus area discussion.
16 I also wanted to note that we did hear Committee Member
17 feedback last meeting on wanting to set the benchmarking methodology prior to
18 selecting measures. However, after further review and discussion with the team,
19 we feel that the measures may also inform which benchmarking process the
20 Committee selects. So it's a little bit, you can go either direction. Benchmarking
21 data, however, is available in your measures workbook and can be reviewed by
22 you during this discussion if that is helpful to inform you during our process; so
23 that information is available to you all. All right.
24 So at this time, next slide, please, I would like to do a quick roll call
25 of DMHC representatives, Committee Members and then introduce the Sellers

1 team.

2 Mary Watanabe, are you on the line?

3 MS. WATANABE: I am here. I hope you can hear me; and I am

4 sorry I can't be there with you in-person today.

5 MS. BROOKS: We can hear you, thank you, Mary.

6 Nathan Nau?

7 MR. NAU: here.

8 MS. BROOKS: Chris Jaeger?

9 MR. JAEGER: Here.

10 MS. BROOKS: Sara Durston, are you on the line?

11 MS. DURSTON: Here.

12 MS. BROOKS: Great. All right, next slide please.

13 All right. Anna Lee Amarnath?

14 MEMBER AMARNATH: Here.

15 MS. BROOKS: Bill Barcellona.

16 (No audible response.)

17 MS. BROOKS: Dannie Ceseña?

18 MEMBER CESEÑA: Here.

19 MS. BROOKS: Alex Chen?

20 (No audible response.)

21 MS. BROOKS: Cheryl Damberg?

22 MEMBER DAMBERG: I am here and Bill Barcellona is raising his

23 hand.

24 MS. BROOKS: Oh, I see you, Bill, on camera, sorry about that. Hi,

25 Bill. Sorry. All right.

1 MEMBER BARCELLONA: Present.
2 MS. BROOKS: And thank you, Cheryl.
3 Diana Douglas?
4 MEMBER DOUGLAS: Here.
5 MS. BROOKS: And Lishaun Francis?
6 (No audible response.)
7 MS. BROOKS: All right, next slide, please. All right, Tiffany
8 Huyenh-Cho?
9 MEMBER HUYENH-CHO: Here.
10 MS. BROOKS: Ed Juhn?
11 MEMBER JUHN: Here.
12 MS. BROOKS: Jeff Reynoso?
13 MEMBER REYNOSO: Here.
14 MS. BROOKS: Rick Riggs?
15 (No audible response.)
16 MS. BROOKS: Bihu Sandhir?
17 MEMBER SANDHIR: Here.
18 MS. BROOKS: Kiran Savage-Sangwan?
19 MEMBER SAVAGE-SANGWAN: Present.
20 MS. BROOKS: Next slide, please. All right.
21 Rhonda Smith.
22 (No audible response.)
23 MS. BROOKS: Kristine Toppe?
24 MEMBER TOPPE: Here.
25 MS. BROOKS: All right. Doreena Wong?

1 MEMBER WONG: Here.
2 MS. BROOKS: Silvia Yee?
3 MEMBER YEE: Present.
4 MS. BROOKS: Next slide, please. All right. Palav Babaria?
5 (No audible response.)
6 MS. BROOKS: Alice Chen? I think Margarita --
7 MEMBER BRANDT: This is Margareta.
8 MS. BROOKS: Margareta, I apologize. Margareta, you are here in
9 her place, is that right?
10 MEMBER BRANDT: Yes, thank you.
11 MS. BROOKS: Great. Thank you so much. Sorry about that. All
12 right. Let's see.
13 Stesha Hodges?
14 MEMBER HODGES: Here.
15 MS. BROOKS: Julia Logan? Lisa, are you on --
16 MEMBER LOGAN: Here.
17 MS. BROOKS: -- for Julia?
18 MEMBER LOGAN: I'm sorry, I am here. This is Julia.
19 MS. BROOKS: Okay. Hi, Julia, thanks so much.
20 All right. And then Starla, I believe we have you on for Robyn, is
21 that right?
22 MEMBER LEDBETTER: Yes, that's correct.
23 MS. BROOKS: All right, thank you, Starla. All right, next slide.
24 And that's just the Seller Dorsey team that is supporting this effort.
25 Next slide.

1 All right. So these meeting materials that are listed up here on the
2 PowerPoint slide will be utilized throughout the meeting today and can be used
3 as reference documents as well.
4 Committee Members should have received several documents
5 ahead of this meeting for your review. So you received the agenda, the
6 Presentation, both the June 8 meeting summary and May 18 transcription,
7 Candidate Measures Workbook, References and Resources Handout, and
8 Epidemiologic and Performance Data Handout. And then I believe also there
9 was a summary of public comment that was provided to you all as well. All of the
10 information, all this information is available on the DMHC website for those that
11 are joining online. Let's see.
12 And just wanted to flag that the Candidate Measures Workbook
13 and Epidemiologic and Performance Data Handout both have performance data
14 when available and may inform some of the decisions you make during today's
15 meeting. So when there was data available we included it in the workbook, both
16 in terms of measure selection and benchmarking. If data are not included for a
17 measure it Is because we have not identified any data at the national or state
18 levels that represent that measure. All right, next slide.
19 So we have Committee Member -- Committee Member --
20 Committee meetings scheduled through August at this time. Committee Meeting
21 7 as you can see July 13th and the eighth, meeting number 8 is August 17.
22 Today's meeting will determine if we need to add an additional
23 meeting. Saying that again. (Laughter.)
24 This slide does identify the steps which will be taken at each
25 meeting to accomplish our process as well.

1 So with that I am going to see if we have any questions in the
2 room, if we have any questions from Committee Members in the room or online.
3 I don't see any hands raised. Shaini, do we have any public
4 comment hands raised online?
5 Do we have any public comment in the room at this time?
6 All right, we will move on to the next slide then please. All right.
7 So the June 8 meeting summary is included in your meeting
8 packets for your review. If there are no changes to the meeting summary they
9 will be considered final and will be posted online. So just asking at this time if
10 there are any Committee Members that have any suggested changes to the
11 June 8 meeting summary?
12 Not seeing any hands raised I will ask if we have any public
13 comment online with respect to this question?
14 Any public comment in the room?
15 So the meeting summary notes will be considered final and will be
16 posted online as I stated before. All right, next slide, please. We will go to slide
17 22. Great.
18 So in past meetings there has been robust discussion and interest
19 in better understanding the DMHC's culturally and linguistically appropriate
20 service requirements.
21 The DMHC measures and monitors different health plan
22 requirements in many ways. Today we have Nathan Nau, DMHC's Deputy
23 Director, Office of Plan Monitoring, to provide additional information on this
24 subject matter and at this time I will pass the presentation over to him.
25 MR. NAU: Thank you. Thank you, Sarah. Good afternoon,

1 everybody. Can you hear me, okay? Okay.
2 Like Sarah said, when we were listening to the last meeting and
3 reflecting afterwards we thought it would be helpful to pass some of this
4 information along, albeit at a high level, given we are going to be considering
5 voting on measures soon.
6 And so we have talked a lot about measures, stratification options,
7 and what we could possibly do. These conversations will continue after this
8 presentation when we talk more about CAHPS measures, but we wanted to pass
9 some information along for you to consider during the decision-making process.
10 Next slide, please.
11 Thank you. So at a high level, in 2013 (sic), SB 853 was passed,
12 which required the Department to take action and improve limited English
13 proficiency access for individuals.
14 We were required to promulgate regulations as well, which we did.
15 And we are also required to report to the legislature every two
16 years for compliance in this matter. We actually have five reports on our website
17 currently, the last one covers calendar year 2019 and '20 and they are posted at
18 a two year interval. I will talk a little bit more about some of the information in
19 those reports here in a few minutes. Next slide, please.
20 So at a high level, what are the requirements?
21 So plans are required to assess the linguistic needs of their
22 enrollees. This requires them to survey their individual enrollees. They actually
23 have to develop a demographic profile and this is supposed to be updated every
24 three years.
25 They are also required to provide translation and interpretive

1 services to enrollees and make it clear that it is free and how these can be
2 accessed.
3 And of course probably the most important part is they are required
4 to train staff in order to provide these services and how to educate enrollees on
5 receiving them.
6 And they are required to have a compliance mechanism in place to
7 oversee these processes, which includes anything that may be delegated. Next
8 slide, please.
9 So what is our oversight process? There's a couple of linchpin
10 items we have listed here.
11 So first, we survey the health plans every three years. Think of this
12 as an audit. So we audit their program to ensure compliance. On that report
13 that I mentioned that we send to the legislature and post on our website, in the
14 last report for calendar year 2019 and '20 we completed 64 health plans surveys.
15 And in those surveys there were 29 deficiencies for this area. That report has
16 more information on what the deficiencies are and it actually breaks them down
17 by plan type and plan size so there's a lot of good information in there.
18 Timely access to care is an annual process but we do more than
19 just measuring timely access to care. Plans are required to submit their
20 processes to us and we review them for compliance, which includes translation
21 services processes.
22 And then of course we have our Help Center, which is very
23 important to us. They track all inquiries and complaints for different categories,
24 which includes this category. And there's more information in that report as well
25 on what calls the Help Center is receiving and what complaints they receive and

1 how many. Next slide, please.

2 So some additional requirements that we wanted to flag. Some of

3 them are on the newer side so we are pretty excited about them.

4 Is health plans are going to be required to do enrollee experience

5 surveys. And can we move the next slide as well? And provider satisfaction

6 surveys. And so this is going to be processes that the plans are going to

7 establish and the DMHC is going to audit and make sure that they are happening

8 and that the plan is doing something with the information.

9 So I apologize for the very high level view here but just in general

10 we wanted to make sure that timely access, language assistance and some

11 additional work on enrollee and provider satisfaction that the Department is going

12 to be engaged on in a few years is kind of at the top of your mind as we go into

13 voting with measures.

14 Are there any questions from Committee Members in the room?

15 Kristine?

16 MEMBER TOPPE: Kristine Toppe, NCQA. Thank you, that was

17 very helpful. I had a quick question. Is the summary of the deficiencies, is there

18 like a kind of a report-out that the Department does on like what the deficiencies

19 were? Were those what drove the set of additional requirements?

20 MR. NAU: Yeah, good question. So what we can do is we can

21 provide the link to the group of the report that's posted online or the page

22 because there's five reports. But the report does have findings by plan. So it

23 lists the plan by plan type. So it could say, for example, dental or behavioral

24 health, and then also it breaks it down by the plan size. And so when looking at,

25 you know, you see that there are findings and it contributes to these

1 requirements. But this is a topic that everyone is, you know, concerned about
2 and it is very important and at the top of most people's lists so there's a lot of
3 contributing factors.
4 Any other questions for -- Kiran.
5 MEMBER SAVAGE-SANGWAN: Yes, thanks, Nathan, for
6 presenting this. I just wanted to confirm on the language access part. You don't
7 have a mechanism right now to actually see the extent to which language
8 assistance services are being provided, right? What you get is more like you
9 look at the policies and procedures for doing so but you don't actually receive or
10 review the information on if and when the services are provided; is that right?
11 MR. NAU: Yes, that's correct. And thanks for that question
12 because that's probably an important one. So we don't have a measure, like a
13 quality measure. We don't receive data. We are in a position where we are
14 auditing the plans' process and making sure that it's there. Everything you said
15 was correct.
16 MEMBER SAVAGE-SANGWAN: Okay, that's really helpful. And I
17 just bring it up because I think there's a, right now a very large gap between, you
18 know, the policies and procedures that you see from health plans and what we
19 hear from LEP consumers in terms of actual access to language assistance. So
20 maybe something we could circle back on in this group.
21 MR. NAU: Sure. Thank you. I don't see any other hands raised.
22 Is there any -- Doreena. Go ahead, you have the floor, Doreena.
23 MEMBER WONG: Yeah, just a follow-up to Kiran's question. I
24 know that you just look at the policies and procedures. I don't remember if
25 there's a, if there is a question about complaints or something like that. But I am

1 wondering if there's any information on those reports. It has been a long time
2 since I have seen it, I should look at it, to possibly obtain information about the
3 effectiveness of the plan or a way to measure -- use it as a measure of some
4 sort. If not now.
5 MR. NAU: Yeah.
6 MEMBER WONG: You know, then in the future. Obviously, since
7 you would have all this information.
8 And then number two, you know, you mentioned that you have kind
9 of patient experience and even provider experience surveys. And I am
10 wondering if we could use that information as a way to measure whether or not
11 people are getting like interpreter services or having problems with their
12 language access?
13 MR. NAU: Yes, thank you, and good points, Doreena, we are
14 always looking for more effective ways to monitor.
15 So in terms of your first question, there is data on the report,
16 number of findings, number of inquiries and complaints from the Help Center.
17 So there is some information we can glean in there for trends. I mean, once we
18 broke it down by plan the numbers are going to get small but we can definitely
19 take a look at that.
20 And the patient satisfaction surveys, that work is forthcoming, but
21 we are excited about it and we will see, you know, what it looks like when we,
22 when we start looking at those processes. I am going to go, I'll go to Silvia first.
23 Silvia.
24 MEMBER YEE: Thank you. This is Silvia with DREDF. I was just
25 curious what the implications are for anybody that has deficiencies, successive

1 deficiency over a number of results?

2 MR. NAU: Yes, good question. So I will answer that at a high level

3 but we would survey the plans every three years. But however, if a plan has a

4 deficiency and it is not closed we go out and we re-survey to make sure the

5 findings are closed in 18 months because they are required to submit a

6 corrective action plan to us.

7 The Department has an entire office called the Office of

8 Enforcement. And so deficiencies would be referred to the Office of

9 Enforcement for further action if they are not fixed and also if it's a trend, like it

10 continuously happens.

11 MEMBER YEE: Thank you.

12 MR. NAU: That's the process at a high level.

13 MEMBER SANDHIR: Bihu Sandhir from AltaMed. Use of provider

14 satisfaction surveys. Are you using something standardized, like Press Ganey or

15 NRC or is it something of developing yourselves at DMHC?

16 MR. NAU: Yes, good question. So these are new requirements

17 that just put, were put into place through regulation and there is no requirement

18 of a standard survey. So likely what will happen is the plans would inform us

19 through their processes what survey they intend to use and then we have, we

20 would, you know, take a look at that and approve it.

21 I don't see any other hands in the room. Are there any hands

22 raised from? Okay.

23 Any public comment in the room?

24 Okay. Well, thank you, everybody. Sarah, I think I will turn this

25 back over to you.

1 MS. BROOKS: All right, thank you, Nathan.
2 We are ahead of schedule. (Laughter.) We have a few minutes
3 before our next presenters are actually here. They will be on at 12:45 to do the
4 CAHPS presentation.
5 So what I was thinking is that why don't we just use this next, sorry,
6 next 15 minutes for Committee Members to take a moment to kind of stop and
7 process the measures if you have not already, the 31 measures that have been
8 selected, and take a look at which kind of 10 to 12 or so measures you would
9 vote potentially to move forward. And just give you an opportunity to look at
10 those measures right now and think a little bit about that as we get prepared for
11 our next presentation, if that makes sense to you all.
12 So if there are questions please just raise your hand and we can
13 come around and talk to you but this information should be available in what was
14 sent to you with the materials for this meeting. Any questions before we go off
15 and do our setting? Okay, all right. We will be back in just a few minutes, then.
16 Thank you so much.
17 MEMBER TOPPE: Sarah? I'm sorry, should I raise my hand?
18 MS. BROOKS: Go ahead.
19 MEMBER TOPPE: Okay. Ignatius reminded me that I could share
20 with the group verbally at least the measures that NCQA added for stratification.
21 That that's a useful piece of information going into the voting process. So
22 if you, is that good?
23 MS. BROOKS (OFF MIC): (Inaudible.)
24 MEMBER TOPPE: Okay. So I'll highlight them. So I will tell you
25 what the measures are and then I will tell you where they fall into the groupings

1 that DMHC has. So we had five domains of measures. So the original, I will go
2 through the original set that have already been set for stratification and then the
3 additional set.
4 So the original set, which you already know, talk into the mic, are
5 the colorectal cancer screening, controlling high blood pressure, hemoglobin A1c
6 control for patients with diabetes, prenatal and postpartum care and child and
7 adolescent well-care visits. Those were established for stratification coming into
8 this process.
9 And then the measures that just passed our board are in the
10 domain of prevention and screening. Immunization for adolescents, adult
11 immunization status, breast cancer screening. So I am reading these as the
12 NCQA set and then I will go back through and tell you where they are in DMHC's
13 set. A respiratory measure of asthma medication ratio, a behavioral health
14 domain measure, two in the behavioral health domain, a follow-up after
15 emergency department visits for substance use and pharmacotherapy for opioid
16 use disorder.
17 And under the access and availability of care domain, initiation and
18 engagement of substance use disorder treatment.
19 And then under what we classify -- again, these are our domains of
20 utilization -- well-child visits in the first 30 months of life.
21 So where those fit in the DMHC, in this Committee's discussion. If
22 you go to --
23 MR. ELLIOTT: This is Marc. I am unable to hear anyone. I don't
24 know if others can hear me.
25 MS. BROOKS: Hello, yes, we can hear you. Yes. Okay, we are

1 going to do a mic check real quick. Thank you for flagging that for us. One
2 moment, please.
3 SPEAKER: Can you hear me?
4 MEMBER DAMBERG: Both Marc and Julie are on the phone now
5 if you want to move forward with the CAHPS presentation?
6 MS. BROOKS: Sure.
7 MS. MYERS: Sarah, I will just say that --
8 MS. BROOKS: Let's check --
9 MS. MYERS: I will just say that I was able to hear Kristine.
10 MS. BROOKS: Okay, thank you, Janel.
11 MR. ELLIOTT: I can see that others are talking. I can see the
12 Chat but I can't hear anybody, unfortunately. I was going to try to present when
13 it was the right time but this may be challenging if I can't hear others. I cannot
14 tell if others can hear me. If others can hear me could somebody say so in the
15 Chat?
16 MS. BROOKS: Marc can't hear us but we are writing him
17 something in the Chat. Okay, we are troubleshooting right now. So I think
18 Kristine, what we will do is we will come back to you; and I apologize. Thank you
19 for everyone. We want to make sure to hear that important information. It's
20 great that we have got Marc and Cheryl and Julie on. We will get the sound
21 figured out and get going on the presentation in just a minute.
22 Okay, we are going to go ahead and move forward with the RAND
23 presentation now. I am just talking quickly because Marc is going to go ahead
24 and present.
25 MR. ELLIOTT: Hi, everyone. Marc Elliott from RAND here to

1 provide a brief introduction to aspects of the CAHPS surveys. Put these slides
2 together with Cheryl and Julie Brown also at RAND. Next slide, please.
3 So just as an overview of the CAHPS surveys, they were originally
4 developed by AHRQ. And in particular the health plan survey focuses on
5 people's recent experiences with their health plans and the services they have
6 received across a variety of settings.
7 They result in public reporting that is intended to incentivize health
8 plans to improve the overall quality of care and member experiences, also to
9 promote accountability and increase the overall transparency. Next slide,
10 please.
11 A little bit of background on CAHPS.
12 CAHPS has a series of organizing principles and one of the key
13 elements is standardization so that there can be valid comparisons across
14 different health care settings and sponsors, including trying to facilitate people
15 who might want to be choosing one plan versus another.
16 But also internally for a given organization or at a broader level so
17 you can evaluate the effectiveness of an intervention that might be intended to
18 improve some aspects of patient experience, either in general or something
19 more specific, or perhaps to improve health equity.
20 And there's a lot of information to back-up this next statement if you
21 are interested that we can point you to, but CAHPS is the most extensively
22 tested, validated, and used measure of patient experience and one that there's
23 regular efforts to evaluate that it is still performing well, that it is still covering
24 topics that are important to people and that can be validly measured with patient
25 input. Next slide, please.

1 So a bit more of background. One thing that we would like to note
2 is that there's more than one kind of patient survey and there's there are a lot of
3 patient satisfaction surveys out there. Patient satisfaction surveys have a focus
4 on market share and amenities in many cases; whereas patient experience
5 surveys such as CAHPS limit themselves to aspects of care that have medical
6 relevance and that are ones where patients are the only, are the best sources of
7 information. For example, you can't figure out from a medical record whether a
8 physician explained the choice that you were about to make or what you should
9 look for when you went home in a way that you can understand.
10 And also the nature of the questions are focused on reports about
11 what happened rather than asking you kind of more of a remove, to describe
12 your satisfaction about what happened. And some of this, in particular, will be
13 discussed in more detail in an article that we have in the back by Rebecca
14 Anhang Price. Next slide please.
15 And then there are sort of two broad kinds of items in CAHPS. So
16 there are some global rating items, rate something on a 0-10 scale. And there
17 also multi-item composites that are focused more on, typically, how often did
18 something happen, a Never to Always scale. Those multi-item composites ask
19 relatively specific questions that are then grouped, often in groups of three or
20 four, under a given topic like Getting Needed Care, Getting Care Quickly. Since
21 our understanding is that access is a particular interest of this group. Among the
22 composites that might be of particular interest would be those two, the Getting
23 Needed Care and Getting Care Quickly composites. Next slide, please.
24 A little bit about health equity application. So health equity has
25 been a focus of CAHPS from the very start. It is no surprise to anyone on this

1 call that there have been real gaps in access to care in the US and in California
2 going back a long time. There is a body of research involving applications of
3 CAHPS to health equity problems that it goes back more than 20 years. For
4 people who are interested, AHRQ is sponsoring a conference on September 22,
5 three months from today, focused on this topic. Other agencies have been, have
6 been using CAHPS as a tool for measuring health equity and I think that some of
7 those applications might provide -- depending on your interests. Here is a link to
8 some of what the Office of Minority Health has done at CMS. Next slide, please.
9 A little bit more on this. And this is, if this seems a little bit down in
10 the weeds, it is in response to some of the questions that I understand have
11 come up about what CAHPS measures would be best for health equity
12 applications.
13 I mentioned earlier that there's sort of two broad types of
14 measures, the sort of zero to one stand-alone ratings and then these global
15 composites.
16 Unfortunately, while they have a lot of value in general, the 0-10
17 ratings aren't the best tool for health equity applications and that's mainly
18 because of evidence that the use of these 0-10 rating scales differ substantially
19 by a number of characteristics associated with different response patterns for
20 race, ethnicity, by race, ethnicity, national origin, education.
21 And some of the ways that we know this is we have actually done
22 experiments where we have shown people vignettes of the same care. And
23 while they tend to give similar answers to the same care scenario with the
24 Always to Never scales, that's not so much the case for the 0-10 ratings.
25 Because of the accumulated evidence on this, the use of CAHPS

1 measures in most health equity applications, including the Health Equity
2 Summary Score, and there's an article about that, and the Health Equity Index
3 that CMS is currently looking into. They all tend to focus on the CAHPS
4 measures that are not subject to this response scale issue, the composite
5 measures. Next slide, please.
6 Another issue that I am told might be of interest is thinking about
7 the sample sizes that might be needed to be able to make plan-specific
8 assessments that are related to health equity.
9 In general, for general uses, CAHPS surveys are usually designed
10 with sample sizes that allow inference at the level of, say, the whole health plan.
11 And the typical design intention is that one year of data allows you to measure
12 the patient experience of people in a given plan.
13 And when there is interest in looking at not everybody in a plan but
14 a subset of people in a plan, for example, Black enrollees or Hispanic enrollees,
15 then it is often necessary to boost your initial sample size by pooling data, say
16 over two years. For example, the Health Equity Summary Score, Health Equity
17 Index, use an approach like this.
18 What kind of sample size do you need, say, to make inferences
19 about a particular group in a particular, in a particular plan. We typically
20 recommend a joint set of criteria. A minimum sample size of 30 regardless, but
21 also a plan level reliability minimum of .7, which is, which is a standard cutoff on
22 a 0-1 scale. While a .7 reliability doesn't always correspond to any particular
23 sample size, in practice it often means that you are going to need about 50 to
24 100 complete, so over two years, for a given group in a CAHPS survey to be
25 able to say something that's, that's well measured for that group.

1 Now, can you, can you make a statement about every group and
2 every plan in a reliable way? Probably not. And some of this is just going to be
3 down to the composition of a plan. If a plan has very few members of a given
4 group then even a relatively large sample won't have many responses from that
5 group. Now, it's a better situation in California than it is in a lot of places
6 because California's population is unusually diverse in the United States. But it
7 is still the case that it won't always be possible to measure every group in every
8 plan. But some of the approaches that are out there, like the, like the Health
9 Equity Summary Score, or the Health Equity Index, are designed to be able to
10 work with some missing spots and still say reasonable things about the health
11 equity performance for a given plan. Next slide, please.
12 There are a number of challenges with the CAHPS survey like any
13 quality measurement effort, I will mention a few of those here.
14 All surveys, including CAHPS surveys, have had declining
15 response rates over the years and response rates have typically been lower for
16 some groups of particular interest. Response rates tend to be lower for young
17 people, they tend to be lower for Asian, Native Hawaiian, Pacific Islander, Black,
18 Hispanic people. And they also tend to be lower for lower income people. So
19 those are, those are significant challenges.
20 There are ways to counteract that. For example, right now, in the
21 commercial sector, most CAHPS data is collected via a single mode approach,
22 often just mail or just phone. There is strong evidence that if you do mail with
23 telephone follow-up you get much higher response rates, much better
24 representativeness. And while Web-based approaches by themselves have
25 particularly poor response rates and representativeness, an approach which

1 starts with Web and follows up with something like phone often does really well.
2 So not to get into the weeds but the short answer is, to the extent that it is
3 possible to mandate sort of a more representative and better survey approach,
4 you can counteract some of the response rate issues.
5 So the reliability. The third bullet is about something which is
6 sometimes a point of confusion. The reliability of using a random sampling
7 approach, the reliability of an estimate is a function not of the fraction of the plan
8 that you measure things from, but of the sample size that you get.
9 So for example, if you are familiar with HEDIS measures, there are
10 a number of HEDIS measures that involve your collecting approximately 400
11 records. And that is as informative about the quality that you get for a plan that
12 has 5,000 members and a plan that has 500,000 members. It is really a function
13 of the sample size, not the sampling fraction.
14 There's a lot of interest in this group as I understand and certainly
15 elsewhere as well in direct measures of discrimination. Those haven't been
16 historically part of a lot of the CAHPS instruments in the core. They are available
17 as supplemental items, but only supplemental items, so anything that involves
18 comparisons of these would have to be added or mandated. Next slide, please.
19 So here are just a couple of citations that may be of interest. The
20 first one is sort of broader background on CAHPS. Next slide, please.
21 And the one here is a bit more background if you are interested in
22 some of the issues about scale use. There are some other articles as well. Next
23 slide.
24 This is sort of another example on the 0-10. Next slide after that,
25 please.

1 And I think this is where I am supposed to stop. And huge
2 apologies, it is probably a technical issue on my end that keeps me from being
3 able to hear others, but I will look for questions in the Chat and try to type -- I
4 guess I should answer out loud since others can hear me.
5 MS. BROOKS: Thank you.
6 MR. ELLIOTT: I recognize that Julie may also want to answer
7 some of these questions.
8 MS. BROOKS: Thank you to Marc for that wonderful presentation.
9 I am going to ask Alex to just Chat him real quick and say we are going to --
10 MR. ELLIOTT: If I stopped sooner than I should please let me
11 know but I think this is the point at which my presentation was supposed to end.
12 MS. BROOKS: Yes. All right. So we will go ahead and keep going
13 and then we will get into a Q&A portion and there will be an opportunity to ask
14 Marc, Julie and Cheryl questions.
15 During the June 8th meeting the following CAHPS measures were
16 discussed and these are several of the ones that you saw that Marc just talked a
17 little bit about in his slides. Getting Needed Care. And then next slide, please.
18 And then Getting Care Quickly.
19 I did want to note that there were two other measures that were
20 mentioned during our last Committee meeting for discussion purposes. An
21 additional CAHPS measure, Getting Care Coordination, which after further
22 review and discussion based on challenges with small sample size and target
23 population, this measure was not elevated as a candidate measure. If there are
24 thoughts on that obviously welcome those during the discussion period.
25 At this point we are going to move to a Q&A period from the

1 Committee and then following that we will take public comment and then we will
2 move to a vote on CAHPS measures specifically.
3 So with this I am going to open it up to Committee Members for
4 questions. I will ask that people in the room use the computer to raise their hand
5 similar to what we did in prior meetings and then those online from the
6 Committee as well. And then we will let Marc know what the questions are as
7 well. So any questions from the Committee Members?
8 Wait just a minute. There we go. Yes, Silvia.
9 MEMBER YEE: Hello, this is Silvia from DREDF. I don't know if I
10 should try to type questions in for Marc or?
11 MS. BROOKS: Go ahead and just ask the question and we will get
12 it to Marc, thank you.
13 MEMBER YEE: Okay, thank you. One question was about
14 whether any plan administers surveys so that they mix patient experience and
15 patient satisfaction questions? And if they do whether that affects the validity of
16 the patient experience questions?
17 And the second question was about measures of discrimination.
18 When it was said that surveys don't usually include measures of discrimination,
19 are they thinking of whether a patient says they experienced discrimination?
20 Because sometimes it can be something that it doesn't depend on feelings or
21 what is said or what is intentional; it can be something like not getting translation,
22 or not getting sign language or not getting help with transfers. Those are
23 discrimination, examples of discrimination under federal law, even though neither
24 the provider nor the patient experiences it as intentional malice. Thank you.
25 MS. BROOKS: So we have typed up all of those great questions,

1 thank you, Silvia, to Marc. We will just pause for a minute and see if he's got a
2 response for you or if others may weigh in as well. It looks like he has a
3 response but we will have him speak to that.
4 MR. ELLIOTT: This is Marc. With respect to the, to the question
5 about a mixture of patient experience and satisfaction items. We found that if
6 you add supplementary satisfaction items at the end of the survey that doesn't
7 create any kind of problem. But we recommend keeping the sort of structure of
8 the core items sort of in place and together, if possible.
9 I also see there was a question about the content of the
10 discrimination measures. Julie has had a role in developing some versions of
11 those measures and so I think she might be the best person to respond to the
12 questions about the content of those measures.
13 MS. BROWN: Yep. Hi, everybody, this is Julie Brown. Thanks,
14 Silvia for that question. I am going to restate it and you can let me know if I
15 captured it correctly. I think you were posing a, pointing out a very important
16 issue that there are multiple ways to measure discrimination. One is in asking
17 questions that ask about perceived discrimination, or times at which I as a
18 patient felt I was treated differently or unfairly because of who I am. We have
19 been developing a measure that has gone through qualitative testing and is in
20 the midst of quantitative testing to measure perceived discrimination.
21 In addition, I think I also heard you point out that another way to
22 capture discrimination is looking at differences in the quality of care received or
23 the experience of care received based on characteristics of the patient. And that
24 speaks to the CMS race-ethnicity reports that Marc mentioned earlier. There
25 was a slide where he cited 20 years of work and included a link. And I think you

1 will find a lot of useful information there that breaks down the quality of care
2 patient experience measures by different racial and ethnic groups as a way of
3 trying to understand if there are disparities in care.
4 And I will stop there to see if that addressed the questions you
5 were raising.
6 MEMBER YEE: I'm sorry, I don't mean to jump the line but I will
7 just respond. Thank you, Julie. This is Silvia with DREDF. That does mostly
8 answer my questions. For those latter, for that latter group, when you are talking
9 about the CMS questions on quality of care. Are those recognized as
10 discrimination questions or are they just seen as quality of care questions?
11 MS. BROWN: Those are quality of care measures. But CMS is
12 monitoring this to make sure that across the board beneficiaries are receiving a
13 fair and equitable treatment and are having fair and equitable experience of care.
14 MEMBER YEE: Thank you.
15 MS. BROOKS: Thank you, Silvia. Diana.
16 MEMBER DOUGLAS: Thank you. Thank you again for the
17 presentation on CAHPS. I will just flag -- sorry, Diana Douglas with Health
18 Access California. We do still just have concerns about sample size and
19 whether the samples are sufficient to capture the full breadth of experience of
20 diverse Californians, especially given issues of lack of translation. I appreciated
21 this sort of brief touching on use of pooling data across years. We would
22 encourage more over-sampling of specific populations and increased pooling of
23 data to make sure that CAHPS is able to capture, you know, across different
24 populations, especially. I do think that the perceived discrimination question has
25 potential to capture dynamics that aren't as easily captured via some other types

1 of measurements. I do just also want to emphasize, though, that --

2 MR. ELLIOTT: I understand there is a question about, about

3 whether sample sizes are large enough and, and a recommendation to over-

4 sample to ensure capturing a, capturing a diverse population. So, I'm sorry, I

5 think I am speaking too soon.

6 MEMBER DOUGLAS: That's okay. No, go ahead, please. Oh, he

7 can't --

8 MR. ELLIOTT: Apologies for, for not being able to hear. So with

9 respect to over-sampling. So, in general, taking larger untargeted samples is a

10 good strategy when that's all that you can do and one that will improve

11 representation of smaller groups. Often, it is not possible to do a targeted over-

12 sample because often there isn't information about race and ethnicity, just to

13 take one example, that you know beforehand.

14 But if you are in a situation where you know about a social

15 determinant of health or an associated characteristic ahead of time and you are

16 in a position to do a targeted over-sample, then I very much agree that can be an

17 efficient way of getting more diverse coverage. It is just that it is not always

18 possible to do so but when it is that's terrific. Otherwise, kind of increasing the

19 total sample size in a less targeted way is often the fallback.

20 MS. BROOKS: Diana, did you have additional comment?

21 MEMBER DOUGLAS: Yeah. I don't know if he can hear me but

22 thank you, Marc.

23 And just finally, I think we have said this, I have said this at the

24 previous meetings, but just saying that from our perspective, even though the

25 patient experience survey questions are more useful, we also just want to be

1 approaching with extreme caution using those as any kind of a proxy measure of
2 timely access to care or quality of care. Consumers are often not aware of, they
3 can speak to their perception of whether care was given quickly enough but they
4 often are not aware of what standards are in place for timely access to care.
5 And if people are used to having extreme delays in care then slightly less
6 extreme delays in care might seem satisfactory but still not be within the
7 standards that we are looking for that are required here in California. Thank you.
8 MS. BROOKS: Thank you, Diana. Doreena.
9 MEMBER WONG: Yes, Doreena Wong, ARI. I just wanted to go
10 back to that question about discrimination because that is important.
11 MR. ELLIOTT: This is Marc. I tried dialing in the number but it
12 didn't like the meeting ID so I am -- Oh, I'm sorry, I am speaking to soon again,
13 sorry.
14 MS. BROOKS: Go ahead, Doreena.
15 MEMBER WONG: Should I wait until he gets on or?
16 MS. BROOKS: Go ahead, Doreena.
17 MEMBER WONG: Okay. Going back to the, I guess the issue of
18 discrimination. I know it's hard to capture but I do think it would be good to try to.
19 Since it can be a measure of quality of care I hope that we can include
20 something that captures that. I believe that CHIS has been working on a
21 discrimination question, the California Health Interview Survey, for several years.
22 I am not sure if they still include it; I know they have included it in the past. But
23 just as a, as a reference point for us to look at, because I was in a workgroup
24 that looked at discrimination and trying to ask and get to that.
25 And I am not sure if we can ask directly but I think trying to get to

1 some of the equity or access questions around if somebody has access to an
2 interpreter or translated materials can also get to the discrimination issue as well
3 so I am hoping we can come up with a question around that.
4 I don't know if we are going to be talking about that in the health
5 equity section or we are going to be adding that. I know that -- at any rate. So I
6 would hope that we could include some kind of measure around that. And I am
7 not sure if we can do that by the end of today because we still have to the point
8 to be voting on it. But I would hope that we could reserve some space for that.
9 MS. BROOKS: Great comments, Doreena. I think that certainly
10 we can include in the report your thoughts and your thinking because I think
11 these are important points that you are making. For purposes of today we have
12 got our measures selected that we are going to vote on. But I think important
13 point that you are making and so we will definitely make a note of that in the
14 report.
15 Bihu, it looks like your hand is raised.
16 MEMBER SANDHIR: Yes. I have a couple of questions and also
17 maybe some comments. But I guess my first question is, are we doing any
18 CAHPS surveys for our Medi-Cal and commercial plans currently? And if we
19 are, what are we using? Because I see some examples that you have put in our,
20 that are here in our packet and one of them is a Medi-Cal survey and one of
21 them is a commercial survey. So I just wanted to understand that. Why are they
22 included here? And I think it's important that we actually look at them because
23 there's a lot of great information and a lot of good questions, which addresses
24 everything that we are just talking about. And then also there's included in here
25 is the AHRQ survey 5.0 measures. And could somebody explain to us what that

1 means and why they are included here because I need to -- it may factor into
2 how we, how we include this.
3 And so the other question I have is, if I understand this right, these
4 are the surveys that the health plan would use to query patients. And would they
5 be in an intervention if there is a problem? That is the part I am not
6 understanding. I mean, this is collecting data but what do we do with the data if
7 they, they have problems with these, the patients who have concerns? I mean,
8 that would be the real way to address discrimination equity, you know. What
9 would be the requirement? Is that an option? I hope I haven't complicated it.
10 MS. BROOKS: No, you haven't complicated this at all.
11 MEMBER SANDHIR: Because we, you know, as a health system I
12 can just tell you, we do our own Press Ganey surveys and so we are used to that
13 and just want to understand. We take, we do actions on that. So what is the
14 health plan's requirements is what I am trying to understand. What will be the
15 end result of this if we were to do this?
16 MS. BROOKS: So great questions, Bihu.
17 Marc has been able to join us on the phone so we are all together
18 now, this is wonderful.
19 So let me just ask if there's anyone who would like to speak
20 specifically to Bihu's questions. I see a couple of hands up. I'm going to -- I
21 want to also ask the state departments if they have anything. Is Palav on at this
22 point?
23 (No audible response.)
24 MS. BROOKS: Any of the other state departments want to
25 comment on just with respect to use of CAHPS at this time, utilization or

1 collection of data on CAHPS?

2 It looks like Margareta. Yes, go ahead, please.

3 MEMBER BRANDT: Hi, this is Margareta with Covered California.

4 So Covered California participates or uses the data from the CMS Quality Rating

5 System, which applies to all health insurance exchanges or all health plans

6 participating in health insurance exchanges nationwide. There is a CAHPS

7 portion of that quality rating system so we do use those CAHPS measures and

8 monitor performance on CAHPS measures. And I can, I can follow-up with the

9 specific measures that are included in the CMS Quality Rating System and

10 provide that, if helpful.

11 MS. BROOKS: Thank you so much. I see Julia has her hand up

12 as well from CalPERS.

13 MEMBER LOGAN: Yeah, hi, this is Julia Logan at CalPERS. We

14 use a modified CAHPS, actually, that's called our health plan members survey,

15 where we use CAHPS as kind of a framework and then add specific questions

16 that are important to our own CalPERS members.

17 MS. BROOKS: Thank you, Julia. And then Palav -- go ahead.

18 MEMBER LOGAN: I'm sorry. Also through NCQA accreditation,

19 the CAHPS survey through that as well.

20 MS. BROOKS: And then Palav, I see you have your hand up.

21 MEMBER BABARIA: Yes. Hi, everyone. Hope you can hear me.

22 Sorry, I was on the phone and don't think it could be heard. Palav Babaria from

23 DHCS.

24 So we also administer the CAHPS survey. The Department

25 previously used to do it every three years then every two years. As of next year

1 we will be conducting the CAHPS survey annually. And then it is also, as Julia
2 mentioned, an NCQA requirement. So by 2026 when all of our plans are
3 required to be NCQA accredited they will be administering the CAHPS survey
4 every single year. But the Department administers it via a vendor for now.
5 MS. BROOKS: Thank you, Palav. Marc, I see you have your hand
6 up so you may have a comment in response to this question as well. Maybe he
7 can't hear me, I don't know. Marc, just checking, can you hear me? Okay, we
8 will keep on working on the technical --
9 MR. ELLIOTT: Hi. Are you --
10 MS. BROOKS: There you are.
11 MR. ELLIOTT: Hi. Can you hear me now?
12 MS. BROOKS: Yes, we can hear you, go ahead.
13 MR. ELLIOTT: Okay. So CAHPS data are confidential at the
14 person level so the goal with the discrimination items would be to identify plans
15 with high rates of problems for plan level intervention rather than trying to
16 intervene with the individual cases. I hope I understood the question correctly.
17 MEMBER SANDHIR: It wasn't specifically asking about that. So it
18 would be at plan level? Could you, could you explain that again, Marc. I am not
19 sure if I understood what you meant. What I guess my question was, if there are
20 problems identified or they are low performing on some of these measures, on
21 some of these questions, is there any ask right now for any intervention? What
22 is the, what are the health plans held accountable to for this? That's what I am
23 trying to understand.
24 MS. BROOKS: So I think --
25 MR. ELLIOTT: In that case.

1 MS. BROOKS: -- that's a great --
2 MR. ELLIOTT: In that case I think I am not the right person to
3 answer that.
4 MS. BROOKS: Yes. I was going to say, I think that's a great
5 question. There are different accountabilities. I don't know, Palav, for example,
6 if you want to speak to CAHPS and, you know, any activities that the Department
7 engages, DHCS engages in with respect to oversight?
8 MEMBER BABARIA: Yeah, hi, folks, this is Palav from DHCS. So
9 as of right now I do not believe we have CAHPS measures on our managed care
10 accountability set, which is the one where we require all plans to hit the minimum
11 performance level. Set -- are very interested in member experience, it is one of
12 the four goals of our comprehensive quality strategy, so we are looking at ways
13 of how we can use the CAHPS survey results more robustly in our accountability
14 approach.
15 MS. BROOKS: So I think it varies depending on health plan and
16 oversight entity. Kristine, I see you have your hand up.
17 MEMBER TOPPE: Thank you. I wanted to make just a couple of
18 points in terms of I think Bihu's question around. So NCQA obviously requires
19 the CAHPS survey be administered to all or by all of its accredited plans annually
20 across the populations depending on what the plan chooses to have accredited
21 or is required to have accredited for Medicaid, commercial, Medicare, et cetera.
22 And so that's an annual reporting requirement.
23 And so, you know, our, the way we structured accreditation is that
24 the intent is that the -- can you hear? Okay. Is that a plan looks
25 comprehensively at all of the inputs that they get around how they are serving

1 their members. So they are intended to look at the results of CAHPS kind of
2 holistically and say, where are we having problems.
3 And then they are also supposed to look at their member complaint
4 data, and then they are supposed to look at their network adequacy and really
5 kind of comprehensively evaluate how well are we doing so that they can do that
6 targeting for quality improvement purposes. And so we -- that's kind of, we look
7 at it as kind of one big package of expectations that a plan is, is really looking at
8 all of those data points to target.
9 And obviously, you can't use the CAHPS results for specific
10 member issues. It's not built that way. But the idea is that you are looking for
11 those big problem areas so that you can target, you know, and address
12 opportunities for improvement.
13 I would also say that from a -- kind of consistent with the points
14 made by the state agencies. We actually feature in the two proposed areas of
15 Getting Care Quickly and Getting Needed Care, in our ratings. So that is
16 something that we feature when we rate plans, whether they are accredited or
17 not, they get evaluated on that, kind of those sets of questions. And that's all
18 publicly available on our report card. Thank you.
19 MS. BROOKS: Thank you, Kristine. Julia, I see you have your
20 hand up. Do you have a question or just a comment and follow-up to our
21 discussion?
22 MEMBER LOGAN: It's a comment and follow-up.
23 MS. BROOKS: Go ahead, please.
24 MEMBER LOGAN: Okay, yeah, just real quickly. So at CalPERS
25 we hold our plans accountable to our health plan member survey and specific

1 member service performance measures and we have a corrective action plan
2 and financial accountability link to that.
3 MS. BROOKS: All right. Ed, it looks like your hand is up.
4 MEMBER JUHN: Hi, Ed, Inland Empire Health Plan. Just to
5 answer Bihu's question. Specifically for us here in Medi-Cal, the CAHPS patient
6 experience surveys actually factors into our plan rating. So this CAHPS score,
7 combined with our HEDIS scores, plus our accreditation score, kind of factor into
8 how we are rated out of five stars for a five rating.
9 And maybe to add to Kristine's point as well, even though we get
10 the CAHPS results and it's not at the member level, some of the questions are
11 more telling for us. You know, for example, was it easy for the respondent to get
12 necessary care, tests or treatment. Or, you know, did the respondent go, you
13 know, to a non-urgent appointment as soon as needed. You know, to help us
14 better understand whether the issue is an access issue or if there's other
15 initiatives that we within the plan can address. So again, even though it is not at
16 the member specific level the trends and the themes help point us in, you know,
17 some quality improvement initiatives for us to get better.
18 MS. BROOKS: Thanks, Ed. Silvia.
19 MEMBER YEE: Thank you. This is Silvia Yee with DREDF. I just
20 had a specific question about discrimination. The CMS questions seem to focus
21 fairly tightly on race and ethnicity and I was just wondering about the other plans
22 that have spoken here, about whether when you -- if you include a discrimination
23 question whether it goes and looks also at other factors, sexual orientation,
24 gender identity, disability, age? Thank you.
25 MS. BROOKS: Thank you, Silvia. All right, Nathan it looks like you

1 have a comment.

2 MR. NAU: Thanks, Sarah. and Nathan Nau, DMHC. So I think

3 the way the Department is looking at CAHPS measures is the same way as all

4 measures we're discussing. So if this makes the final recommended list and we

5 adopt it we are also going to be looking for a recommendation on a benchmark

6 and we want to try to drive improvement on those measures as well. So I think

7 all these measures we talked about so far probably vary in terms of enforcement

8 and quality improvement activities. But I think, think of it in that same realm. If

9 you want the measure then we will look, we will look to a benchmark and we will

10 look to try drive improvement as best as we can.

11 MS. BROOKS: Thanks, Nathan. Bihu.

12 MEMBER SANDHIR: Yes, thank you. Bihu Sandhir, AltaMed. So

13 I just want to -- thank you for all these, actually it really clarified a lot. So what is

14 included in the packet right now? Are these examples of the CAHPS surveys

15 that we are actually using right now at the health plans? Is that what these are?

16 Currently being used?

17 MS. BROOKS: Yes, that's correct.

18 MEMBER SANDHIR: And the only thing that seems to be missing

19 is the part about the discrimination (indiscernible) NCQA. Are these already

20 NCQA certified or recognized, the ones that we that we have here?

21 MEMBER TOPPE: Yes. This is Kristine Toppe. Yes, the

22 measures that they have proposed are within the CAHPS survey. They are --

23 MEMBER SANDHIR: (Overlapping.)

24 MEMBER TOPPE: -- common practice, commonly in use.

25 MEMBER SANDHIR: Okay.

1 MEMBER TOPPE: I did have a follow-up. Do you want me to
2 wait?
3 MS. BROOKS: Go ahead.
4 MEMBER TOPPE: I think there's -- so it's related to Bihu's
5 comment about being able to provide some additional recommendations or
6 maybe concepts for around discrimination that aren't already in there. Is that an
7 option for us to provide in writing?
8 MS. BROOKS: I think that's a great point, Kristine, and following
9 up on Doreena's comment from earlier. If there are additional things beyond
10 what we vote on today that you think should be included we would recommend
11 or we would ask that you provide to us in writing that information so that we can
12 incorporate it into the final report.
13 MEMBER TOPPE: Okay, that's great. Because I learned actually
14 between last week -- or the last meeting and this meeting that there is some
15 activity that we are tracking in that space and it's not necessarily built into the
16 CAHPS survey but it might be something that the Department would want to
17 consider. And there's kind of more detail but I don't want to take the time
18 because it's fairly in-depth.
19 MS. BROOKS: Got it, okay. Thank you, Kristine and Bihu. Andy.
20 DR. BASKIN: Yes, thank you. Hi, it's Andy Baskin. So I just would
21 like to ask someone from RAND or maybe even Kristine would know. I mean, I
22 know I have experience with this. Is just so everybody on the Committee really
23 understand some facts here about the number. Is that for any managed care
24 organization for, let's say a commercial plan just as an example, how many
25 CAHPS surveys actually go out in a standard sampling, which I believe is about

1 411 but I may be off on that. What is the usual response rate? So meaning how
2 many actual surveys come back. They go back to a third party, I understand
3 that.
4 And then to note that if that response rate let's say is 30% and you
5 are sending out 400 surveys, you are talking about 120 surveys for a plan. And
6 then if you stratify by a, let's say a racial group that is only 20% of the population.
7 Now you are talking 20% of, what did I say, of 120, so you are talking about 24
8 surveys. And I think we have heard from Marc that that may not be enough to
9 make the comparisons between some racial or ethnic groups. They are certainly
10 a subgroup with that many surveys.
11 So I just want someone to confirm that these numbers are real that
12 I am saying because I believe they are. So that when you are making decisions
13 of putting in a measure like this is really what are you getting, And it may not
14 turn out to be as statistically significant as you may assume that it was. At least
15 in the use that you are talking about, as opposed to, you know, an aggregated
16 information, which is very different. Thank you.
17 MR. ELLIOTT: This is Marc. To be clear, we do generally find in
18 the Medicare plan applications, which is the ones that I am most directly involved
19 in, that we do need two years of pooled data to get the sample size that are
20 needed.
21 But that said, we are able to make inferences about specific groups
22 in specific plans with two years of pooled data. And we give an example of that
23 in the, in the HESS article that you can look at and we also actually produce
24 plan-specific racial and ethnic group specific scores for health plans, Medicare
25 health plans right now on the Office of Minority Health website.

1 So I think the short answer is if you pool two years of data you can
2 generally do this. I will say I am less familiar with the minimum sample sizes for
3 commercial health plans that NCQA requires and it may be that you want to up
4 the sample sizes as has been suggested to bolster your ability to do this. But at
5 least in other settings two years of pooled data will generally support this.
6 MEMBER DAMBERG: Marc, do you want to comment at all in
7 terms of the value of using composites over individual items?
8 MR. ELLIOTT: Yes. On some of the slides I saw that single items
9 within composites were selected. And given that the data is being collected
10 anyway, my recommendation would be to use the full composites. It improves
11 your measurement properties if you do that and you can still drill down on
12 individual items if you want to.
13 MEMBER DAMBERG: But Andy, I think, you know, with the use of
14 composites you can also often get sort of a stronger signal on performance. So
15 something to consider.
16 MS. BROOKS: Great. Thanks, Andy, Cheryl, Marc, we appreciate
17 that. Not seeing any other hands raised from the Committee, pausing for a
18 second.
19 Shaini, do we have any public comments online that have raised
20 their hands?
21 All right. Do we have any public comment in the room? Yes
22 please, sir. And if you could just make sure the green light is on, on the
23 microphone and introduce yourself.
24 REV. SHORTY: I've got a green light. Can you hear me?
25 MS. BROOKS: I can hear. We can see you and hear you, thank

1 you so much.

2 REV. SHORTY: It's a great survey. People are not probably filling

3 it out because it's kind of long, 40 questions. You probably would get a better

4 response from the members, which being me because I am a member of a plan.

5 But if you was to, I would fill this out while waiting 30 or 45 minutes for my

6 appointment. But if you sent this to me at home I would just throw it in the trash.

7 This is something that the plans should be doing while the member

8 is in their doctor's office waiting to be seen, 45 minutes to an hour. I specifically

9 every time I ask my doctor for an appointment time, are you going to see me at

10 10:00 o'clock, 10:30, 11:45, what time. If I am going to sit there for an hour I try

11 to never go. My time is just as valuable as his.

12 Great survey, just need to shorten it. The public, we appreciate

13 shortness. Something quick, easy. Forty questions is a lot. That's 40, that's, oh.

14 Just imagine sitting there, there's no coffee, there's no cookies, there's no

15 doughnuts, there's not even a breath mint at the doctor's office waiting room.

16 So, you know, I mean, if they expect the members to really participate in these

17 surveys and to really get them to respond then shorten it and offer some

18 goodies. I once went to a seminar and they said the best way to get participation

19 to always have food or a snack.

20 And great survey, don't get me wrong. I probably wouldn't trash it.

21 If I am sitting there waiting for the doctor that hour. It will would give me

22 something to do besides sitting there patting my feet becoming more angry. The

23 Reverend don't want to be angered but I want to be seen properly. I don't, you

24 know, and 45 minutes is valuable time.

25 So that would be my only response to the Committee. Just, you

1 know, figuring out a way to better look at the questions maybe. Some of them
2 are basically the same question but asked in different ways. If we could just
3 shorten it, it probably would get better response. Or maybe have survey takers
4 and just periodically stop at different locations and hey, I am so-and-so and we
5 are here to do a survey. Do you have a few minutes while you're waiting to see
6 the doctor? Go through the survey with you.
7 Believe it or not, a lot of older people, their health conditions,
8 they're already tired and wore out. So having somebody read these questions to
9 them is very helpful while they are sitting there waiting. To actually ask those
10 members to read it, fill it out, not going to do it. Thank you.
11 MS. BROOKS: Thank you, sir. We appreciate your comments.
12 Any other public comment in the room?
13 Marc if you want to go ahead and respond, I see your hand is
14 raised.
15 MR. ELLIOTT: Yes. I was going to try to respond briefly to, I think,
16 three ideas that were raised in the gentleman's comments. One was noting the
17 often really long wait times that people experience. And I agree that's an issue.
18 And wanted to note that that's one of the things that the CAHPS survey
19 specifically measure so that, so that we can identify which -- the wait times.
20 Secondly, there was the idea of trying to fill out those surveys in the
21 waiting room rather than at home. And there's a hospital survey that's done that
22 at discharge and that does work really well. So far nobody has been able to
23 figure out how to do that for a plan survey because a plan survey needs to reach
24 people, even when they don't get to, to the doctor's office, because sometimes
25 their negative experiences at the doctor's office might, might keep them from

1 going and we still want to hear about that.

2 The third idea was about item links and duplication. And the

3 surveys are sometimes long. We found that shortening them improves response

4 rates a little bit, but not a lot. So for example, eliminating two dozen questions is

5 usually associated with about a 3 or 4% increase in response rate. So the

6 biggest barriers seem to be whether people want to participate at all; length

7 helps some. We do, we will continue to take it under advisement, to try to look at

8 opportunities to shorten the survey where we can. But in many cases there's a

9 trade off with trying to also make sure that we capture important aspects of care,

10 including things like discrimination. So these are all really helpful ideas and we

11 certainly want to keep providing the survey to address all these concerns.

12 MS. BROOKS: Thank you, Marc. Kristine.

13 MEMBER TOPPE: Yes, thanks. I just wanted to follow-up on

14 Andy's question, just verifying how NCQA requires the survey to be

15 administered. So the end goal is to have at least 411 completed responses and

16 so the typical experience is that plans will send out up to, you know, over 2,000

17 surveys with the intent of getting that, you know, basically a quarter of that, well,

18 you know, roughly. Yeah, if you are doing 2,000.

19 But the intent is to be able to also have a minimum of 100

20 completed responses in order to be able to calculate the individual rates and

21 then the subsequent composite. So the list is, as I said, is high in order to get

22 that response rate. And for the points that Marc already shared, you know,

23 there's complexity in terms of trying to kind of get to, you know, ensure that you

24 have enough valid results for all of the purposes that we are talking about here

25 as well as the way it has been built to date. Thank you.

1 MS. BROOKS: Thank you, Kristine. All right.
2 So we are now going to move to conducting a vote on CAHPS measures. So
3 while we are voting on CAHPS measures for consideration in the final report it
4 may turn out that there are no CAHPS measures included in the final set, and
5 that is okay. So just telling you that the selection here would be to vote on either
6 Getting Needed Care, Getting Care Quickly, or to just state that no CAHPS
7 measure would be included in the measure set itself for recommendation to the
8 DMHC.
9 Alex is going to go ahead and conduct a roll call. She won the, she
10 drew the short stick. Should there be a close follow-up, information on the action
11 -- option will be included in the report. So for example, if we take a vote and
12 there's a close follow-up then we will make sure that that information is also
13 reflected in the report itself. So I am going to turn it over to Alex.
14 MS. KANEMARU: -- do a roll call in alphabetical order by last
15 name and when I do just state your top option. So starting it off with Anna Lee
16 Amarnath. Oh, Sorry.
17 MEMBER DAMBERG: Can you repeat the option?
18 MS. KANEMARU: Getting Needed Care, Getting Care Quickly, or
19 No CAHPS Measure.
20 MEMBER DAMBERG: And one and two are either/or, they can't
21 be both; is that correct?
22 MS. BROOKS: So we are asking that you provide a vote for one
23 measure, either Getting Needed Care, Getting Care Quickly or No CAHPS
24 Measure. But as I said before, if one measure is close to the second measure
25 then we will definitely include that in the report for consideration. Okay. All right,

1 Anna Lee, you are up first.

2 MEMBER AMARNATH: I would vote for the third option to not

3 include the CAHPS measures in the final set.

4 MS. KANEMARU: Phil Barcellona?

5 MEMBER BARCELLONA: No inclusion of a CAHPS measure.

6 MS. KANEMARU: Thank you.

7 Dannie Ceseña?

8 MEMBER CESEÑA: No inclusion.

9 MS. KANEMARU: Alex Chen is absent today.

10 Cheryl Damberg?

11 MEMBER DAMBERG: I would include Getting Needed Care.

12 MS. KANEMARU: Diana Douglas?

13 MEMBER DOUGLAS: I would vote for Getting Needed Care.

14 MS. KANEMARU: Thank you.

15 Lishaun Francis? Not present.

16 Tiffany Huyenh-Cho?

17 MEMBER HUYENH-CHO: I would vote for Getting Needed Care.

18 MS. KANEMARU: Ed Juhn?

19 MEMBER JUHN: I would vote for the third, no CAHPS measures.

20 MS. KANEMARU: Jeffrey Reynoso?

21 MEMBER REYNOSO: Vote is for Getting Needed Care.

22 MS. KANEMARU: Rick Riggs is not present.

23 Bihu Sandhir?

24 MEMBER SANDHIR: I would vote for Getting Needed Care.

25 MS. KANEMARU: Kiran Savage-Sangwan?

1 MEMBER SAVAGE-SANGWAN: Getting Needed Care.
2 MS. KANEMARU: Rhonda Smith?
3 MEMBER SMITH: Getting Needed Care.
4 MS. KANEMARU: Kristine Toppe?
5 MEMBER TOPPE: Getting Needed Care.
6 MS. KANEMARU: Doreena Wong?
7 MEMBER WONG: Getting Needed Care.
8 MS. KANEMARU: And Silvia Yee?
9 MEMBER YEE: Getting Needed Care.
10 MS. KANEMARU: Okay. So with 10 votes from the Committee it
11 looks like Getting Needed Care will move forward as a recommendation in the
12 final report.
13 MS. BROOKS: Thank you, Alex, and thanks to all of you. We got
14 through our first vote. I think we should pat ourselves on the back a little bit, we
15 have come a long way.
16 Ed, I see your hand is up. Is that from before or did you have a
17 question? I can't hear you, you might be on mute.
18 MEMBER JUHN: Yes, thank you. Just my only question is for
19 Getting Needed Care the second question, Question 18, is dependent on the
20 prior question that they have to respond positively to. So I just want to make
21 sure that we recognize that. So it's dependent on the question that comes
22 before it.
23 MEMBER DAMBERG: I think you -- item.
24 MEMBER JUHN: So that might even make the sample size even
25 smaller. But I just, again, not to change the vote or the direction but just

1 something to consider because I don't know if we talked about that. I think
2 Getting Needed Care question number 9, you know, makes sense. But it sounds
3 like in this vote it is Getting Needed Care inclusive of both question 9 and 18.
4 Question 18 is where we may want to at least consider reviewing, given that it is
5 dependent on the prior questions.
6 MEMBER DAMBERG: shall I --
7 MS. BROOKS: So I think -- go ahead.
8 MEMBER DAMBERG: I can speak to that. I think you are referring
9 to the screener item. I don't have the survey up in front of me right at the
10 moment.
11 MR. ELLIOTT: This is Marc. The composite works together as a
12 whole and so the psychometric properties that I described do consider the
13 screening for eligibility items as well. So it is, it is not the case that this item has
14 been overlooked. But the psychometric properties of the composite as a whole,
15 do you consider the screener item, which is meant to make sure that people who
16 didn't have a particular experience don't answer a particular question. But it
17 doesn't reduce the total sample size for the composite as a whole. As Cheryl
18 mentioned, it actually increases the sample size and the reliability of the
19 composite as a whole.
20 MEMBER JUHN: Thank you.
21 MS. BROOKS: Thanks, Marc. Thanks, Ed. All right. So we are
22 going to move on to focus area measures. All right. So during the last two
23 Committee meetings, sorry, we narrowed the list of measures from hundreds,
24 literally, to 31 candidate measures. I am going to briefly review the candidate
25 measures now for Committee review that will ultimately be voted on. And what I

1 was thinking, Kristine, not to put you on the spot but putting you on the spot,
2 maybe as I go through the measures that's when you can flag if NCQA has
3 chosen them. Sound good? Okay.
4 So after conducting a national and state scan the following list of 12
5 areas was developed for the Committee's consideration and adjusted based on
6 Committee Member feedback. For example, we changed Maternal and Child
7 Health to Birthing Persons and Children, and Coordination of Care to
8 Appropriateness of Care.
9 As a reminder, there may be focus areas where we do not select or
10 we did not select measures in this initial process. While all these measures and
11 focus areas are important, there may not be a measure that aligns with the
12 Committee's priorities, guiding principles and so on, or the focus area may be
13 addressed through measures included under a different focus area.
14 If there is a measure, and this keys into what Kristine and Doreena
15 were asking about earlier, if there is a measure that you feel should be included
16 for consideration in the final set that is not in the list of candidate measures that
17 we are voting on today, please submit the measure you would recommend, in
18 writing, to Alex and the public comments inbox. We will provide that to you to
19 make sure you have it in writing. All right, next slide, please.
20 So as a reminder, during the April meeting the Committee
21 preliminarily agreed upon the cervical, breast and colorectal cancer screening
22 measures. And let me just -- I believe that one of those is flagged for you,
23 Kristine, is that right?
24 MEMBER TOPPE: Right. So of the ones that are on this slide, the
25 breast cancer and colorectal cancer screening measures will be stratified for

1 NCQA reporting purposes. Yes, sorry.

2 SPEAKER (OFF MIC): (Inaudible.)

3 MEMBER TOPPE: Yes, yes, by race and ethnicity.

4 MS. BROOKS: All right, so the next slide, please.

5 All right. During the April meeting there was a lot of discussion and

6 agreement that the Hemoglobin A1c Control for Patients with Diabetes measure

7 should be considered as a candidate measure.

8 In the May meeting there was Committee consensus around the

9 Controlling High Blood Pressure and Asthma Medication Ratio measures as well.

10 Kristine, anything to note there?

11 MEMBER TOPPE: So the Hemoglobin A1c Control for Patients

12 with Diabetes, Controlling High Blood Pressure and Asthma Medication Ratio will

13 all be specified for health equity reporting by race and ethnicity, stratified

14 reporting.

15 MS. BROOKS: Thanks, Kristine. Next slide, please. Oh, Anna

16 Lee, I'm sorry, if you want to go back. Anna Lee has her hand up, I apologize.

17 MEMBER AMARNATH: Anna Lee Amarnath with the Integrated

18 Healthcare Association. I just had a question comparing the list here on the slide

19 to the Excel. There are two controlling diabetes/blood pressure measures, two

20 Hemoglobin A1c measures. Are they both up for vote? And maybe it's a follow-

21 up question. Are they both up for stratification? I just want to be specific about

22 that.

23 MS. BROOKS: So great question. They are not up for vote, both

24 up for -- does Andy, do you want to speak to that, Andy? Yes, yes.

25 DR. BASKIN (OFF MIC): (Inaudible.)

1 MS. BROOKS: Anna Lee, great question. All right.
2 So we are on Slide 49. In the May meeting there was Committee
3 consensus around the following measures in the Mental Health focus area: So
4 Depression Screening and Follow-Up for Adolescents and Adults; Follow-Up
5 After Hospitalization for Mental Illness and Follow-Up After Emergency
6 Department Visit for Mental Illness.
7 MEMBER TOPPE: This is Kristine Toppe. None of these
8 measures were currently selected for this round of stratification.
9 MS. BROOKS: All right, next slide, please.
10 In the May meeting there was Committee consensus around the
11 following measures in the Substance Use focus area: Pharmacotherapy for
12 Opioid Use Disorder and Unhealthy Alcohol Use Screening and Follow-Up.
13 Anything on?
14 MEMBER TOPPE: Yes. Press the button. Kristine Toppe. So the
15 first measure, Pharmacotherapy for Opioid Use Disorder has been selected for
16 stratification by race and ethnicity.
17 MS. BROOKS: Thank you, Kristine. All right.
18 So Slides 51 and 52 reflect the measures that I will be going
19 through next. In the May meeting there was Committee consensus around the
20 following measures in the Birthing Persons and Children Measures focus area:
21 Cesarean Rate for Nulliparous Singleton Vertex, thank you for the help. Prenatal
22 and Postpartum Care. Contraceptive Care for All Women. Childhood
23 Immunization Status Combo 10. Weight Assessment and Counseling for
24 Nutrition and Physical Activity for Children/Adolescents. Topical Fluoride Varnish
25 for Children. Well-Child Visits in the First 30 months of Life and child. And Child

1 and Adolescent Well-Care Visits.

2 MEMBER TOPPE: So the -- sorry, I am not looking at looking at

3 the right slide. Did we jump ahead?

4 MS. BROOKS: Maybe go back to Slide 51 real quick.

5 MEMBER TOPPE: Yes, thank you. The Prenatal and Postpartum

6 Care measure was selected for stratification. And, sorry, I am just double-

7 checking myself there. And then on the next slide that you were reading to the

8 whole group. Okay. Then measures 7 and 8, the Well-Child Visits in the First 30

9 Months of Life; and the Child and Adolescent Well-Care Visits were selected as

10 well.

11 MS. BROOKS: All right, so -- go ahead Andy.

12 DR. BASKIN: Kristine, you had mentioned that there was a

13 possibility that the topical fluoride varnish would become a new NCQA measure

14 this may be appropriate to let us know. Did that happen or not?

15 MEMBER TOPPE: Thank you, Andy, for raising that. It is -- it is

16 slightly different in that the measure only recognizes topical -- let me just get my

17 notes so I am saying this correctly. That it is, two applications by any provider,

18 children ages 1-4, fluoride varnish only. So I don't know how that changes things

19 for folks but it is different from the core set measure because it doesn't recognize

20 the other fluorides.

21 DR. BASKIN: When will that start for NCQA?

22 MEMBER TOPPE: I think that's a 2023 measurement year; I will

23 double-check.

24 MS. BROOKS: All right, so next slide please. All right. So in the

25 June 8 meeting there was Committee consensus around the following utilization

1 measure: Avoidable Emergency Room Visits. So just flagging that this measure
2 was proposed during the June 8 meeting and so for additional details please
3 refer to the candidate measures workbook if you are interested in finding that
4 information.
5 Next slide, please.
6 In the June 8 meeting there was Committee consensus around the
7 following Appropriateness of Care measures, previously the Coordination of
8 Care focus area: Plan All-Cause Readmissions. Transitions of Care: Medication
9 Reconciliation Post-Discharge. Timely Follow-Up After Acute Exacerbations of
10 Chronic Conditions. Again, this third measure was proposed during the June 8
11 meeting and additional details are also available to you in your workbook. Next
12 slide, please.
13 All right. So during prior meetings there was feedback that an
14 Obesity, excuse me, and Adult Immunization measure should be considered for
15 Committee review.
16 In the June 8 meeting there was Committee consensus around the
17 following population health measures: Adult Immunization Status. But during the
18 April meeting and based on Committee feedback the Adult Immunization Status
19 measure was recommended for inclusion. And just flagging that although we did
20 hear from the Committee preference for an immunization measure that includes
21 the COVID-19 vaccine, there is not currently a measure at this time. And then of
22 note, NCQA is also proposing updating the new pneumococcal indicator to
23 include two new vaccines and expanding the age range for reporting across
24 commercial, Medicaid and Medicare plans in accordance with the vaccination
25 guidelines. All right.

1 In addition to Adult Immunization Status we also recommended
2 moving forward the Body Mass Index Screening and Follow-Up Plan. BMI is a
3 common and reliable measurement to identify overweight and obese individuals.
4 But it is worth mentioning that BMI is not a direct measure of severe
5 overweightness. In addition, research has found that BMI and its associated
6 disease and mortality risks appear to vary among ethnic subgroups such that
7 certain populations may experience mortality risk at different BMI indicators. So
8 flagging that for you all.
9 And then the third measure was Obesity Prediabetes and Diabetes
10 A1c Control. As mentioned in a previous meeting, this measure specifically was
11 developed as part of the Minnesota Community Measurement Program, which
12 may create challenges because the data needed isn't currently collected by
13 California health plans. This measure was also noted for potential challenges
14 just because the diagnosis of prediabetes is not standardized as well. Okay,
15 next slide, please.
16 MEMBER TOPPE: Um.
17 MS. BROOKS: Go ahead.
18 MEMBER TOPPE: Sorry, I just want -- this is Kristine. I want --
19 MS. BROOKS: I'm sorry, Kristine. I skipped you, I'm sorry.
20 MEMBER TOPPE: That's okay. The Adult Immunization Status
21 has been chosen for stratification as well.
22 MS. BROOKS: Great, thank you, Kristine; my fault about that. Go
23 ahead, Andy.
24 DR. BASKIN: Kristine, it's Andy Baskin. I think you also mentioned
25 there was a possibility that the age range for the body mass index screening

1 measure might change to include an older age group. This is just the children
2 and adolescents, I believe, the younger age. Was that, was I mistaken. We just
3 want to, I just wanted to clarify that this is the younger population only and that
4 NCQA is not planning to expand that to an older population? I may have
5 misunderstood you at another meeting.
6 (No audible response.)
7 MS. WATANABE: We can't hear the response if somebody is
8 talking.
9 MS. BROOKS: Oh, my apologies.
10 MEMBER TOPPE: I apologize, the mic was off. I have to follow-
11 up and to -- this is Kristine. I need to verify Andy's question regarding the obesity
12 measure, BMI.
13 MS. BROOKS: We are just checking, taking a moment just to look
14 something up right now.
15 MEMBER TOPPE: Yes, okay. So I'm sorry, I was following up on
16 Andy's question regarding the fluoride because I have got some folks -- so that is
17 measurement year 2023. And then just to make sure I am clear on the specific
18 question regarding the age range?
19 DR. BASKIN: Currently we had on here, I thought we had the BMI
20 one for children. Yeah. And I thought you had mentioned that NCQA was
21 thinking about expanding that into adults. The ones we -- the one we have on
22 here for adults is not an NCQA measure and because of that, there will be some
23 issues with that measure. So I wanted to know whether there was an NCQA
24 alternative that was coming in the near future because I thought you mentioned it
25 once. But I, once again --

1 MEMBER TOPPE: Yeah, no, I am not remembering back to that
2 meeting. I just need to -- can we circle back to that? Thank you.
3 MS. BROOKS: Certainly, certainly. All right. So we will move on
4 to the next slide, please.
5 All right. So for Health Equity during our meeting earlier this month
6 there was a great deal of input and interest to include RAND's Health Equity
7 Index and NCQA's Health Equity Accreditation as recommendations in the final
8 report for the DMHC's review.
9 In the June 8 meeting there was Committee consensus around the
10 following Health Equity measures: Meaningful access to Health Care Services
11 for Persons with Limited English Proficiency. Recently developed by the Oregon
12 Health Authority, this measure is a hybrid structural measure with self-attestation
13 to policies and procedures, and then reporting on the quantitative member
14 utilization of interpreter services. The self-attestations have gone smoothly but
15 there is ongoing definition and redefinition of the appropriate numerators and
16 denominators for the quantitative member utilization data. So just some
17 information on that measure.
18 The second measure that we identified was Patients Receiving
19 Language Services Supported by Qualified Language Services Providers.
20 Research finds that using untrained interpreters or friends and family can result
21 in an increase in medical errors, poor patient/provider communication and poor
22 follow-up and adherence to clinical instructions. This measure provides
23 information on the extent that language services are provided by assessed and
24 trained interpreters or assessed bilingual providers at key points in care.
25 The third measure, Cultural Competency Implementation

1 Subdomain: Quality Improvement. The Quality Improvement Subdomain of this
2 measure is recognized for its relevancy to the Principal Standard of the National
3 Culturally and Linguistically Appropriate Services Standards, also known as
4 CLASS, which encompass practices and policies related to providing equitable,
5 effective and quality care to culturally and linguistically diverse populations.
6 Cheryl, I know you are still on the line so just wanted to ask real quickly if you
7 have any comments as that measure itself, I believe, was developed by RAND.
8 MEMBER DAMBERG: I don't personally have direct experience
9 with it.
10 MS. BROOKS: Okay.
11 MEMBER DAMBERG: I could certainly get some information for
12 you.
13 MS. BROOKS: This is great. we just wanted to check in, so thank
14 you so much, Cheryl.
15 MEMBER DAMBERG: (Overlapping.)
16 MS. BROOKS: All right. So I did want to circle back on two things.
17 Oh, sorry, go ahead, Cheryl, my fault.
18 MEMBER DAMBERG: Oh, no, no, no. Just thanks for checking.
19 MS. BROOKS: Oh, thank you, yes. I did want to circle back on
20 two things that I have seen.
21 One is that, Anna Lee, your question about the two measures.
22 People did not hear your response, Andy, that you made; people online did not
23 hear the response that you made. So I don't know if you can repeat that just to
24 make sure that we communicate that effectively to everybody on the Committee
25 and in the public.

1 DR. BASKIN: So thank you, it's Andy Baskin. So you will just note
2 in the list of measures that there's like A, B or A, B and C. You know, several
3 lines for the same measure. And really all it means is that there are, there's
4 more than one number reported. There may be two numbers reported, maybe a
5 basically it is not a single number of performance, there's multiple sections to the
6 measure, but it's still all considered one measure. So the Hemoglobin A1c <8
7 and >9, in some way you have two sub-measures but we are including it as one
8 measure, including both portions of the measure.
9 MS. BROOKS: Thank you, Andy.
10 Just a quick reminder, I know we all love the Chat and it makes
11 things easier. But just Bagley-Keene does have requirements and restrictions
12 around utilizing it so just a reminder to not use the Chat, please.
13 Kiran also had a -- well, there was a comment in the Chat that I am
14 responding to, apologies. Just a question about, Kristine, the information that
15 you provided as we went through the measures, if we could update the slides to
16 include that information. Unfortunately, due to Bagley-Keene we can't update
17 the slides but what we thought is as we go through and take the measure can we
18 just have you once more say, again, if it is a measure that you selected or not?
19 MEMBER TOPPE: Yes.
20 MS. BROOKS: Okay, I apologize. Giving you a heads up now.
21 Thank you.
22 MEMBER TOPPE (OFF MIC): (Inaudible.)
23 MS. BROOKS: Perfect. Yes. All right, thank you, Kristine. All
24 right, so we are going to go ahead and just discuss all of the information that we
25 just walked through. It is information that, you know, we have had thorough

1 discussions on in prior meetings, but just wanted to see if there are any
2 comments from Committee Members, either online or in the room. Shaini, I don't
3 see any raised?
4 Do we have any public hands raised at this time?
5 Do we have public comment in the room?
6 Not at this time. All right.
7 So at this point, we have a full list of candidate measures. As I
8 talked about earlier, I encourage all of you to think about maybe the top 12 to 14
9 measures that you would prioritize and elevate to be included in the final
10 measure set. These recommendations also should really reflect the knowledge
11 and expertise that you all bring to this Committee, just recognizing everyone
12 brings something different to the table.
13 As a reminder, you are not limited to a number of measures and
14 additional measures may be considered. But, you know, just looking at a way to
15 filter down the number of measures based on what the feedback from the
16 Committee is. All right, next slide, please.
17 All right. All right. So when we get to the end of the section we will
18 conduct the following steps for each candidate measure. We will have
19 Committee Member vote on each measure for inclusion in the final set, measure
20 set. If a measure receives a "yes" vote from 60% or more of the Committee it
21 will be considered for the final set. Next slide please.
22 If a measure receives 40 to 59% of "yes" votes, it will be included
23 on a list for further discussion.
24 If a measure receives less than 39% of "yes" votes it will not be
25 included moving forward. Next slide please.

1 For measures that fall in the 40 to 59% "maybe" range we will
2 discuss in further detail and conduct a second round of votes, if that makes
3 sense.
4 For composite measures, in follow-up to your comment, Anna Lee,
5 earlier or your question, we will vote on the measure as a whole. For example,
6 Hemoglobin A1c <8% or >9%. Next slide, please.
7 If at the end of this process and more than 10 to 12 measures are
8 voted "yes" for recommendation in the final set, we will move and conduct a rank
9 vote as opposed to a yes or no vote.
10 As we continue to narrow the final measure set and review
11 measure-specific performance, measures in which California Medi-Cal and
12 commercial plans are performing well in may be measures to consider excluding
13 from your top 12 to 14 priority measures; so if there's already good performance.
14 And just to comment that, you know, I think as we go through the
15 votes, there are 31 votes to go through. And you heard Alex, she did a great job
16 at going through CAHPS measure. If we get through, you know, a fair number of
17 them and it seems that we are all voting "yes" on every one then we will probably
18 pause and move to a rank vote at that time, so we may not get through all the
19 measures. I just wanted to flag that for you all. So we will just read the room
20 and how things are going.
21 So we will now take questions. So let me just see. I see Bihu has
22 her hand up already so go ahead, Bihu.
23 MEMBER SANDHIR: Bihu Sandhir from AltaMed. I think one
24 question I have, is there an opportunity before we vote or as we vote, that we
25 look at the data with it, because I think that could impact how we think about the

1 measure. Because when you are looking at a measure I think it is important to
2 consider, I think we have discussed this in the past, is the impact on the whole.
3 Is it really an impactful measure for us? So would that be an option so that way
4 we could make more, a little bit more of an informed decision? That's the
5 question I have.
6 MS. BROOKS: I think it's an excellent question, Bihu. And
7 certainly we wanted to provide as much information as possible to you all to
8 make these decisions as we moved along, which was kind of the purpose of
9 providing the measures workbooks. So I think if there are, in this discussion as
10 we are talking right now, if there are things that people want to call out explicitly
11 or specifically about certain data then let's talk about that now before we get into
12 the vote itself.
13 Other comments in the room or -- Silvia?
14 MEMBER YEE: Hi, this is Silvia with DREDF. And I was just
15 wondering if the benchmark and stratification discussions impact on our
16 decisions? Is it then, is it just too late because the vote is finalized?
17 MS. BROOKS: So what I would say is that, you know, the
18 benchmarking information and stratification information could influence the
19 measures that you choose. The measures that you choose could influence how
20 things are benchmarked and what the stratification looks like. We have included
21 that benchmark data in the information that we provided to you, Silvia, so it is
22 available to you to take a look at as you are going through and voting.
23 MEMBER YEE: Thank you.
24 MS. BROOKS: Andy.
25 DR. BASKIN: Yeah, what we do intend to do is each time we get to

1 a measure for a vote we will mention whether there is benchmarking information
2 available or not available. We won't actually look at the benchmarking
3 information, you will have that in your, in your packet.
4 But there are a couple of structural informational things about the
5 measures we will say before the vote happens. So that when Sarah mentions a
6 measure I may say that, you know, this measure has benchmarks available or
7 does not have benchmarks available. Or there may be a couple of other things
8 about the measure that would make it potentially difficult with our criteria that we
9 set at the beginning to even do the measure, so that sort of thing. So just to let
10 you know, there will be a little of that --
11 MS. BROOKS: Thanks, Andy. I think just summarizing kind of
12 what you just said, which was excellent. Before each vote we will have a quick
13 blurb about each measure. I know we have gone through a lot of information
14 and just want a just, you know, friendly, quick reminder. Not a complete run-
15 through of everything, obviously, but a friendly quick reminder. Palav? No. Any
16 other hands from Committee Members?
17 Okay, Shaini, any hands from the public raised online?
18 Any public comment in the room? Yes, sir. Please.
19 If you could please introduce yourself. Thank you.
20 REV. SHORTY: Reverend Mac Shorty, Community Repower
21 Movement, also a part of the Campaign for Equity in Obesity Care.
22 I see obesity on the list; but it is something that really needs to be
23 addressed because people are dying from it. I come here month after month to
24 remind the Committee Members that my community where I live, we are 3600
25 doctors short, our area. The community's fault? No. Government fault? Could

1 be. But here is a committee that has a chance to address obesity. California
2 has always been looked to as a state where we lead and other states follow.
3 And this is a chance now. The government has tried it, the Obama
4 administration when they were in office, they tried the healthy thing with the
5 children and adults. It's like kicking a soccer ball. If the next player don't kick the
6 ball down the line it won't reach the goal.
7 Today is our chance to reach the goal for obesity care. Today is
8 the time to say we can address it. We can have doctors talk about it to their
9 patients more than just two minutes. My doctor tells me all the time, take some
10 gummy bears. I'm like, take some gummy bears? I mean, that's the stuff I
11 would tell my kid. What are gummy bears going to do for me, an adult? I need
12 more information than to be told to take some gummy bears.
13 But I don't blame him because he is still in practice at almost
14 eighty-something years old. And I tell him all the time, I love you, but go home to
15 your sick wife. He has a sick wife at home. I says, Doc. I ain't going to call his
16 name out. I said, Dr. Robert, I love you, but your wife needs you more than I do.
17 Because all you are telling me to do is take some gummy bears.
18 I want to live to reach 80 years old. I want to live to reach that. But
19 if I don't address my obesity I am not going to make it. I already have COPD,
20 high blood pressure, A1c is over 8.5 already. Once it reaches 9 I have been told
21 I will be on the needle.
22 So it has to be addressed. California could take the lead. We
23 must take the lead. Can't continue to keep sending overweight people to the
24 hospital. I read last night, 3:00 o'clock in the morning, I think we are somewhere
25 at 20, last year over $20 billion in obesity care spent in hospital care, crazy. That

1 money could be spent in better situations, better places, and the time is now.
2 Can't continue.
3 We are running out of space to bury people in California. I know I
4 don't want nobody buried in my backyard. I don't live in the country no more. I
5 left from down south a long time ago, my grandparents and them. And when I
6 go back there to visit and I see those tombstones in the backyard, I can't sleep.
7 My relatives is rocking the room. I can't sleep.
8 But here's our chance. Our coalition is sending good letters,
9 representing hundreds of thousands of people. But today you have enough
10 people in this room and on the line to say, listen, let's at least kick the ball
11 because somebody has already kicked it to us. And let's see if we can really do
12 some good work here. The time is now. Not tomorrow, not next year, because
13 some of us not going to be here. And I specifically told my kid, if I should die this
14 year to mail each and every one of you people in this room an obituary; and on
15 that obituary it is going to say, our father died because nobody cared. Thank
16 you.
17 MS. BROOKS: Thank you for your comments, sir.
18 Other public comments in the room?
19 All right. We are going to move into a vote then. So we will now
20 conduct a vote on the recommended measure set. Alex will conduct a roll call
21 for each measure. When she says your name state "yes" if you are in favor of
22 including the measure in the final set, or "no" if not. At the end of each roll call
23 for each measure Alex will state if the measure will be considered for the final
24 set, if the measure requires further discussion, or if the measure did not pass.
25 So just two things that we are flagging that we will be doing for

1 each vote. We are going to have, Andy is going to quickly give a snapshot on
2 each measure and then, Kristine, you are going to weigh in on if NCQA included
3 it in its health equity. So all right, so I am going to pass it over to Alex. Take it
4 away.
5 MS. KANEMARU: Sounds good. So first we are
6 going to do Cervical Cancer Screening. Andy.
7 DR. BASKIN: Thank you. So I don't sound like a broken record,
8 some of the things that I may say are things that have to do with some of our
9 initial criteria. In other words, it potentially impacts because of some disease
10 prevalence, those sorts of things. Whether there's available benchmarking
11 information, some feasibility issues or usability issues. Not, is this measure
12 being successfully used somewhere other than one of our three programs,
13 because we did include some measures that didn't necessarily currently align
14 with the programs in California. So if it's outside of that I may mention that just
15 so you remember it. Okay.
16 So with that, cervical cancer screening. The only thing I really want
17 to say about -- well, there are only a couple of things I want to say. Yes, this is a
18 HEDIS measure, there is benchmarking data available, readily available. We did
19 provide some prevalence data in one early meeting although I don't think we
20 ever actually said it out loud at the meeting. But just remember that at least
21 relatively speaking when you talk about cervical cancer, colorectal cancer and
22 breast cancer, that colorectal and breast cancer, the incidence of those cancers
23 are 10 times or more greater than cervical cancer. Not to belittle cervical cancer,
24 it's certainly a very important issue, but it is certainly a less prevalent issue than
25 the others. And now I will stop with that.

1 MS. KANEMARU: Kristine?

2 MEMBER TOPPE: Thank you. Thank you, Ignatius. Kristine

3 Toppe. So the cervical cancer screening measure has not been selected for

4 stratification. That was your ask of me?

5 MS. KANEMARU: Mm-hmm.

6 MEMBER TOPPE: For many, for many of the reasons that Andy

7 articulated in terms of, of the spectrum of measures, that one did not rise to the

8 top immediately as getting the most value for the purposes of stratification.

9 MS. KANEMARU: Thanks, Kristine. And then we will begin the

10 vote now. So we will start it off with Anna Lee?

11 MEMBER AMARNATH: Yes.

12 MS. KANEMARU: Bill Barcellona?

13 MEMBER BARCELLONA: Yes.

14 MS. KANEMARU: Can you repeat that?

15 MEMBER BARCELLONA: Yes.

16 MS. KANEMARU: Dannie Ceseña?

17 MEMBER CESEÑA: Yes.

18 MS. KANEMARU: Cheryl Damberg?

19 MEMBER DAMBERG: No.

20 MS. KANEMARU: Diana Douglas?

21 MEMBER DOUGLAS: No.

22 MS. KANEMARU: Lishaun Francis is not present.

23 Tiffany Huyenh-Cho?

24 MEMBER HUYENH-CHO: No.

25 MS. KANEMARU: Ed Juhn?

1 MEMBER JUHN: No.

2 MS. KANEMARU: Jeffrey Reynoso?

3 MEMBER REYNOSO: No.

4 MS. KANEMARU: Bihu Sandhir?

5 MEMBER SANDHIR: Yes.

6 MS. KANEMARU: Kiran Savage-Sangwan?

7 MEMBER SAVAGE-SANGWAN: Yes.

8 MS. KANEMARU: Rhonda Smith?

9 MEMBER SMITH: Yes.

10 MS. KANEMARU: Kristine Toppe?

11 MEMBER TOPPE: No.

12 MS. KANEMARU: Doreena Wong?

13 MEMBER WONG: Yes.

14 MS. KANEMARU: And Silvia Yee?

15 MEMBER YEE: Yes.

16 MS. KANEMARU: So 41% of the Committee voted "yes" on this
17 measure. With this being the case we will put it in the bucket for further
18 discussion.

19 The next measure is colorectal cancer screening. Andy, take it
20 away.

21 DR. BASKIN: Yes, hi. So obviously, a well-known illness,
22 colorectal cancer screening. Note that the original measure was ages 50 to 75.
23 It is now, I believe, 45 to 75 due to recent recommendations. So it does expand
24 the population for at least the commercial population, which we are -- and the
25 Medi-Cal population, as opposed to Medicare Advantage, which obviously is not

1 part of this project. And there are certainly readily available benchmarking data.
2 MS. KANEMARU: Kristine?
3 MEMBER TOPPE: Sorry. That measure has been selected for
4 stratification.
5 MS. BROOKS: And, Kristine, do you know when the benchmark
6 will be available for that measure specifically?
7 MEMBER TOPPE: Not for several years because we have to
8 collect the data, evaluate it and then assess whether or not, you know, it needs
9 more time.
10 MS. KANEMARU: We will begin the vote. Anna Lee Amarnath?
11 MEMBER AMARNATH: I vote, yes.
12 MS. KANEMARU: Bill Barcellona?
13 MEMBER BARCELLONA: Yes.
14 MS. KANEMARU: Dannie Ceseña?
15 MEMBER CESEÑA: No.
16 MS. KANEMARU: Cheryl Damberg?
17 MEMBER DAMBERG: Yes.
18 MS. KANEMARU: Diana Douglas?
19 MEMBER DOUGLAS: Yes.
20 MS. KANEMARU: Lishaun Francis is not present.
21 Tiffany Huyenh-Cho?
22 MEMBER HUYENH-CHO: Yes.
23 MS. KANEMARU: Ed Juhn?
24 MEMBER JUHN: Yes.
25 MS. KANEMARU: Jeffrey Reynoso?

1 MEMBER REYNOSO: Yes.

2 MS. KANEMARU: Rick Riggs is not present.

3 Bihu Sandhir?

4 MEMBER SANDHIR: Yes.

5 MS. KANEMARU: Kiran Savage-Sangwan?

6 MEMBER SAVAGE-SANGWAN: Yes.

7 MS. KANEMARU: Rhonda Smith?

8 MEMBER SMITH: Yes.

9 MS. KANEMARU: Kristine Toppe?

10 MEMBER TOPPE: Yes.

11 MS. KANEMARU: Doreena Wong?

12 MEMBER WONG: Yes.

13 MS. KANEMARU: And Silvia Yee?

14 MEMBER YEE: Yes.

15 MS. KANEMARU: Okay. So with 71% of the Committee voting
16 "yes" on this measure it will be included in the report for recommendation.

17 Next measure, breast cancer screening. Andy?

18 DR. BASKIN: Yeah. Not much different to say than colorectal
19 cancer. Certainly a highly prevalent condition. A well known measure. There
20 will obviously be readily available benchmarking data.

21 MS. KANEMARU: Kristine?

22 MEMBER TOPPE: And that measure was also selected for
23 stratification.

24 MS. KANEMARU: Thank you. Start it off with Anna Lee?

25 MEMBER AMARNATH: Yes.

1 MS. KANEMARU: Bill Barcellona?
2 MEMBER BARCELLONA: Yes.
3 MS. KANEMARU: Dannie Ceseña?
4 MEMBER CESEÑA: Yes.
5 MS. KANEMARU: Cheryl Damberg?
6 MEMBER DAMBERG: Yes.
7 MS. KANEMARU: Diana Douglas?
8 MEMBER DOUGLAS: Yes.
9 MS. KANEMARU: Tiffany Huyenh-Cho?
10 MEMBER HUYENH-CHO: Yes.
11 MS. KANEMARU: Ed Juhn?
12 MEMBER JUHN: Yes.
13 MS. KANEMARU: Jeffrey Reynoso?
14 MEMBER REYNOSO: Yes.
15 MS. KANEMARU: Bihu Sandhir?
16 MEMBER SANDHIR: Yes.
17 MS. KANEMARU: Kiran Savage-Sangwan?
18 MEMBER SAVAGE-SANGWAN: Yes.
19 MS. KANEMARU: Rhonda Smith? Rhonda Smith?
20 MEMBER SMITH: Yes.
21 MS. KANEMARU: Kristine Toppe?
22 MEMBER TOPPE: Yes.
23 MS. KANEMARU: Doreena Wong?
24 MEMBER WONG: Yes.
25 MS. KANEMARU: Silvia Yes?

1 MEMBER YEE: No.

2 MS. KANEMARU: Okay. With 76% of the Committee voting "yes"
3 on this measure it will be included in the final report.

4 The next measure is the Hemoglobin A1c control for patients with
5 diabetes. Andy?

6 DR. BASKIN: Yes. A highly prevalent illness, diabetes. You will
7 know, as I noted earlier, two sub-measures to it but it's all one measure. So both
8 the Hemoglobin A1c <8 and >9, one being good control, one being poor control,
9 are both included in the measure. So you are only voting once for the
10 combination. And there's certainly readily available benchmarking data.

11 MEMBER TOPPE: And that measure -- this is Kristine Toppe.
12 And that measure has also been selected for stratification.

13 MEMBER SANDHIR: Bihu Sandhir from AltaMed. I just wanted to
14 understand how would we -- would we report on both measures? Is that the
15 intent, is what you are asking?

16 DR. BASKIN: And this is Andy Baskin. Yes, both would be
17 reported, so both sub-measures would be reported. Now how the accountability
18 will work on that will be, I guess, part of our later decision in terms of a
19 recommendation to DMHC. But as it stands today, yes, they will report both,
20 both sub-measures.

21 MS. KANEMARU: We'll start off with Anna Lee.

22 DR. BASKIN: I should note that both sub-measures have separate
23 benchmarking information. I mean, there is not a benchmark for the
24 combination, it is a benchmark for each of the sub-measures. But they are
25 readily available today because those measures have been in place even before

1 they were combined.

2 MEMBER SANDHIR (OFF MIC): Which (inaudible)?

3 DR. BASKIN: Both, both.

4 MS. KANEMARU: Anna Lee?

5 MEMBER AMARNATH: Yes.

6 MS. KANEMARU: Bill Barcellona?

7 MEMBER BARCELLONA: Yes.

8 MS. KANEMARU: Dannie Ceseña?

9 MEMBER CESEÑA: Yes.

10 MS. KANEMARU: Cheryl Damberg?

11 MEMBER DAMBERG: Yes.

12 MS. KANEMARU: Diana Douglas?

13 MEMBER DOUGLAS: Yes.

14 MS. KANEMARU: Tiffany Huyenh-Cho?

15 MEMBER HUYENH-CHO: Yes.

16 MS. KANEMARU: Ed Juhn?

17 MEMBER JUHN: Yes.

18 MS. KANEMARU: Jeffrey Reynoso?

19 MEMBER REYNOSO: Yes.

20 MS. KANEMARU: Bihu Sandhir?

21 MEMBER SANDHIR: Yes.

22 MS. KANEMARU: Kiran Savage-Sangwan?

23 MEMBER SAVAGE-SANGWAN: Yes.

24 MS. KANEMARU: Rhonda Smith?

25 MEMBER SMITH: Yes.

1 MS. KANEMARU: Kristine Toppe?

2 MEMBER TOPPE: Yes.

3 MS. KANEMARU: Doreena Wong?

4 MEMBER WONG: Yes.

5 MS. KANEMARU: Silvia Yee?

6 MEMBER YEE: Yes.

7 MS. KANEMARU: Okay, with 82% of the votes being "yes" this

8 measure will be included in the final report.

9 Next measure is controlling high blood pressure.

10 DR. BASKIN: So not to sound like a broken record, but certainly a

11 very common condition, high blood pressure. It is a measure that has

12 benchmarking available, it has been a measure in use as part of the HEDIS set.

13 MEMBER TOPPE: And this is Kristine Toppe. The measure has

14 been selected for race and ethnicity stratification.

15 MS. KANEMARU: Thank you. Anna Lee Amarnath?

16 MEMBER AMARNATH: Yes.

17 MS. KANEMARU: Bill Barcellona?

18 MEMBER BARCELLONA: Yes.

19 MS. KANEMARU: Dannie Ceseña?

20 MEMBER CESEÑA: Yes.

21 MS. KANEMARU: Cheryl Damberg?

22 MEMBER DAMBERG: Yes.

23 MS. KANEMARU: Diana Douglas?

24 MEMBER DOUGLAS: Yes.

25 MS. KANEMARU: Tiffany Huyenh-Cho?

1 MEMBER HUYENH-CHO: Yes.

2 MS. KANEMARU: Ed Juhn?

3 MEMBER JUHN: Yes.

4 MS. KANEMARU: Jeffrey Reynoso?

5 MEMBER REYNOSO: Yes.

6 MS. KANEMARU: Bihu Sandhir?

7 MEMBER SANDHIR: Yes.

8 MS. KANEMARU: Kiran Savage-Sangwan?

9 MEMBER SAVAGE-SANGWAN: Yes.

10 MS. KANEMARU: Rhonda Smith?

11 MEMBER SMITH: Yes.

12 MS. KANEMARU: Kristine Toppe?

13 MEMBER TOPPE: Yes.

14 MS. KANEMARU: Doreena Wong?

15 MEMBER WONG: Yes.

16 MS. KANEMARU: And Silvia Yee?

17 MEMBER YEE: Yes.

18 MS. KANEMARU: With 82% of the votes being "yes" it will move
19 forward for recommendation.

20 Next measure, asthma medication ratio.

21 DR. BASKIN: This is Andy again. So asthma, once again, a very
22 common condition; and I think we heard across some of the racial and ethnic
23 groups a definite issue. There is readily available benchmarking data on this.
24 Just to be clear, that this is a measure with a denominator of those with
25 persistent asthma. It is not everybody that has asthma. But a asthma

1 medication ratio would only make sense for those that had not just your everyday
2 intermittent asthma but some ongoing issues with asthma, which is what the
3 persistent asthma is meant to identify.
4 MEMBER TOPPE: And this measure has also been selected for
5 stratification.
6 MS. KANEMARU: Thank you. Anna Lee Amarnath?
7 MEMBER AMARNATH: Yes.
8 MS. KANEMARU: Bill Barcellona?
9 MEMBER BARCELLONA: Yes.
10 MS. KANEMARU: Dannie Ceseña?
11 MEMBER CESEÑA: Yes.
12 MS. KANEMARU: Cheryl Damberg?
13 MEMBER DAMBERG: Yes.
14 MS. KANEMARU: Diana Douglas?
15 MEMBER DOUGLAS: Yes.
16 MS. KANEMARU: Tiffany Huyenh-Cho?
17 MEMBER HUYENH-CHO: Yes.
18 MS. KANEMARU: Ed Juhn?
19 MEMBER JUHN: Yes.
20 MS. KANEMARU: Jeffrey Reynoso?
21 MEMBER REYNOSO: Yes.
22 MS. KANEMARU: Bihu Sandhir?
23 MEMBER SANDHIR: Yes.
24 MS. KANEMARU: Kiran Savage-Sangwan?
25 MEMBER SAVAGE-SANGWAN: Yes.

1 MS. KANEMARU: Rhonda Smith?

2 MEMBER SMITH: Yes.

3 MS. KANEMARU: Kristine Toppe?

4 MEMBER TOPPE: Yes.

5 MS. KANEMARU: Doreena Wong?

6 MEMBER WONG: Yes.

7 MS. KANEMARU: Silvia Yee?

8 MEMBER YEE: Yes.

9 MS. KANEMARU: With 82% percent of the votes the measure will

10 also move forward for the Committee's recommendation.

11 The next measure is depression screening and follow-up for

12 adolescents and adults.

13 DR. BASKIN: Yes. So this measure is, will have some

14 benchmarking data available. One thing I don't remember is the age of this

15 measure for the reporting. I think lead benchmarking data should already be

16 available for this but maybe Kristine would be able to confirm that because I

17 think it's been around for at least a couple of years to have collected data. And

18 certainly depression, well, at least in the behavioral health/mental illness realm,

19 the most common condition that requires screening and treatment.

20 MEMBER TOPPE: None of the measures on this slide, oh, we

21 don't, we don't have a slide up, sorry. That measure has not been selected for

22 stratification.

23 MS. MYERS: And, Andy, to your question on the age range, it's 12

24 and up. And there's not benchmark data available on the Quality Compass.

25 DR. BASKIN: Do you know how long the measure has have been

1 in place? Does anybody know from NCQA? Because obviously, as Kristine
2 noted, a measure has to be in place for a couple of years so they can see the
3 first year or the first two years of data. And then you know, before they can
4 come up with some benchmarking information. So I don't -- that's what was my
5 concern. But there will be benchmarking and it will be -- I just don't know if it's
6 next year or the year after.
7 MEMBER TOPPE: I don't know, I would have to go back and look
8 at the measure workbook.
9 MS. KANEMARU: Anna Lee, we'll start with you?
10 MEMBER AMARNATH: I'm going to say "yes."
11 MS. KANEMARU: Okay.
12 Bill Barcellona?
13 MEMBER BARCELLONA: Yes.
14 MS. KANEMARU: Dannie Ceseña?
15 MEMBER CESEÑA: Yes.
16 MS. KANEMARU: Cheryl Damberg?
17 MEMBER DAMBERG: No.
18 MS. KANEMARU: Diana Douglas?
19 MEMBER DOUGLAS: Yes.
20 MS. KANEMARU: Tiffany Huyenh-Cho?
21 MEMBER HUYENH-CHO: Yes.
22 MS. KANEMARU: Ed Juhn?
23 MEMBER JUHN: No.
24 MS. KANEMARU: Jeffrey Reynoso?
25 MEMBER REYNOSO: Yes.

1 MS. KANEMARU: Bihu Sandhir?

2 MEMBER SANDHIR: Yes.

3 MS. KANEMARU: Kiran Savage-Sangwan?

4 MEMBER SAVAGE-SANGWAN: Yes.

5 MS. KANEMARU: Rhonda Smith?

6 MEMBER SMITH: Yes.

7 MS. KANEMARU: Kristine Toppe?

8 MEMBER TOPPE: Yes.

9 MS. KANEMARU: Doreena Wong?

10 MEMBER WONG: Yes.

11 MS. KANEMARU: Silvia Yee?

12 MEMBER YEE: Yes.

13 MS. KANEMARU: With 71% of the votes being "yes" this will move
14 forward for the Committee's recommendation.

15 The next measure is follow-up after hospitalization for mental
16 illness.

17 DR. BASKIN: Yes, hi. And you can see that there are two
18 components to this measure, a 7 day follow-up and a 30 day follow-up. They are
19 essentially sub measures, as I have spoken, within the same measure so they
20 will both be reported as part of this.

21 I should point out in terms of, just in terms of prevalence, that while
22 mental illness is rather prevalent, but hospitalization for mental illness is not
23 terribly prevalent. I don't have exact numbers for you but it is not a large
24 population that we are talking about, despite the fact that follow-up is important
25 for those folks. So just pointing that out.

1 This is another one for which I don't know whether the
2 benchmarking is available yet but will be because it is part of the HEDIS set and
3 certainly there will be results, I just don't know that this measure been around
4 that long.
5 MS. MYERS: Andy, there is benchmark data available for that
6 measure.
7 DR. BASKIN: It's already out. Okay, good. So benchmarking is
8 readily available today. Thank you.
9 MEMBER TOPPE: Failing in my duties. That measure has not
10 been selected for stratification.
11 MS. KANEMARU: Start it off with Silvia Yee this time. Silvia?
12 MEMBER YEE: No.
13 MS. KANEMARU: Doreena Wong?
14 MEMBER WONG: No.
15 MS. KANEMARU: Kristine Toppe?
16 MEMBER TOPPE: Yes.
17 MS. KANEMARU: Rhonda Smith?
18 MEMBER SMITH: Sorry, yes.
19 MS. KANEMARU: Kiran Savage-Sangwan?
20 MEMBER SAVAGE-SANGWAN: No.
21 MS. KANEMARU: Bihu Sandhir?
22 MEMBER SANDHIR: Yes.
23 MS. KANEMARU: Jeffrey Reynoso?
24 MEMBER REYNOSO: No.
25 MS. KANEMARU: Ed Juhn?

1 MEMBER JUHN: No.

2 MS. KANEMARU: Tiffany Huyenh-Cho?

3 MEMBER HUYENH-CHO: No.

4 MS. KANEMARU: Diana Douglas?

5 MEMBER DOUGLAS: No.

6 MS. KANEMARU: Cheryl Damberg?

7 MEMBER DAMBERG: Yes.

8 MS. KANEMARU: Dannie Ceseña?

9 MEMBER CESEÑA: Yes.

10 MS. KANEMARU: Bill Barcellona?

11 MEMBER BARCELLONA: No.

12 MS. KANEMARU: And Anna Lee Amarnath?

13 MEMBER AMARNATH: No.

14 MS. KANEMARU: With 24% of the votes this measure does not,

15 will not move forward for the recommendations.

16 Next measure is follow-up after emergency department visit for

17 mental illness.

18 DR. BASKIN: Similar to the prior measures, this is a two sub-

19 measures, a 7 day follow-up and 30 day follow-up. Remember that the

20 emergency room visit has to be for the purpose of mental illness for the follow-up

21 to occur and so it makes it, once again, probably a relatively small population in

22 terms of the primary reason that somebody actually went to the emergency

23 room. But once again, follow-up is important. And there will be benchmarking

24 information available for this measure.

25 MEMBER TOPPE: This measure was not selected for

1 stratification.

2 MS. KANEMARU: Okay. Silvia Yee?

3 MEMBER YEE: Yes.

4 MS. KANEMARU: Doreena Wong?

5 MEMBER WONG: Yes.

6 MS. KANEMARU: Kristine Toppe?

7 MEMBER TOPPE: No.

8 MS. KANEMARU: Rhonda Smith?

9 MEMBER SMITH: Sorry, yes.

10 MS. KANEMARU: Kiran Savage-Sangwan?

11 MEMBER SAVAGE-SANGWAN: Yes.

12 MS. KANEMARU: Bihu Sandhir?

13 (No audible response.)

14 MS. KANEMARU: Jeffrey Reynoso?

15 MEMBER REYNOSO: Yes.

16 MS. KANEMARU: Ed Juhn?

17 MEMBER JUHN: No.

18 MS. KANEMARU: Tiffany Huyenh-Cho?

19 MEMBER HUYENH-CHO: No.

20 MS. KANEMARU: Diana Douglas?

21 MEMBER DOUGLAS: No.

22 MS. KANEMARU: Cheryl Damberg?

23 MEMBER DAMBERG: No.

24 MS. KANEMARU: Dannie Ceseña?

25 MEMBER CESEÑA: Yes.

1 MS. KANEMARU: Bill Barcellona?

2 MEMBER BARCELLONA: No.

3 MS. KANEMARU: And Anna Lee?

4 MEMBER AMARNATH: No.

5 MS. KANEMARU: Okay. With 41% of the votes this will be further

6 discussed.

7 Pharmacotherapy for opioid use disorder.

8 DR. BASKIN: So a measure of pharmacotherapy use. And

9 specifically the measure is that to have had appropriate pharmacotherapy use

10 that you have had it for 180 days or more to have met the measure. And of

11 course the subset of the population is those with opioid use disorder. And once

12 again, a HEDIS measure so benchmarking will be available at some point if not

13 already.

14 MEMBER TOPPE: This measure has been chosen for

15 stratification.

16 MS. MYERS: And I would just add that there is benchmarking

17 available at this time.

18 MS. KANEMARU: There is benchmarking data available; it is

19 available in your candidate measures workbook.

20 We will start back with you, Anna Lee?

21 MEMBER AMARNATH: No.

22 MS. KANEMARU: Bill Barcellona?

23 MEMBER BARCELLONA: No.

24 MS. KANEMARU: Dannie Ceseña?

25 MEMBER CESEÑA: Yes.

1 MS. KANEMARU: Cheryl Damberg?
2 MEMBER DAMBERG: No.
3 MS. KANEMARU: Diana Douglas?
4 MEMBER DOUGLAS: Yes.
5 MS. KANEMARU: Tiffany Huyenh-Cho?
6 MEMBER HUYENH-CHO: Yes.
7 MS. KANEMARU: Ed Juhn?
8 MEMBER JUHN: No.
9 MS. KANEMARU: Jeffrey Reynoso?
10 MEMBER REYNOSO: Yes.
11 MS. KANEMARU: Bihu Sandhir?
12 MEMBER SANDHIR: Yes.
13 MS. KANEMARU: Kiran Savage-Sangwan?
14 MEMBER SAVAGE-SANGWAN: Yes.
15 MS. KANEMARU: Rhonda Smith?
16 MEMBER SMITH: No.
17 MS. KANEMARU: Kristine Toppe?
18 MEMBER TOPPE: Yes.
19 MS. KANEMARU: Doreena Wong?
20 MEMBER WONG: Yes.
21 MS. KANEMARU: And Silvia Yee?
22 MEMBER YEE: Yes.
23 MS. KANEMARU: With 47% of the votes we will move this forward
24 for further discussion.
25 Next measure is unhealthy alcohol use screening and follow-up.

1 DR. BASKIN: So, the population is actually broad because the
2 screening is across the population, not just looking for alcohol use, unhealthy
3 alcohol use. There will be -- there is benchmarking data available. This is a
4 HEDIS measure; and it is essentially a screening measure.
5 MEMBER TOPPE: And this measure has not been selected for
6 stratification.
7 MS. KANEMARU: you. Anna Lee Amarnath?
8 MEMBER AMARNATH: No.
9 MS. KANEMARU: Bill Barcellona?
10 MEMBER BARCELLONA: No.
11 MS. KANEMARU: Dannie Ceseña?
12 MEMBER CESEÑA: Yes.
13 MS. KANEMARU: Cheryl Damberg?
14 MEMBER DAMBERG: No.
15 MS. KANEMARU: Diana Douglas?
16 MEMBER DOUGLAS: No.
17 MS. KANEMARU: Tiffany Huyenh-Cho?
18 MEMBER HUYENH-CHO: No.
19 MS. KANEMARU: Ed Juhn?
20 MEMBER JUHN: No.
21 MS. KANEMARU: Jeffrey Reynoso?
22 MEMBER REYNOSO: No.
23 MS. KANEMARU: Bihu Sandhir?
24 MEMBER SANDHIR: No.
25 MS. KANEMARU: Kiran Savage-Sangwan?

1 MEMBER SAVAGE-SANGWAN: Sorry, just to confirm, this is the
2 unhealthy alcohol use?
3 MS. KANEMARU: Yes.
4 MEMBER SAVAGE-SANGWAN: Okay, then my vote is no.
5 MS. KANEMARU: Rhonda Smith?
6 MEMBER SMITH: No.
7 MS. KANEMARU: Kristine Toppe?
8 MEMBER TOPPE: No.
9 MS. KANEMARU: Doreena Wong?
10 MEMBER WONG: No.
11 MS. KANEMARU: Silvia Yee?
12 MEMBER YEE: No.
13 MS. KANEMARU: -- vote it will not move forward for the
14 Committee's recommendation.
15 The next measure is cesarean rate for nulliparous singleton vertex.
16 DR. BASKIN: I mean, just to remind people; so this is, nulliparous
17 is essentially your first pregnancy and singleton meaning you are having one
18 baby instead of double, triplets or whatever. And it's just that you didn't get a
19 cesarean section is the object is measure. So it is a population of, obviously,
20 women that are delivering.
21 This is one of the few times I am going to say that there is
22 benchmarking information available, even though it is not a HEDIS measure, it is
23 a Joint Commission measure. But this has been well published and there's a lot
24 of cesarean section rate data out there. And I believe -- we may not have it in
25 our packet but we could probably come back at a later time and provide some

1 national data on this one, I am pretty sure that it's available.

2 MEMBER TOPPE: This is not an NCQA measure.

3 MS. KANEMARU: Oh yes, sorry.

4 MEMBER TOPPE: That's okay.

5 MS. KANEMARU: Anna Lee Amarnath?

6 MEMBER AMARNATH: No.

7 MS. KANEMARU: Bill Barcellona?

8 MEMBER BARCELLONA: No.

9 MS. KANEMARU: Dannie Ceseña?

10 MEMBER CESEÑA: No.

11 MS. KANEMARU: Cheryl Damberg?

12 MEMBER DAMBERG: No.

13 MS. KANEMARU: Diana Douglas?

14 MEMBER DOUGLAS: No.

15 MS. KANEMARU: Tiffany Huyenh-Cho?

16 MEMBER HUYENH-CHO: No.

17 MS. KANEMARU: Ed Juhn?

18 MEMBER JUHN: No.

19 MS. KANEMARU: Jeffrey Reynoso?

20 MEMBER REYNOSO: No.

21 MS. KANEMARU: Bihu Sandhir?

22 MEMBER SANDHIR: No.

23 MS. KANEMARU: Kiran Savage-Sangwan?

24 MEMBER SAVAGE-SANGWAN: Yes.

25 MS. KANEMARU: Rhonda Smith?

1 MEMBER SMITH: Yes.

2 MS. KANEMARU: Kristine Toppe?

3 MEMBER TOPPE: No.

4 MS. KANEMARU: Doreena Wong?

5 MEMBER WONG: Yes.

6 MS. KANEMARU: Silvia Yee?

7 MEMBER YEE: No.

8 MS. KANEMARU: With 12% of the votes this measure does not

9 move forward.

10 Next measure is prenatal and post-partum care.

11 DR. BASKIN: This is prenatal and postpartum care. Once again

12 two sub-measures, one that says prenatal care occurred in a timely manner; and

13 then two, that the post-partum care occurred in a timely manner. There will

14 certainly be benchmarking information available for this measure as it is a HEDIS

15 measure.

16 MEMBER TOPPE: And this measure, excuse me, has been

17 selected for stratification.

18 MS. KANEMARU: Okay. Anna Lee?

19 MEMBER AMARNATH: Yes.

20 MS. KANEMARU: Bill Barcellona?

21 MEMBER BARCELLONA: Yes.

22 MS. KANEMARU: Dannie Ceseña?

23 MEMBER CESEÑA: Yes.

24 MS. KANEMARU: Cheryl Damberg?

25 MEMBER DAMBERG: Yes.

1 MS. KANEMARU: Diana Douglas?
2 MEMBER DOUGLAS: Yes.
3 MS. KANEMARU: Tiffany Huyenh-Cho?
4 MEMBER HUYENH-CHO: Yes.
5 MS. KANEMARU: Ed Juhn?
6 MEMBER JUHN: Yes.
7 MS. KANEMARU: Jeffrey Reynoso?
8 MEMBER REYNOSO: Yes.
9 MS. KANEMARU: Bihu Sandhir?
10 MEMBER SANDHIR: Yes.
11 MS. KANEMARU: Kiran Savage-Sangwan?
12 MEMBER SAVAGE-SANGWAN: Yes.
13 MS. KANEMARU: Rhonda Smith?
14 MEMBER SMITH: Yes.
15 MS. KANEMARU: Kristine Toppe?
16 MEMBER TOPPE: Yes.
17 MS. KANEMARU: Doreena Wong?
18 MEMBER WONG: Yes.
19 MS. KANEMARU: And Silvia Yee?
20 MEMBER YEE: Yes.
21 MS. KANEMARU: -- of the vote it will move
22 forward in the Committee's recommendation.
23 Next measure, contraceptive care, all women ages 15 to 44.
24 DR. BASKIN: Yes. So this is actually two, once again two sub-
25 measures as well about providing most or moderately effective contraception.

1 And then access to LARC, which is a long-acting type of contraception.
2 Benchmarking will be difficult here. It is certainly not a HEDIS measure. There
3 will be some data out there, probably some national data about some current
4 rates, which my recollection is are very low. But it is unclear whether we will be
5 able to apply those benchmarks specifically to a managed care organization
6 because that is not how the data is available today.
7 MS. KANEMARU: Anna Lee?
8 MEMBER AMARNATH: No.
9 MS. KANEMARU: Bill Barcellona?
10 MEMBER BARCELLONA: I really want to include this but without
11 the benchmarking I have to vote, no.
12 MS. KANEMARU: Dannie Ceseña?
13 MEMBER CESEÑA: No.
14 MS. KANEMARU: Cheryl Damberg?
15 MEMBER DAMBERG: No.
16 MS. KANEMARU: Diana Douglas?
17 MEMBER DOUGLAS: No.
18 MS. KANEMARU: Tiffany Huyenh-Cho?
19 MEMBER HUYENH-CHO: No.
20 MS. KANEMARU: Ed Juhn?
21 MEMBER JUHN: No.
22 MS. KANEMARU: Jeffrey Reynoso?
23 MEMBER REYNOSO: No.
24 MS. KANEMARU: Bihu Sandhir?
25 MEMBER SANDHIR: No.

1 MS. KANEMARU: Kiran Savage-Sangwan?
2 MEMBER SAVAGE-SANGWAN: No.
3 MS. KANEMARU: Rhonda Smith?
4 MEMBER SMITH: No.
5 MS. KANEMARU: Kristine Toppe?
6 MEMBER TOPPE: No.
7 MS. KANEMARU: Doreena Wong?
8 MEMBER WONG: No.
9 MS. KANEMARU: Silvia Yee?
10 MEMBER YEE: No.
11 MS. KANEMARU: That measure does not move forward.
12 MEMBER BARCELLONA: Mary, could we put this on a future
13 consideration list? I know you have to update these on a two year cycle. Is this
14 one that we could note, if benchmarks become available, should be included in
15 the future.
16 MS. WATANABE: So I will just add that we are not updating every
17 two years. But for the Sellers Dorsey team, we certainly can consider adding
18 things to the report.
19 MEMBER BARCELLONA: Okay.
20 MS. KANEMARU: The next measure, childhood immunization
21 status.
22 DR. BASKIN: So as you may be aware, of course, this is a HEDIS
23 measure. There is certainly benchmarking available. There actually are multiple
24 HEDIS measures on child immunization, we picked the one is the child
25 immunization status 10, which is the most comprehensive. So there actually will

1 be reports on the individual, reporting on the individual vaccines as well as in
2 combinations that somebody has received the combinations of vaccines. So at
3 some later point, if we choose this measure, we will have to talk about whether
4 all of those will be considered for benchmarking as individuals or in some
5 combination or a single combination. But that information will be available when
6 that time comes for that discussion.
7 MEMBER TOPPE: And this measure was not selected for
8 stratification.
9 MS. KANEMARU: Silvia Yee, we will start with you.
10 MEMBER YEE: Yes. And perhaps there are people in the middle
11 who would love to start (laughter).
12 MS. KANEMARU: Maybe after the break we will change it up.
13 Doreena Wong?
14 MEMBER WONG: Yes.
15 MS. KANEMARU: Kristine Toppe?
16 MEMBER TOPPE: -- sense with this one. I am going to say, no.
17 MS. KANEMARU: Rhonda Smith?
18 MEMBER SMITH: No.
19 MS. KANEMARU: Kiran Savage-Sangwan?
20 MEMBER SAVAGE-SANGWAN: Yes.
21 MS. KANEMARU: Bihu Sandhir?
22 MEMBER SANDHIR: Yes.
23 MS. KANEMARU: Jeffrey Reynoso?
24 MEMBER REYNOSO: Quick question. Could you please clarify
25 what vaccines may be included?

1 DR. BASKIN: Do you want to read them, Kristine? Okay. I will
2 read them here. So it's the, it's the diphtheria, tetanus and pertussis vaccine; the
3 polio, measles, mumps and rubella, which is a combination vaccine; hemophilus
4 influenza; the hepatitis B; chicken pox or varicella is the other name for that;
5 pneumococcal vaccine; hepatitis A; rotavirus, which is a gastrointestinal virus
6 common in young children; and influenza vaccine. That's the, that's the set of
7 vaccines.
8 MEMBER SANDHIR (OFF MIC): I think the age range is --
9 MEMBER REYNOSO: Thank you, doctor. So my vote is a, yes.
10 DR. BASKIN: Somebody asked in the room and I will repeat it
11 simply because it wasn't on the, through the microphone, the age range here.
12 And this is two years of age children because all of these vaccines are
13 recommended sometime between birth and two years of age for the initial set of
14 vaccinations.
15 MS. KANEMARU: Ed Juhn?
16 MEMBER JUHN: Yes.
17 MS. KANEMARU: Tiffany Huyenh-Cho?
18 MEMBER HUYENH-CHO: Yes.
19 MS. KANEMARU: Diana Douglas?
20 MEMBER DOUGLAS: Yes.
21 MS. KANEMARU: Cheryl Damberg?
22 MEMBER DAMBERG: Yes.
23 MS. KANEMARU: Dannie Ceseña?
24 MEMBER CESEÑA: Yes.
25 MS. KANEMARU: Bill Barcellona?

1 MEMBER BARCELLONA: Yes.
2 MS. KANEMARU: And Anna Lee Amarnath?
3 MEMBER AMARNATH: Yes. And after you do the count I have a
4 question.
5 MS. KANEMARU: Sure. So 71% voted yes so it will be included in
6 the report as a recommendation.
7 And go ahead, Anna Lee.
8 MEMBER AMARNATH: I was just remembering from one of the
9 Committee meetings, I thought there was a lot of conversation on immunizing
10 adolescents and I really thought I remembered that the group felt strongly about
11 moving that one forward, including the one that included the HPV vaccine. And I
12 am just not seeing it on the workbooks. I was wondering -- I was not at the last
13 Committee meeting, my apologies. Did I miss something and it is no longer up
14 for discussion? And I'm sorry, I didn't catch that earlier when I was reviewing.
15 MS. BROOKS: So you are asking a good question.
16 MEMBER AMARNATH: Immunization of adolescents.
17 MS. BROOKS: Yeah.
18 MEMBER AMARNATH: Did it drop off on purpose or?
19 MS. BROOKS: I am trying to think back about our discussion at
20 the last meeting.
21 MEMBER TOPPE (OFF MIC): (Inaudible.)
22 MS. BROOKS: Go ahead, Kristine. All right, for folks remote, we
23 are passing the box. I had a similar recollection. I didn't think about it until Anna
24 Lee mentioned it. It is among the measures that we are planning for stratification
25 for HEDIS reporting. So immunizations for adolescents is a measure that we are

1 planning to have for stratification for the benefit of the group. And I am not sure
2 if it is in the workbook, I was looking for the measure.
3 MS. BROOKS: Okay. So great question. Let us just go back and
4 clarify. This is perfect timing because we were actually just going to take a
5 break. So I am sure you all are -- okay. So we will go ahead and take a 15
6 minute break, come back, can I count, at 2:50. And just appreciate everybody's
7 ongoing contributions. Thank you so much.
8 (Off the record at 2:36 p.m.)
9 (On the record at 2:51 p.m.)
10 MS. BROOKS: Welcome back everyone. Appreciate your
11 continued participation and we were going to move on with the vote.
12 Before the break Anna Lee Amarnath brought up a good point. We
13 were to have immunization for adolescents on our list and so we are going to go
14 ahead and make sure that we include that in the vote here. So just wanted to
15 make sure that we flagged that for you. And we are going to go ahead and just
16 do that now as a part of the appropriate focus area. So I am going to pass it
17 back over to Alex.
18 MS. KANEMARU: Immunization for adolescents.
19 DR. BASKIN: You are going to have to help me here because I
20 think it is four different vaccinations and I can remember three off the top of my
21 head without going to look for notes. I know it includes the flu vaccine, the
22 meningococcal vaccine as the HPV vaccine, but what's the fourth? Is it tetanus?
23 SPEAKER (OFF MIC): Tdap.
24 DR. BASKIN: Is it Tdap? Tdap is the tetanus, diphtheria, pertussis
25 combination.

1 MEMBER SANDHIR (OFF MIC): Only those three.

2 DR. BASKIN: No, I think it's all four, isn't it?

3 MEMBER AMARNATH: Andy, Anna Lee Amarnath from IHA. I
4 believe it's meningococcal, HPV and Tdap. Flu is not a part of this measure, is
5 my understanding.

6 DR. BASKIN: I thought they had a fourth, okay.

7 MS. MYERS: That's correct. I do have those specifications up and
8 can confirm those are the correct vaccines.

9 DR. BASKIN: Okay, so Tdap, meningitis and HPV, sorry to have
10 caused confusion, in adolescents. And there is an age range for that that's
11 within a period of a couple of years, I --

12 MS. MYERS: The age begins at 13.

13 DR. BASKIN: And yes, there will be benchmarking data available,
14 obviously, because it's a HEDIS measure.

15 MS. BROOKS: Okay, and clarification for me the layperson, I
16 apologize. So the difference between the CIS 10 that we just voted on and the
17 immunization for adolescents, I just wanted to make sure that was clear for the
18 Committee Members. So it looks like you have a comment.

19 DR. BASKIN: Yeah, I mean, the CIS 10 age is up to age 2. This is
20 an adolescent one, which I believe is like ages 11 and 12 or 11 to -- go ahead,
21 Chris.

22 SPEAKER: Thirteen.

23 DR. BASKIN: By age 13.

24 MEMBER SANDHIR: By age 13.

25 DR. BASKIN: It's by age 13. So the immunizations are actually

1 given around ages 11 and 12. In fact, HPV is supposed to be given at the ages
2 of 11 and 12. But it's by 13 so we all agree on the age range, thank you.
3 MEMBER TOPPE: And this measure has been selected for race
4 and ethnicity stratification.
5 MS. KANEMARU: Start it off with Anna Lee?
6 MEMBER AMARNATH: Yes.
7 MS. KANEMARU: Bill Barcellona?
8 MEMBER BARCELLONA: Yes.
9 MS. KANEMARU: Dannie Ceseña?
10 MEMBER CESEÑA: Yes.
11 MS. KANEMARU: Cheryl Damberg?
12 MEMBER DAMBERG: Yes.
13 MS. KANEMARU: Diana Douglas?
14 MEMBER DOUGLAS: Yes.
15 MS. KANEMARU: Tiffany Huyenh-Cho?
16 MEMBER HUYENH-CHO: Yes.
17 MS. KANEMARU: Ed Juhn?
18 MEMBER JUHN: No.
19 MS. KANEMARU: Jeffrey Reynoso? Jeffrey Reynoso?
20 MEMBER REYNOSO: Yes.
21 MS. KANEMARU: Bihu Sandhir?
22 MEMBER SANDHIR: Yes.
23 MS. KANEMARU: Kiran Savage-Sangwan?
24 MEMBER SAVAGE-SANGWAN: Yes.
25 MS. KANEMARU: Rhonda Smith?

1 MEMBER SMITH: Yes.

2 MS. KANEMARU: Kristine Toppe?

3 MEMBER TOPPE: Yes.

4 MS. KANEMARU: Doreena Wong?

5 MEMBER WONG: Yes.

6 MS. KANEMARU: Silvia Yee?

7 MEMBER YEE: Yes.

8 MS. KANEMARU: Okay. With 76% of the votes this measure will

9 be included in the final recommendation.

10 Okay, so the next measure is the weight assessment and

11 counseling for nutrition and physical activity for children and adolescents.

12 DR. BASKIN: Thank you. So it's Andy Baskin. So this is a

13 measure specific to the age group of 3 to 17, as you can recall. There's actually

14 three sub-measures so you can, there will be three reported performance scores.

15 One is that you actually document the BMI, not just the BMI but the BMI

16 percentile because this is kids and there's no set BMI. It changes as the age

17 changes and there's charts for that. And then whether they -- if it's positive

18 whether they receive counseling for nutrition. And then separately whether they

19 have received counseling for physical activity. It is a HEDIS measure, there will

20 be benchmarking available for this measure.

21 MEMBER TOPPE: And this measure has not been selected for

22 stratification.

23 MS. BROOKS: Thank you, Kristine and Andy.

24 MS. KANEMARU: Anna Lee?

25 MEMBER AMARNATH: Yes.

1 MS. KANEMARU: Bill Barcellona?
2 MEMBER BARCELLONA: No.
3 MS. KANEMARU: Dannie Ceseña?
4 MEMBER CESEÑA: Yes.
5 MS. KANEMARU: Cheryl Damberg?
6 MEMBER DAMBERG: No.
7 MS. KANEMARU: Diana Douglas?
8 MEMBER DOUGLAS: No.
9 MS. KANEMARU: Tiffany Huyenh-Cho?
10 MEMBER HUYENH-CHO: No.
11 MS. KANEMARU: Ed Juhn?
12 MEMBER JUHN: No.
13 MS. KANEMARU: Jeffrey Reynoso?
14 MEMBER REYNOSO: No.
15 MS. KANEMARU: Bihu Sandhir?
16 MEMBER SANDHIR: Yes.
17 MS. KANEMARU: Kiran Savage-Sangwan?
18 MEMBER SAVAGE-SANGWAN: No.
19 MS. KANEMARU: Rhonda Smith?
20 MEMBER SMITH: No.
21 MS. KANEMARU: Kristine Toppe?
22 MEMBER TOPPE: No.
23 MS. KANEMARU: Doreena Wong?
24 MEMBER WONG: Yes.
25 MS. KANEMARU: Silvia Yee?

1 MEMBER YEE: No.

2 MS. KANEMARU: Okay. With 24% of the votes this measure will
3 not move forward.

4 The next measure is topical fluoride varnish for children. Andy.

5 DR. BASKIN: Yeah. So some additional information about this
6 measure that you need to be aware of. So a couple of things. One is this is a
7 measure, at least the version we are talking about came from the Oregon Health
8 Authority, which was modified from the Dental Quality Alliance who created this
9 measure initially. It is ages 1-21 and it is fluoride treatment. But it -- while it says
10 fluoride varnish it actually recognizes whether you have received fluoride varnish
11 or fluoride topical, other solutions that are available out there.

12 And the measure is not necessarily all children ages to 21. As I
13 looked into the details of this measure it is those that are considered at elevated
14 risk. Now it's only a moderate elevated risk, but they have to be at some higher
15 risk for issues to receive this. So it's a little bit of a difficult measure. It has not
16 universally been used outside of I think the Oregon Health Authority, at least for
17 health plan reporting today, so benchmarking will be non-existent for us.

18 I should also note only because Kristine had mentioned it before
19 and she and I confirmed that NCQA has created a measure for topical fluoride
20 varnish which will start next year for ages 1-4. It will be specific to topical fluoride
21 varnish. I don't believe it is -- I believe it is for all children and not just high-risk
22 children. Yes, I am getting the head shake. It is for all children. However, the
23 first measurement year will be 2023 so benchmarking won't be available for a
24 couple of years after that when credible data starts to come in.

25 We did not, obviously, look at that measure because we only knew

1 that it was a possibility in the past. But it is something that you need to know
2 because the current measure may or may not be to your liking knowing that
3 something's coming down the pipe that will have some benchmarking and be
4 more universally available and used by health plans, or reported by health plans.
5 Thank you.
6 MEMBER TOPPE: And it has not been selected for stratification; it
7 is a brand new measure.
8 MS. KANEMARU: Thank you, Kristine.
9 Anna Lee, did you have any commentary you wanted to provide in
10 response to that?
11 MEMBER AMARNATH: Before we vote I was just wondering if we
12 could clarify before being asked to vote specifically on the Oregon Health
13 Authority's technical specification measure, if we are being asked to vote on it
14 more conceptually for, you know, applying topical fluoride varnish and that we
15 would be discussing other technical specifications like NCQA's measure? Or are
16 we voting on both? I am just trying to make sure I understand what the actual
17 vote is specifically for, for this one.
18 DR. BASKIN: So from my point of view, we are voting on the
19 specific measure that we looked at, which was the only one we looked at, which
20 is the Oregon Health Authority measure. And while we could put on somewhere
21 at the end to talk about the potential NCQA measure, since the measure is not
22 actually being measured today it is not, you know what I mean? It's a future
23 consideration most likely as opposed to something you could select today
24 because it is really not in place until next year. But we are voting on the Oregon
25 measure, the one that was, that was the measure that --

1 MS. BROOKS: So I think, Anna Lee, that's an opportunity if you
2 have feedback on that to submit written commentary and we are happy to take a
3 look at that and incorporate it into the report. Kiran?
4 MEMBER SAVAGE-SANGWAN: I think he answered. My
5 question was, why is it that specific measure? And it sounds like that's because
6 that's the only one that's in use today, is that right?
7 MS. BROOKS: That's correct.
8 MS. KANEMARU: So we'll start the vote with Anna Lee.
9 MS. MYERS: Sarah, I just wanted to clarify that this measure, I
10 believe, is being used in a California program. It's in Medi-Cal's measure set.
11 Unless --
12 MS. BROOKS: Thank you, Janel. I think for purposes of -- this
13 measure that we are looking at is the Oregon measure specifically but I think
14 that's helpful information, thank you, Janel.
15 So okay, I think we can move to the vote.
16 MEMBER SAVAGE-SANGWAN: Sorry, now I am -- why aren't we
17 using the one that Medi-Cal uses then if there is one in existence in use there?
18 MEMBER SMITH: Kiran, could you say what you said again. I
19 didn't get all, it wasn't clear what you were saying.
20 MEMBER SAVAGE-SANGWAN: I was just asking if there is one
21 that the Medi-Cal program is using why isn't that the one that's on the list versus
22 this Oregon one?
23 MS. BROOKS: Just clarifying it is the same measure so we are
24 voting on the same, it is the same measure. If I said something that caused
25 confusion on that that's my fault, my apologies.

1 MEMBER SAVAGE-SANGWAN: Oh, okay, no worries.
2 MS. BROOKS: So it is the same measure.
3 MEMBER SAVAGE-SANGWAN: Thanks, thanks.
4 MS. BROOKS: Okay. Thank you, Kiran, for clarifying that.
5 MS. KANEMARU: Anna Lee?
6 MEMBER AMARNATH: No.
7 MS. KANEMARU: Bill Barcellona?
8 MEMBER BARCELLONA: I stand with the great state of Oregon,
9 yes. (Laughter.)
10 MS. KANEMARU: Take that as a "yes."
11 Dannie Ceseña?
12 MEMBER CESEÑA: No.
13 MS. KANEMARU: Cheryl Damberg?
14 MEMBER DAMBERG: No.
15 MS. KANEMARU: Diana Douglas?
16 MEMBER DOUGLAS: No.
17 MS. KANEMARU: Tiffany Huyenh-Cho?
18 MEMBER HUYENH-CHO: No.
19 MS. KANEMARU: Ed Juhn?
20 MEMBER JUHN: No.
21 MS. KANEMARU: Jeffrey Reynoso?
22 MEMBER REYNOSO: Yes.
23 MS. KANEMARU: Bihu Sandhir?
24 MEMBER SANDHIR: No.
25 MS. KANEMARU: Kiran Savage-Sangwan?

1 MEMBER SAVAGE-SANGWAN: Yes.
2 MS. KANEMARU: Rhonda Smith?
3 MEMBER SMITH: Yes.
4 MS. KANEMARU: Kristine Toppe?
5 MEMBER TOPPE: No.
6 MS. KANEMARU: Doreena Wong?
7 MEMBER WONG: Yes.
8 MS. KANEMARU: And Silvia Yee?
9 MEMBER YEE: Yes. And could I ask a question?
10 MS. BROOKS: Yes, one moment. Let's finish the vote on this one
11 and then we will move to your question, one second.
12 MS. KANEMARU: Okay, with 35% of the vote this measure does
13 not move forward for recommendation.
14 MS. BROOKS: Thanks, Alex. Go ahead, Silvia.
15 MEMBER YEE: So I -- we were -- I think we were told that there is
16 a -- if we have suggestions for measures that aren't on the list we are supposed
17 to write in about that; is that correct?
18 MS. BROOKS: Yes, that would be great if you could provide
19 written comments if there are additional measures that you think should be, the
20 DMHC should be looking at or thinking about for either current or future.
21 MEMBER YEE: Right. And especially for future because this is a
22 list that is set up and there are measures that we heard about that are just
23 starting. That there won't be benchmarks yet but after a few years there might
24 be. That's the kind of thing that you might want comment on, something for -- I
25 mean, obviously this Committee considers -- we can't take a vote on something

1 that hasn't been actually implemented yet. But if we wanted it to be considered
2 in the future how does that work? Where do we write about that? I didn't --
3 MS. BROOKS: So I think that it's an excellent question you are
4 asking. We will have a section in the report that you all will review, comment on
5 and provide feedback on, that will incorporate comments, if you have additional
6 comments, about other measures or things that should be considered or that the
7 DMHC should look at potentially or that may not have been created yet or
8 something of that sort. So there's that opportunity and that information will be
9 included in the report. And then let me just pass this to Nathan real quick.
10 MR. NAU: Nathan Nau, DMHC. It also states in the legislation that
11 if we want to adjust the list after we create it we have to reconvene the meeting
12 at least once to talk about it. So down the road when we look to make
13 adjustments the Committee community will be reconvened.
14 MEMBER YEE: Thank you.
15 MS. BROOKS: Thanks, Silvia.
16 MS. KANEMARU: Okay. Next measure is well-child visits in the
17 first 30 months of life.
18 DR. BASKIN: Yes. As you know, this was a combination of two
19 measures, one was the first 15 months, one was the next 15 months to 30
20 months. They have been combined by NCQA; we are voting on them as one
21 measure. I will ask Kristine, though, whether the current benchmarking, which is
22 really two separate measures, will they still be reported as some measures
23 separately with one combined or -- so it will make a difference to benchmarking.
24 In other words, we will have some information. But if, let's say the benchmarking
25 for the first 15 months is, you know, 54% performance and the 15-30 is 62%,

1 what do we use for a benchmark for the combination? It could be a little difficult.
2 But there will be -- eventually be benchmarking for the combination. Thank you.
3 MEMBER TOPPE: My assumption is that the individual race is still
4 benchmarkable but I don't know how the newly combined -- I don't know -- And I
5 apologize, I didn't prepare for that. I don't know how they are planning on having
6 that roll up.
7 MS. MYERS: Um.
8 MEMBER TOPPE: It is identified. Oh.
9 MS. MYERS: Sorry, Kristine, you can continue.
10 MEMBER TOPPE: I was just going to say it has been identified as
11 for stratification. I'll see if I can find the answer to Andy's question. I don't know
12 if it will (overlapping).
13 MS. MYERS: I am just going to clarify. The benchmarking is done
14 by each of the indicators and they are available already.
15 MEMBER TOPPE: Say that again, Janel.
16 MS. MYERS: That the benchmarking is done by the for the first 15
17 months and then for the secondary part the 15-30 months. It's not a combined
18 benchmark.
19 DR. BASKIN: Yeah, Janel, that's today. But the new measure is
20 the combination and the question is if -- will the plans still have to report separate
21 numbers for the two ages within the measure or will they only be reporting one
22 number for the entire up to 30 months? I don't know the answer to that and we
23 won't know because it hasn't been reported yet so that's why Kristine is going to
24 check with NCQA. Does that make sense to you?
25 MS. MYERS: It does. I mean, the latest Quality Compass did

1 separate those out, which is what I am saying. But if there's going to be a
2 change moving forward then we can move on.
3 MS. BROOKS: Great.
4 MS. KANEMARU: Start it off with Anna Lee.
5 MEMBER AMARNATH: Yes.
6 MS. KANEMARU: Bill Barcellona?
7 MEMBER BARCELLONA: Yes.
8 MS. KANEMARU: Dannie Ceseña?
9 MEMBER CESEÑA: Yes.
10 MS. KANEMARU: Cheryl Damberg?
11 MEMBER DAMBERG: Yes.
12 MS. KANEMARU: Diana Douglas?
13 MEMBER DOUGLAS: Yes.
14 MS. KANEMARU: Tiffany Huyenh-Cho?
15 MEMBER HUYENH-CHO: Yes.
16 MS. KANEMARU: Ed Juhn?
17 MEMBER JUHN: Yes.
18 MS. KANEMARU: Jeffrey Reynoso?
19 MEMBER REYNOSO: Yes.
20 MS. KANEMARU: Bihu Sandhir?
21 MEMBER SANDHIR: Yes.
22 MS. KANEMARU: Kiran Savage-Sangwan?
23 MEMBER SAVAGE-SANGWAN: Yes.
24 MS. KANEMARU: Rhonda Smith?
25 MEMBER SMITH: Yes.

1 MS. KANEMARU: Kristine Toppe?

2 MEMBER TOPPE: Yes.

3 MS. KANEMARU: Doreena Wong?

4 MEMBER WONG: Actually can I ask a question before I vote? I
5 just wanted to understand the difference between 7 and 8, the well-child visits
6 and then the child well-care?

7 MEMBER SANDHIR (OFF MIC): It is the same type of visit, it is
8 the age range is different.

9 MEMBER WONG: Oh.

10 MEMBER SANDHIR: Bihu Sandhir from AltaMed. It's the age
11 range is different. It is well-care visits. And they just call it well-child visits for
12 younger patients and then for the older population we call them well-care visits.
13 The child and adolescent, I think it's actually the age range is different. Andy, I
14 don't know if you can clarify that.

15 DR. BASKIN: I will repeat again, I didn't have the microphone on.
16 The well-child visit one that we are voting on now is up to 30 months of age there
17 has to be a certain number of visits recommended until 30 months of age. When
18 we get to the next measure, which is well-care, we are talking age 3 up to age
19 21, so we are talking about different, different age of kids. This is in their first 30
20 months of life so it's under three years old.

21 MEMBER WONG: But there is a little overlap?

22 DR. BASKIN: No, there is no --

23 MEMBER WONG: Oh, because you said --

24 DR. BASKIN: -- overlap. Up to 30 months is -- 36 months would
25 be 3 years of age. The next measure starts at 36 months and older so there is

1 no overlap --

2 MEMBER WONG: Okay. Okay.

3 DR. BASKIN: -- in time whatsoever.

4 MEMBER WONG: Excuse me. I thought you said 2 years of age.

5 To me, I would choose one if it included, you know, if it included some of the

6 younger. This is helping me to try to figure out which of the two to vote for, that's

7 all. But that's helpful.

8 MS. BROOKS: Would you vote yes or no?

9 MEMBER WONG: I am going to, I am going to vote yes for that

10 one.

11 MS. BROOKS: Thank you, Doreena.

12 MS. KANEMARU: Thank you. Silvia Yee?

13 MEMBER YEE: Yes.

14 MS. KANEMARU: With 82% of the votes this measure will move

15 forward for the report. Next measure is child and adolescent well-care visits.

16 DR. BASKIN: So as we have just stated, child and adolescent well-

17 care visits are a, it's a measure of whether someone has had a well-care visit

18 anytime, just one visit during a year, anywhere. And the age range is ages 3 to

19 21. How this -- just because it's subtle, I know, and because I happen to be a

20 physician and know a little bit about these measures, there is a little difference

21 here in that, in that the well-child visits up to age 30 months where there's X

22 numbers of visits, you know, up until you are 30 months old, is a very specific

23 recommendation of the American Academy of Pediatrics that you have, you

24 know, 7 visits up to age 15 months and then X number of visits up to 30 months;

25 and they count them.

1 Unfortunately, the well-care visits ages 3-21 is not so clear cut of a
2 recommendation by any organization. Certainly it is very common for a
3 recommendation out there to be that, well, you should go to the doctor once a
4 year whether you need it or not. But in fact, there is no, you know, kind of major
5 guideline out there that says everybody should go to the doctor every year in that
6 age range of 3-21 years old, it's sort of a recommendation. And it's nice that it
7 happens and it is being measured but it's not, it's not a super strong, well-
8 documented, well-evidenced recommendation.
9 So a little difference between sort of the history of these measures
10 and what got behind them. And I'm sorry, I didn't mean to editorialize, but I just
11 thought it was important for you to know that difference. -- benchmarking
12 available for this measure,
13 MEMBER TOPPE: Yes. This measure will be stratified by race
14 and ethnicity as well. So there are, just I think to reiterate there, when they
15 change measures, when organizations like ours develop measures and change
16 them, there are, you know, implications for how they get reported because they
17 are -- like this particular measure has been -- is a combination of two previous
18 measures.
19 And so does -- and this one will have lots of age stratification. So
20 instead of having two different measures that were one was bucketing kids, you
21 know, 3, 4, 5 and 6, and then a second bucket of adolescent well-care, now it's
22 kind of one big bucket of well-care visits across the age span that Andy
23 described up to age 21. It gives you kind of that comprehensive array. But it
24 does change kind of, in terms of age, for that, for that particular type of visit. But
25 it does, it is going to produce different, a different set of rates. So some of it will

1 be you will be able to carry it forward and some will be new so there are those
2 considerations in terms of the benchmarking.
3 But we prioritized -- for what it's worth, we prioritized it for
4 stratification because we felt like it was an important measure. So I think that
5 that's certainly one of the drivers for us in the importance of the measure and the
6 selection of it for stratification.
7 MS. BROOKS: Anna Lee, it looks like you have your hand raised.
8 MEMBER AMARNATH: It may be a follow-up question for Andy. I
9 mean, you said that there's not recommendations for annual well visits and I was
10 wondering if you could explain that a little bit more considering AAP Bright
11 Futures and the recommendations that have come out of that group, and, you
12 know, I am just not sure if I am understanding what you mean around there not
13 being clear recommendations around annual visits or that type of care.
14 DR. BASKIN: So it's a little bit of a semantics thing about
15 recommendations versus guidelines or evidence-based guidelines. There's
16 certainly recommendations out there that you hear all the time, come back next
17 year, or come back in a year, or come back every year, type of thing. And I don't
18 fault that in any way because people oftentimes go to their doctors every year
19 and it's nice to stay in touch with your primary care doctor and there are good
20 things that happen about that.
21 That's very different than a, you know, than an evidence-based
22 guideline like let's say the United States Preventive Services Task Force
23 reviewed the evidence out there and came out with a guideline that's saying
24 there's enough evidence to show that there's a great net benefit to health by
25 doing this, versus any harm to doing it, and therefore we are going to make that

1 a, you know, A or B level recommendation. Which is, which is a higher level
2 standard as to, as to what kind of that -- that becomes a guideline, in my mind, or
3 an evidence-based recommendation. Which is stronger than, than, I think it's a
4 good idea and, you know, people should get annual visits.
5 This one doesn't have the strength of the recommendation that the
6 other one has, is all I am saying, in terms of whether it's, you know, been
7 reviewed at kind of a, at a higher evidence-based type of recommendation. It's
8 rather subtle.
9 I mean, it happens a lot. It happens in adults a lot. Maybe that
10 would be another way of pointing it out, you know. Your doctor says, come back
11 next year to get a checkup, when you are 45 years old. And in fact there is no
12 organization of evidence-based doctor groups that actually say that there's a net
13 benefit to seeing a doctor once a year if you don't have any reason to go, let
14 alone the blood tests that happen every year.
15 So those are the kinds of things where it's versus a
16 recommendation, versus somebody did an evidence-based review and this was
17 the conclusion that they came to. So apologize for the long-winded answer but it
18 is kind of subtle so I understand where it can be confusing.
19 MEMBER AMARNATH: I guess I am just sort of confused because
20 you also mentioned that the newborn visit recommend -- you talked about that
21 like a guideline as opposed to a recommendation. If we are making a
22 distinguishing factor between if USPSTF raises to the level of what you would
23 consider a guideline and AAP Bright Futures is more of a recommendation,
24 maybe you could explain why you differentiate then the visits for newborns from
25 the recommended -- you mentioned AAP Bright Futures having clear guidelines

1 on newborn visits and so I wonder why there's a distinction based on your age
2 group from what AAP says for newborns versus older children.
3 DR. BASKIN: And I apologize, I am not a pediatrician, although I
4 have been in these discussions before. You know, there, I can't give you criteria
5 for where the line gets drawn that you got above the line in terms of the amount
6 of evidence. But a lot of things happen in the young, in the visits between 0-30
7 months' time which include -- it is not just going to the doctor for a checkup,
8 that's when you get your vaccines. And if you don't actually go for the visit of
9 your well-child visit the likelihood that you will get vaccines will go down.
10 So there's some evidence out there that says if you follow this
11 schedule for the younger kids when all these other things have to happen, where
12 developmental milestones have to be checked, you have to get vaccinations, you
13 need to get weighed to make sure you are developing physically as well as
14 mentally developing. That those other things, there is some significant evidence
15 that there's some great benefit to doing those things. And how do you do those
16 things? Well you come in for a well-child visit and without the visit, the other
17 things don't occur.
18 So it's those things that have the evidence of the great benefit to
19 your health versus any potential risks. Those same things don't happen as you
20 get older because, you know, your developmental milestones and your
21 vaccinations are fewer and far between so they don't happen every year. You
22 don't get a vaccine every year as a 3-21. And you don't necessarily get a
23 developmental review in terms of, you know, are you developing mentally, at risk
24 of autism, those sorts of things, because those things have passed and
25 happened at a younger age.

1 MS. BROOKS: All right, so some good discussion there. Thank
2 you both, Anna Lee and Andy. Silvia, I see your hand is raised.
3 MEMBER YEE: I hope this is -- Silvia at DREDF and I hope this is
4 a quick-ish kind of question. I was just wondering, Andy, when you are talking
5 about evidence-based standards, whether we have evidence-based standards
6 that actually are stratified in any way that actually look at whether adolescent
7 visits are especially warranted or needed by children of color or certain kinds of
8 families. Like I am not aware of evidence -- of stratified or race and ethnicity
9 aware standards, but I just wanted to ask about that.
10 DR. BASKIN: Yeah. So not to belabor the point but let me provide
11 a point here. There are certainly things that happen during adolescence and
12 during between the ages of 3 and 21 which there is evidence behind. Including
13 immunizations that we just talked about for adolescents and other things that
14 occur during that age period. Certain types of examinations, gynecologic
15 examinations start, certain kinds of discussions, things like that happen.
16 The problem is that they don't happen every year. And this is
17 measuring whether you saw a doctor in any given year between the age of 3 and
18 21 and there's really not that kind of evidence that you should see a doctor when
19 you are 3 -- well, maybe when you are 3 but necessarily when you are 6 and 7
20 and 8 and 12 and 13 and 15, 16 every year.
21 So there are certainly things that occur during the range of ages 3
22 and 21 which can be measured such as immunizations and there could be
23 measures of other things that are tremendous evidence behind and certainly
24 they should occur. But that's not what this measure is measuring. This is just
25 measuring whether you went for a routine visit in any given year. And since it is

1 not necessarily clear that everyone should have it in every given year then 100%
2 would not be the goal because if everybody went every year then that would be
3 essentially an over-utilization of well, of well-visits for not good reason.
4 MS. BROOKS: Thank you, Andy.
5 So I see, Cheryl, your hand up. Let's go ahead, Cheryl, with your
6 comment and then I think let's get back on track with voting just because I know
7 we are having good discussion here but I know that we want to get through all of
8 our votes. Go ahead, Cheryl.
9 MEMBER DAMBERG: Sure. I was just going to follow-up on
10 Silvia's question. Generally, the way that evidence is built is through things like
11 randomized controlled trials and typically those trials have under-representation
12 of certain subgroups. And so typically, the existing evidence that's out there is
13 not stratified by say, individuals of different race/ethnicities. So that information
14 is lacking as to whether there would be additional or benefit conferred for certain
15 subgroups.
16 MS. BROOKS: Thank you, Cheryl, that's very helpful in clarifying,
17 thank you.
18 All right, Alex.
19 MS. KANEMARU: We'll start it off with Anna Lee Amarnath and we
20 are on the child and adolescent well-care visits.
21 MEMBER AMARNATH: Yes.
22 MS. KANEMARU: Bill Barcellona?
23 MEMBER BARCELLONA: Yes.
24 MS. KANEMARU: Dannie Ceseña?
25 MEMBER CESEÑA: Yes.

1 MS. KANEMARU: Cheryl Damberg?

2 MEMBER DAMBERG: No.

3 MS. KANEMARU: Diana Douglas?

4 MEMBER DOUGLAS: No.

5 MS. KANEMARU: Tiffany Huyenh-Cho?

6 MEMBER HUYENH-CHO: Yes.

7 MS. KANEMARU: Ed Juhn?

8 MEMBER JUHN: Yes.

9 MS. KANEMARU: Jeffrey Reynoso?

10 MEMBER REYNOSO: Yes.

11 MS. KANEMARU: Bihu Sandhir?

12 MEMBER SANDHIR (OFF MIC): Yes.

13 MS. KANEMARU: Kiran Savage-Sangwan?

14 MEMBER SAVAGE-SANGWAN: Yes.

15 MS. KANEMARU: Rhonda Smith?

16 MEMBER SMITH: Yes.

17 MS. KANEMARU: Kristine Toppe?

18 MEMBER TOPPE: Yes.

19 MS. KANEMARU: Doreena Wong?

20 MEMBER WONG: Yes.

21 MS. KANEMARU: And Silvia Yee?

22 MEMBER YEE: Yes.

23 MS. KANEMARU: Okay. With 71% of the votes this measure will

24 move forward for the final report.

25 The next measure is avoidable emergency room visits.

1 DR. BASKIN: Yes. So perhaps you know that this is basically the
2 emergency room visits where the diagnosis is such that potentially care could
3 have occurred elsewhere and therefore it is deemed avoidable. This particular
4 measure is once again from our friends in Oregon. And I mean that in a nice
5 way because they have obviously advanced the measure use in Oregon so I
6 don't want to be saying anything negative about it. But it is not necessarily a
7 widespread measure. There are other variations of this measure floating around
8 so the measure would have to be somehow maintained and up to date. And
9 well, anyway, we won't have good benchmarking data for this particular measure,
10 at least not for California medical plans.
11 MS. KANEMARU: Start it off with Anna Lee Amarnath?
12 MEMBER AMARNATH: No.
13 MS. KANEMARU: Bill Barcellona?
14 MEMBER BARCELLONA: No.
15 MS. KANEMARU: Dannie Ceseña?
16 MEMBER CESEÑA: No.
17 MS. KANEMARU: Cheryl Damberg?
18 MEMBER DAMBERG: No, with the reminder, I think at the last
19 meeting I had noted that I think a better measure is the ambulatory care
20 sensitive admissions.
21 MS. KANEMARU: Thank you, Cheryl. Could you repeat that
22 measure title?
23 MEMBER DAMBERG: Yeah, it's the AHRQ, AHRQ --
24 MS. KANEMARU: Okay.
25 MEMBER DAMBERG: -- quality indicator that is around

1 ambulatory sensitive admissions to hospitals.

2 MS. KANEMARU: Thank you. Diana Douglas?

3 MEMBER DOUGLAS: No.

4 MS. KANEMARU: Tiffany Huyenh-Cho?

5 MEMBER HUYENH-CHO: No.

6 MS. KANEMARU: Ed Juhn?

7 MEMBER JUHN: No.

8 MS. KANEMARU: Jeffrey Reynoso?

9 MEMBER REYNOSO: No.

10 MS. KANEMARU: Bihu Sandhir?

11 MEMBER SANDHIR (OFF MIC): No.

12 MS. KANEMARU: Kiran Savage-Sangwan?

13 MEMBER SAVAGE-SANGWAN: No.

14 MS. KANEMARU: Rhonda Smith?

15 MEMBER SMITH: No.

16 MS. KANEMARU: Kristine Toppe?

17 MEMBER TOPPE: No.

18 MS. KANEMARU: Doreena Wong?

19 (No audible response.)

20 MS. KANEMARU: Silvia Yee?

21 MEMBER YEE: No.

22 MS. KANEMARU: Okay. With 6% of the votes this measure will

23 not move forward for the Committee's recommendation.

24 The next measure is transitions of care, medication reconciliation

25 post-discharge.

1 DR. BASKIN: Thank you. It's Andy Baskin again. So this is the
2 measure of whether medications reconciled post an inpatient stay in an acute
3 care hospital. So basically, you know, have your medications been updated from
4 what happened prior to your hospitalization to make sure there is no confusion
5 there. Theoretically avoid -- well, not theoretically, but can avoid readmissions
6 and promote better care post-hospitalization.
7 This is a HEDIS measure. Yes, there will be benchmarking data
8 available for this measure.
9 MEMBER TOPPE: It is not a stratified measure.
10 MEMBER BARCELLONA: Oh. Oh.
11 MS. KANEMARU: Okay. Anna Lee Amarnath?
12 MEMBER AMARNATH: Yes.
13 MS. KANEMARU: Bill Barcellona?
14 MEMBER BARCELLONA: Yes.
15 MS. KANEMARU: Dannie Ceseña?
16 MEMBER CESEÑA: Yes.
17 MS. KANEMARU: Cheryl Damberg?
18 MEMBER DAMBERG: No.
19 MS. KANEMARU: Diana Douglas?
20 MEMBER DOUGLAS: No.
21 MS. KANEMARU: Tiffany Huyenh-Cho?
22 MEMBER HUYENH-CHO: No.
23 MS. KANEMARU: Ed Juhn?
24 MEMBER JUHN: No.
25 MS. KANEMARU: Jeffrey Reynoso?

1 MEMBER REYNOSO: No.

2 MS. KANEMARU: Bihu Sandhir?

3 MEMBER SANDHIR (OFF MIC): Yes.

4 MS. KANEMARU: Kiran Savage-Sangwan?

5 MEMBER SAVAGE-SANGWAN: Yes.

6 MS. KANEMARU: Rhonda Smith?

7 MEMBER SMITH: Yes.

8 MS. KANEMARU: Kristine Toppe?

9 MEMBER TOPPE: No.

10 MS. KANEMARU: Doreena Wong?

11 MEMBER WONG: No.

12 MS. KANEMARU: And Sylvia Yee?

13 MEMBER YEE: Yes.

14 MS. KANEMARU: With 41% of the votes this measure will be
15 further discussed.

16 The next measure is plan all-cause readmission.

17 DR. BASKIN: So this is a measure that is a HEDIS measure, there
18 will be benchmarking available. Remember, this deals with patients that have
19 been discharged for an in-patient stay at an acute care hospital and whether they
20 have been readmitted within 30 days. And as I noted when the measure came
21 up, it is really not a measure of the hospitalization itself but is a measure of
22 moving that patient, transitioning them to an out-patient and appropriately giving
23 them the care that they need so that they are unlikely to rebound back into the
24 hospital. So it's really a measure of the care after the hospitalization as opposed
25 to the care within the hospitalization.

1 MEMBER TOPPE: It is not up for stratification.

2 MS. KANEMARU: Anna Lee Amarnath?

3 MEMBER AMARNATH: This is plan all-cause readmission?

4 MS. KANEMARU: Yes.

5 MEMBER AMARNATH: I am voting yes and I am acknowledging I

6 think I lost track of which measure we are on and I skipped ahead one, I'm sorry.

7 I don't know if there is a way to note that I voted incorrectly on the last measure

8 for myself.

9 SPEAKER (OFF MIC): (Inaudible.)

10 MEMBER AMARNATH: Yeah. I'm sorry. I'm sorry, I lost track.

11 MS. BROOKS (OFF MIC): (Inaudible). I don't think it changed, it

12 won't change --

13 MEMBER AMARNATH: It won't change it. Okay, good.

14 MS. BROOKS (OFF MIC): Thank you for letting us know.

15 MS. KANEMARU: So "yes" plan all-cause readmissions. Sorry,

16 you said --

17 MEMBER AMARNATH: Yes.

18 MS. KANEMARU: Yes, okay.

19 Bill Barcellona?

20 MEMBER BARCELLONA: No.

21 MS. KANEMARU: Dannie Ceseña?

22 MEMBER CESEÑA: Yes.

23 MS. KANEMARU: Cheryl Damberg?

24 MEMBER DAMBERG: Yes.

25 MS. KANEMARU: Diana Douglas?

1 MEMBER DOUGLAS: No.

2 MS. KANEMARU: Tiffany Huyenh-Cho?

3 MEMBER HUYENH-CHO: Yes.

4 MS. KANEMARU: Ed Juhn?

5 MEMBER JUHN: Yes.

6 MS. KANEMARU: Jeffrey Reynoso?

7 MEMBER REYNOSO: Yes.

8 MS. KANEMARU: Bihu Sandhir?

9 (No audible response.)

10 MS. KANEMARU: Kiran Savage-Sangwan?

11 MEMBER SAVAGE-SANGWAN: Yes.

12 MS. KANEMARU: Rhonda Smith?

13 MEMBER SMITH: Yes.

14 MS. KANEMARU: Kristine Toppe?

15 MEMBER TOPPE: Yes.

16 MS. KANEMARU: Doreena Wong?

17 MEMBER WONG: Yes.

18 MS. KANEMARU: And Silvia Yee?

19 MEMBER YEE: Yes.

20 MS. KANEMARU: Okay. With 71% of the votes this measure will

21 be included in the final report.

22 Next measure, timely follow-up after acute exacerbations of chronic

23 conditions.

24 DR. BASKIN: Yes, it's Andy Baskin here. So this was a measure

25 that there was some conceptual support for it so we put it on the list but you had

1 never actually seen the measure itself in all of its glory. This is a measure that
2 actually was developed by an organization called IMPAQ, I-M-P-A-Q,
3 International. I have not personally had an experience with the measure but
4 read about it.
5 So just so you understand, this is a measure of those people who
6 had an -- those members who had an acute event requiring either an emergency
7 room department visit or a hospitalization for one of six chronic conditions.
8 Those conditions are hypertension, asthma, heart failure, coronary artery
9 disease, chronic obstructive pulmonary disease, or diabetes mellitus. Meaning
10 that's the reason that they were -- that was -- the event was related to those
11 particular conditions and did they have timely follow-up?
12 It is not clear to me exactly the timing of the follow-up, I have to
13 recheck on it. I believe it is about a week or so and I don't know if it changes for
14 a condition. But basically that they had follow-up in a non-emergency --
15 MEMBER SANDHIR (OFF MIC): (Inaudible.)
16 DR. BASKIN: Oh, it can be longer than seven days, I apologize.
17 We will get those details for you.
18 We will not have any benchmarking for this. I am sure this was
19 created and being used by somebody but it is not one of those measures that we
20 are, that is known to be widely in use today. And certainly not reported by MCOs
21 today and not any of the current reporting within the state of California. So just
22 that as an FYI.
23 MS. KANEMARU: Anna Lee?
24 MEMBER AMARNATH: No.
25 MS. KANEMARU: Bill Barcellona?

1 MEMBER BARCELLONA: No.
2 MS. KANEMARU: Dannie Ceseña?
3 MEMBER CESEÑA: Yes.
4 MS. KANEMARU: Cheryl Damberg?
5 MEMBER DAMBERG: Yes.
6 MS. KANEMARU: Diana Douglas?
7 MEMBER DOUGLAS: Yes.
8 MS. KANEMARU: Tiffany Huyenh-Cho?
9 MEMBER HUYENH-CHO: No.
10 MS. KANEMARU: Ed Juhn?
11 MEMBER JUHN: No.
12 MS. KANEMARU: Jeffrey Reynoso?
13 MEMBER REYNOSO: No.
14 MS. KANEMARU: Bihu Sandhir?
15 MEMBER SANDHIR (OFF MIC): Yes.
16 MS. KANEMARU: Kiran Savage-Sangwan?
17 MEMBER SAVAGE-SANGWAN: Yes.
18 MS. KANEMARU: Rhonda Smith?
19 MEMBER SMITH: No.
20 MS. KANEMARU: Kristine Toppe?
21 MEMBER TOPPE: No.
22 MS. KANEMARU: Doreena Wong?
23 MEMBER WONG: Yes.
24 MS. KANEMARU: And Silvia Yee?
25 MEMBER YEE: No.

1 MS. KANEMARU: Okay. With 24% of the votes this will not move
2 forward for further consideration.
3 Next measure is adult immunization status.
4 DR. BASKIN: So this, as I misspoke on the adolescent one
5 because I was confusing it with the adult one which is actually four different
6 vaccines, involves -- and it includes influenza, the Tdap, which is that tetanus,
7 diphtheria, pertussis combination, herpes zoster, which is the one for shingles,
8 as well as a pneumococcal vaccination. They due at different age times for
9 adults.
10 Now, remember that some of these measures are, some of these
11 are for adults. Certainly some of them are age over 50 but some may be a little
12 older than that, specifically the herpes zoster. While some people recommend it
13 at age 50 there are others and say start at age 60. So there's -- it's available at
14 age 50 but the stronger recommendation is age 60. So just talking about the
15 age and the patients that we are talking about here because we are not including
16 Medicare Advantage.
17 There will be benchmarking, although the benchmarking won't be
18 available immediately because of the way the measure was adjusted recently in
19 terms of which immunizations were in there. So it may take a little time to get the
20 data in for the benchmarking but it will be available to us.
21 MEMBER TOPPE: This is Kristine. It is selected for stratification.
22 MS. KANEMARU: Anna Lee?
23 MEMBER AMARNATH: Yes.
24 MS. KANEMARU: Bill Barcellona?
25 MEMBER BARCELLONA: No.

1 MS. KANEMARU: Dannie Ceseña?

2 MEMBER CESEÑA: Yes.

3 MS. KANEMARU: Cheryl Damberg?

4 MEMBER DAMBERG: Yes.

5 MS. KANEMARU: Diana Douglas?

6 MEMBER DOUGLAS: No.

7 MS. KANEMARU: Tiffany Huyenh-Cho?

8 MEMBER HUYENH-CHO: Yes.

9 MS. KANEMARU: Ed Juhn?

10 MEMBER JUHN: No.

11 MS. KANEMARU: Jeffrey Reynoso?

12 MEMBER REYNOSO: Yes.

13 MS. KANEMARU: Bihu Sandhir?

14 (No audible response.)

15 MS. KANEMARU: Kiran Savage-Sangwan?

16 MEMBER SAVAGE-SANGWAN: Yes.

17 MS. KANEMARU: Rhonda Smith?

18 MEMBER SMITH: Yes.

19 MS. KANEMARU: Kristine Toppe?

20 MEMBER TOPPE: Yes.

21 MS. KANEMARU: Doreena Wong?

22 MEMBER WONG: Yes.

23 MS. KANEMARU: And Silvia Yee?

24 MEMBER YEE: Yes.

25 MS. KANEMARU: With 59% of the votes this measure will move

1 on for further discussion with the Committee.

2 MS. BROOKS: Certainly, sir. I think it is important that we take all

3 public comment and there was, just to recognize there was an issue with Zoom

4 and so thank you for flagging that. We are going to get through all the votes and

5 then we will take public comment. It is very important to hear from you and your

6 colleague, thank you.

7 MS. KANEMARU: The next measure is body mass

8 index screening and follow-up plan.

9 DR. BASKIN: So once again the Committee had expressed

10 interest in a measure of adults, so this is 18 years and older, very similar to the

11 HEDIS measure we talked about earlier but this one is not a HEDIS measure.

12 This is body mass screening and a follow-up plan documented in the record of

13 the physician who did the screening.

14 This is actually a CMS measure. It is used in the MIPS program.

15 So this measure has been reported by physicians voluntarily or physician groups.

16 I am not aware of it being used at this point in time, at least this

17 particular measure, as an MCO measure in any widespread use so there would

18 be some little technical issues about using it for that purpose. There may be

19 some tweaking that would have to be done, technical issues.

20 And certainly there will be no benchmarking, at least from the point

21 of view of managed care organizations. And for those of you who say, well,

22 there will be MIPS data. MIPS data is voluntary in that, in that physicians choose

23 which measures. And therefore it is not a representation of all physicians, it is

24 those physicians who choose to, to basically report on this measure. And we do

25 know separately that you pick a MIPS measure that you will do well in to

1 voluntarily report on so it's not, we can't use that as a benchmark, is all I am
2 trying to point out.
3 MS. KANEMARU: Anna Lee?
4 MEMBER AMARNATH: No.
5 MS. KANEMARU: Bill Barcellona?
6 MEMBER BARCELLONA: No.
7 MS. KANEMARU: Dannie Ceseña?
8 MEMBER CESEÑA: No.
9 MS. KANEMARU: Cheryl Damberg?
10 MEMBER DAMBERG: No.
11 MS. KANEMARU: Diana Douglas?
12 MEMBER DOUGLAS: No.
13 MS. KANEMARU: Tiffany Huyenh-Cho?
14 MEMBER HUYENH-CHO: No.
15 MS. KANEMARU: Ed Juhn?
16 MEMBER JUHN: No.
17 MS. KANEMARU: Jeffrey Reynoso? Jeffrey Reynoso?
18 (No audible response.)
19 MS. KANEMARU: Bihu Sandhir?
20 MEMBER SANDHIR (OFF MIC): No.
21 MS. KANEMARU: Kiran Savage-Sangwan?
22 MEMBER SAVAGE-SANGWAN: No.
23 MS. KANEMARU: Rhonda Smith?
24 MEMBER SMITH: No.
25 MS. KANEMARU: Kristine Toppe?

1 MEMBER TOPPE: No.

2 MS. KANEMARU: Doreena Wong?

3 MEMBER WONG: No.

4 MS. KANEMARU: And Silvia Yee?

5 MEMBER YEE: Yes.

6 MS. KANEMARU: Okay. I am just going to double check if Jeffrey

7 Reynoso is on.

8 (No audible response.)

9 MS. KANEMARU: Okay. With 12% of the votes this measure will

10 not move forward for further discussion or be included in the final report.

11 Next measure is obesity, pre-diabetes and diabetes A1c control.

12 DR. BASKIN: Thank you. So this is one of the Minnesota

13 Community measures. This is the one where there was the most interest

14 expressed. So a little bit about this measure. It is the adult -- adolescent and

15 adult age group, it is a wide age group of 12-75. And the denominator is those

16 with diabetes, Type 2 diabetes, not the childhood diabetes, or pre-diabetes, who

17 are also obese and what happens to their Hemoglobin A1c? In other words, are

18 they well controlled with their sugars?

19 So understand that this is a very new measure, even for Minnesota

20 Community Measurement. It is my understanding this measure was only put into

21 effect this year. It was created last year. So there is no full year of

22 measurement available today. And it is unclear that it is actually an MCO

23 measure versus individual providers who report this measure in Minnesota. So

24 we certainly won't have any benchmarking in the near future. And since there's

25 not even the first year of measure it may take several years to have

1 benchmarking. Yeah, so it's just starting to be in use, I guess is my point, this
2 year so there may be some issues that are found out about the measure, which
3 often happens in the state measurement programs and then tweaks have to
4 occur. So there's a learning curve here that we are just at the very beginning of.
5 MS. KANEMARU: Anna Lee Amarnath?
6 MEMBER AMARNATH: No.
7 MS. KANEMARU: Bill Barcellona?
8 MEMBER BARCELLONA: No.
9 MS. KANEMARU: Dannie Ceseña?
10 MEMBER CESEÑA: Yes.
11 MS. KANEMARU: Cheryl Damberg?
12 MEMBER DAMBERG: No.
13 MS. KANEMARU: Diana Douglas?
14 MEMBER DOUGLAS: Yes.
15 MS. KANEMARU: Tiffany Huyenh-Cho?
16 MEMBER HUYENH-CHO: Yes.
17 MS. KANEMARU: Ed Juhn?
18 MEMBER JUHN: No.
19 MS. KANEMARU: Jeffrey Reynoso?
20 MEMBER REYNOSO: Yes.
21 MS. KANEMARU: Bihu Sandhir?
22 MEMBER SANDHIR (OFF MIC): (Inaudible.)
23 MS. KANEMARU: Kiran Savage-Sangwan?
24 MEMBER SAVAGE-SANGWAN: Yes.
25 MS. KANEMARU: Rhonda Smith?

1 MEMBER SMITH: Yes.
2 MS. KANEMARU: Kristine Toppe?
3 MEMBER TOPPE: No.
4 MS. KANEMARU: Doreena Wong?
5 MEMBER WONG: Yes.
6 MS. KANEMARU: And Silvia Yee?
7 MEMBER YEE: Yes.
8 MS. KANEMARU: With 47% of the votes this will move forward for
9 further discussion. The next measure is meaningful access to health care
10 services for persons with limited English proficiency.
11 DR. BASKIN: I am going to ask Ignatius, probably these next three
12 are for you to give comment, not comment but some -- so thank you.
13 MR. BAU: Sure. So as Janel mentioned, this is a measure that
14 was developed from Oregon and it has two components. One is a structural
15 component that asks the help plan to report on their processes around
16 interpreter services; and then the second part of the measure is a quantitative
17 measure to see whether or not health plan members who are identified as limited
18 English proficient actually got interpreter services in their visit.
19 The first part of the measure in Oregon is only about two years old,
20 has gone pretty smoothly. The second part, as I noted, there is still some
21 ongoing clarification about how to count who is identified as limited English
22 proficient and then how to count whether or not they actually got interpreter
23 services. Because again, not every member has an encounter that year and so
24 how you figure out that denominator is still, they are still trying to work out a lot of
25 those details. But it is an existing measure in use in one state. Again, there will

1 be some challenges in trying to apply that benchmarking data that they come up

2 with to California.

3 MS. KANEMARU: Anna Lee Amarnath?

4 MEMBER AMARNATH: No.

5 MS. KANEMARU: Bill Barcellona?

6 MEMBER BARCELLONA: No.

7 MS. KANEMARU: Dannie Ceseña?

8 MEMBER CESEÑA: Yes.

9 MS. KANEMARU: Cheryl Damberg?

10 MEMBER DAMBERG: No.

11 MS. KANEMARU: Diana Douglas?

12 MEMBER DOUGLAS: Yes.

13 MS. KANEMARU: Tiffany Huyenh-Cho?

14 MEMBER HUYENH-CHO: Yes.

15 MS. KANEMARU: Ed Juhn?

16 MEMBER JUHN: No.

17 MS. KANEMARU: Jeffrey Reynoso?

18 MEMBER REYNOSO: Yes.

19 MS. KANEMARU: Bihu Sandhir?

20 MEMBER SANDHIR (OFF MIC): (Inaudible.)

21 MS. KANEMARU: Kiran Savage-Sangwan?

22 MEMBER SAVAGE-SANGWAN: Yes.

23 MS. KANEMARU: Rhonda Smith?

24 MEMBER SMITH: Yes.

25 MS. KANEMARU: Kristine Toppe?

1 MEMBER TOPPE: I'm going to say "no," I have too many
2 questions, I'm sorry.
3 MS. KANEMARU: Doreena Wong?
4 MEMBER WONG: Yes.
5 MS. KANEMARU: And Silvia Yee?
6 MEMBER YEE: Yes.
7 MS. KANEMARU: Okay. With 47% of the votes it will move
8 forward for further discussion amongst the Committee.
9 The next measure is patients receiving language services
10 supported by qualified language service providers.
11 MR. BAU: So this is a measure that was developed by George
12 Washington University quite a number of years ago. It was endorsed by the
13 National Quality Forum; it since has lapsed in terms of that endorsement. It was
14 used by a number of hospitals and health systems to measure, again, whether
15 an individual patient received language services that needed language services.
16 And so, again, there will be some challenges in applying that to a health plan but
17 it is a measure of whether or not someone actually got language services or not.
18 MS. BROOKS: Sylvia, did you have a question?
19 MEMBER YEE: Hi, this is Silvia from DREDF; and yes, I did, thank
20 you.
21 I was just wondering whether -- we are voting on a specific
22 measure and I don't know if measure two included language services for people
23 with disabilities or only for limited English proficient persons?
24 MR. BAU: So that's a great question, Silvia. This one is about
25 spoken language so it would include ASL to the extent that somebody identified

1 as a language need.

2 MEMBER YEE: Okay. Not necessarily Braille, let's say, or large

3 font?

4 MR. BAU: Correct, because it is only interpreter services at a

5 hospital, primarily.

6 MEMBER YEE: Thank you.

7 MS. KANEMARU: Anna Lee?

8 MEMBER AMARNATH: No.

9 MS. KANEMARU: Bill Barcellona?

10 MEMBER BARCELLONA: No.

11 MS. KANEMARU: Dannie Ceseña?

12 MEMBER CESEÑA: Yes.

13 MS. KANEMARU: Cheryl Damberg?

14 MEMBER DAMBERG: No.

15 MS. KANEMARU: Diana Douglas?

16 MEMBER DOUGLAS: Yes.

17 MS. KANEMARU: Tiffany Huyenh-Cho?

18 MEMBER HUYENH-CHO: Yes.

19 MS. KANEMARU: Ed Juhn?

20 MEMBER JUHN: No.

21 MS. KANEMARU: Jeffrey Reynoso?

22 MEMBER REYNOSO: Yes.

23 MS. KANEMARU: Bihu Sandhir?

24 MEMBER SANDHIR (OFF MIC): (Inaudible.)

25 MS. KANEMARU: Kiran Savage-Sangwan?

1 MEMBER SAVAGE-SANGWAN: Yes.

2 MS. KANEMARU: Rhonda Smith?

3 MEMBER SMITH: Yes.

4 MS. KANEMARU: Kristine Toppe?

5 MEMBER TOPPE: No.

6 MS. KANEMARU: Doreena Wong?

7 MEMBER WONG: Yes.

8 MS. KANEMARU: Silvia Yee?

9 MEMBER YEE: Yes.

10 MS. KANEMARU: With 47% of the votes it will move forward just

11 for further discussion amongst the Committee.

12 Last measure, cultural competency implementation,

13 subdomain quality improvement.

14 MR. BAU: So this is part of a much larger, full assessment of an

15 organization's cultural competency, developed by RAND. Was -- these particular

16 measures, this subset of that much broader survey, was endorsed by the

17 National Quality Forum. Again, to my knowledge, it has not been used in the

18 health plan context and so there would also be no benchmarking data at this

19 time.

20 MS. KANEMARU: Thank you, Ignatius.

21 Anna Lee? Oh.

22 MS. BROOKS: Hi, Kiran. Go ahead.

23 MEMBER SAVAGE-SANGWAN: Just maybe, Ignatius, if you can

24 clarify. It looks like there's five questions. Are they designed to be answered just

25 as yes/no questions?

1 MR. BAU: Correct.

2 MS. KANEMARU: Anna Lee?

3 MEMBER AMARNATH: No.

4 MS. KANEMARU: Bill Barcellona?

5 MEMBER BARCELLONA: No.

6 MS. KANEMARU: Dannie Ceseña?

7 MEMBER CESEÑA: Yes.

8 MS. KANEMARU: Cheryl Damberg?

9 MEMBER DAMBERG: No.

10 MS. KANEMARU: Diana Douglas?

11 MEMBER DOUGLAS: No.

12 MS. KANEMARU: Tiffany Huyenh-Cho?

13 MEMBER HUYENH-CHO: Yes.

14 MS. KANEMARU: Ed Juhn?

15 MEMBER JUHN: No.

16 MS. KANEMARU: Jeffrey Reynoso?

17 MEMBER REYNOSO: Yes.

18 MS. KANEMARU: Bihu Sandhir?

19 (No audible response.)

20 MS. KANEMARU: Kiran Savage-Sangwan?

21 MEMBER SAVAGE-SANGWAN: No.

22 MS. KANEMARU: Rhonda Smith?

23 MEMBER SMITH: Yes.

24 MS. KANEMARU: Kristine Toppe?

25 MEMBER TOPPE: No.

1 MS. KANEMARU: Doreena Wong?
2 MEMBER WONG: Yes.
3 MS. KANEMARU: And Silvia Yee?
4 MEMBER YEE: No.
5 MS. KANEMARU: With 24% of the votes this measure will not
6 move forward.
7 MS. BROOKS: All right. Thank you all. That was a lot. So what
8 time is it? That can go on the record. Sorry, it's 10 until 4:00. So what I am
9 going to do is just ask for you all not to, you can't leave. No, don't leave. But just
10 let Alex and I confer for a couple of minutes and then we will circle, we will come
11 back. Just wanted to check on the results and talk further with you all.
12 SPEAKER (OFF MIC): (Inaudible.)
13 MS. BROOKS: Oh, and we did definitely want to take the public
14 comment, let's go ahead and do that. Yes, let's go ahead and take public
15 comment right now. So I know there's an issue with the Zoom. Sir, if you can
16 call the name or tell us the name of your, of your colleague we can then -- we
17 can then --
18 (SPEAKER (OFF MIC): (Inaudible.)
19 MS. BROOKS: Perfect.
20 MS. MUÑOZ: Hello.
21 MS. BROOKS: Oh, there she is. All right. Irma, go ahead, we can
22 hear you.
23 MS. MUÑOZ: Okay. I am sorry I didn't speak before you earlier
24 because I want to talk to you about obesity and diabetes.
25 But before I start I want to thank each and every one of you for

1 your work on the Health Equity and Quality Committee. You have been there
2 since 12:00 o'clock and I know you are tired but you are very dedicated and
3 committed to the health of the residents of the state of California. I know how
4 exhausting these meetings can be because I am on the Los Angeles Regional
5 Water Quality Board and we usually meet from 9:00 to 6:00 p.m. And so thank
6 you so much for your energy, your focus and your commitment.
7 Saying all of that, I wanted to let you know that when I first heard
8 that there was a Health Equity Committee established in the state of California I
9 asked the question, how do they define equity? Because right now, equity for
10 the last couple of years has been like the word one uses to get in to places. For
11 people to convince I am in, I am good, you know, I am equitable.
12 But there's no, I guess, platform where equity is more needed than
13 ever before than in the platform of health. And in particular, in the platform of
14 diabetes and obesity. And I say that to you because equity is not just health, it is
15 economic, it is environmental, educational. And according to our great governor,
16 he launched the race equity measure last year because he understood that
17 many things are being impacted and there is no equity based on race; and he is
18 absolutely right about it. So I think that there are a lot of imbalances when it
19 comes to health equity.
20 And I will tell you, I am both diabetic and obese. And I was
21 diagnosed as a diabetic 35 years ago. And I knew I needed to lose weight.
22 Since the age of six years old I was called pudgy. I was told, don't worry about it,
23 she's going to get rid of that baby fat, she's plump, she's just a little overweight.
24 And they would take me to the doctor and the doctor would say she will grow out
25 of it. Well, you don't grow out of being fat or obese. And that has been always a

1 big concern.

2 So what did I do as an adult? I did all sorts of things. I went to

3 Weight Watchers. I spent $1,000 on Lindora. Thousands of dollars on Optifast.

4 And then the doctor once said, I am going to give you pills to decrease your

5 appetite. And I said, What are the consequences? He said, you can get

6 addicted, you are going to be very hyper; and I said, no, I am not going to do

7 that.

8 So I am a highly educated woman. I went to the UC system for my

9 bachelor's, I have a law degree. I worked for President Clinton in Washington

10 DC. So I am intelligent. But intelligence has nothing to do with obesity and

11 diabetes, they are health conditions. They are health conditions.

12 And they are beyond health conditions because I grew up poor with

13 my sisters, a family of six sisters, my mom and dad. They cooked with lard.

14 They bought the fattiest cuts of meat. We did not grow up with vegetables or

15 fruits because they were expensive. If we had vegetables it's because my

16 mother grew tomatoes and zucchini in the backyard.

17 So when we talk about equity you have to look at it through a

18 relevant cultural lens from all communities. All communities of color. All

19 communities that speak other languages other than English. The most

20 frustrating thing is taking my mom, my 94 year old mother to the doctor and they

21 still don't understand after five years that she doesn't understand English. And

22 so I wanted to give my presentation to you in Spanish so you can understand

23 how people feel when they don't understand a word that you are saying.

24 So I did do a little bit of research and sometimes a little bit, a little

25 research can be dangerous. But if you look under the Centers for Disease

1 Control and Prevention you will see a diabetes and obesity map. And they focus
2 on each State of the Union. And California's story does not look very good. So
3 it's a combination of obesity and diabetes. I suggest that you look at that and
4 review it because this is very important.
5 Also, there is a growing phenomenon where diabetes and obesity,
6 they are now calling it -- let me see, I want to make sure I get this right. They are
7 calling it, diobesity because it's become an epidemic. And many parts of the
8 country, like Cleveland and other places, are looking at it because they see if you
9 are obese you will probably eventually get diabetes.
10 So I am urging you that you take this seriously. That you do more
11 research and that you have meetings with people who are both obese and
12 diabetic so they can tell you about their experiences. You have the power and
13 the authority to change that for many of us.
14 And I am born native Californian. And I work with women through
15 my nonprofit called Mujeres de la Tierra, Women of the Earth. And we talk
16 about weight. We talk about health. We talk about the lack of access to health
17 care.
18 So please step out of your, wherever you -- whatever you --
19 whatever talents you bring and knowledge you bring and start talking to some of
20 your neighbors, your church members, so they can tell you about their
21 experiences with diabetes and obesity. You have so much authority and power
22 to change so many lives. And diabetes is not something that happened, started
23 5 years ago or 30 years -- 30 years ago when AIDS started happening.
24 We have always had diabetes. But diabetes was always seen as a
25 elder person's disease. And obesity is the same. You have more children now

1 who are obese, and I am not talking about 5 pounds or 10 pounds, I am talking
2 about 20, 30 and 40 pounds. So please, for the health of all of these people and
3 communities really have someone or experts to come and talk to you about the
4 connection of diabetes and obesity, because I am not sure that has happened.
5 Thank you for your time and attention.
6 MS. BROOKS: Irma, thank you so much for your comments. They
7 are greatly appreciated and we have taken note of them for the record, the
8 record and inclusion in the final report that we are submitting to the DMHC on
9 behalf of the Committee.
10 Sir, is there anyone else that you are aware of? No. Anybody else
11 in the room have somebody that they are aware of that is on public comment,
12 trying to make a public comment? Okay, I just wanted to make sure, okay. I
13 think we are okay. All right.
14 So with that we are just going to take a couple of minutes in the
15 room here while Alex and I confer briefly just on the vote and where we are with
16 the measure counts and all of that and then we will be back in just a minute.
17 Just a minute. All right, thank you so much.
18 (Off the record at 3:58 p.m.)
19 (On the record at 4:03 p.m.)
20 MS. BROOKS: Welcome back. Thank you for taking a few
21 minutes and letting Alex and I kind of coordinate here in terms of where we are
22 with our team members.
23 Just to give you a summary of where we are. We have -- currently
24 we have 12 "yes" votes, 7 "maybes," so that fell in that center part of the vote,
25 and then 11 "nos."

1 So we are going to go ahead and take a stab at the 7 maybes
2 again just to see if there -- there are some measures that perhaps could be
3 looked at, as you know, you might pick one over the other. So we will go through
4 what those measures are on the maybe list and then we will go through and vote
5 on those again.
6 There is a hand up I see from Ed.
7 MEMBER JUHN: Hi, Ed, Inland Empire Health Plan. Could you
8 just review what those 12 "yes" votes are just to refresh our memory?
9 MS. BROOKS: I can. I am going to let Alex do that.
10 MS. KANEMARU: Perfect.
11 MS. BROOKS: Sorry, Alex.
12 MS. KANEMARU: The 12 "yes" votes are currently colorectal
13 cancer screening, breast cancer screening, hemoglobin A1c control for patients
14 with diabetes, controlling high blood pressure, asthma medication ratio,
15 depression screening and follow-up for adolescents and adults, prenatal and
16 postnatal care, childhood immunization status, well-child visits in the first 30
17 months of life, child and adolescent well-care visits, plan all-cause readmissions
18 and immunization for adolescents. And the CAHPS measure.
19 MS. BROOKS: And the CAHPS measure, yes.
20 Okay, so those are the 12 measures that are currently in the Yes
21 column.
22 We will go through -- so with respect to maybe we have cervical
23 cancer; follow-up after an ED visit for mental illness; pharmacotherapy opioid
24 measure, I don't remember the full measure, I'm sorry; adult immunization;
25 obesity pre-diabetes; meaningful access for -- meaningful access for LEP and

1 then qualified language services.

2 So what we are going to do is go ahead and take a vote on those

3 seven measures again, just to see if there are -- and I would just, you know, take

4 a moment to think about those seven measures and whether or not there are

5 any that might overlap with each other, overlap with one that you already voted

6 to move forward, and so on. Question, Andy, or comment, Andy?

7 DR. BASKIN: Just a comment that -- it's Andy Baskin. Please

8 think about this. There are a subset of those measures which have never been

9 applied to a managed care organization. And for those that aren't in the

10 measurement world, there are some real technical issues of taking a measure

11 that has never been used for a managed care organization and just -- you just

12 can't flip a switch and turn it on.

13 I am not saying you can't vote for the measure. I am not saying

14 you can't say it's a great measure and all that. I am just saying that I don't know

15 that DMHC has the, has the folks to tweak measures. They are not measure

16 developers, they have told us that previously, and that is a time-consuming

17 process and requires some review of preliminary results. As NCQA, you know,

18 puts a measure in place and the first year, they don't even report the measure

19 results publicly because they know that there are tweaks that will have to occur.

20 The measures aren't perfect, no matter how hard you work on them in advance.

21 So I just -- only because there are many on that Committee who

22 have not done the technical work with measures and may not understand that

23 aspect of it. It's -- just because we say that those measures are good doesn't

24 mean that it is feasible to do that in a reasonable period of time or that the

25 resources are even available to DMHC to, in other words, create a newer version

1 of that measure for your purpose. So I wasn't pointing to any particular measure
2 so I don't want to influence you in that sense, but I think it is a characteristic of
3 the measures that you really need to pay attention.
4 MS. BROOKS: Thank you so much, Andy. It looks like Silvia has
5 her hand up. Silvia.
6 MEMBER YEE: Hi, this is Silvia at DREDF. I would -- is it possible
7 to see the seven measures? See which one of the seven, which ones of the
8 seven have never been applied to an MCO. And be reminded again of which
9 ones are stratified or have been stratified NCQA. I'm sorry but I just can't hold all
10 of this in my head in memory.
11 MEMBER BARCELLONA: Good.
12 MS. BROOKS: We are just dialoguing here for a minute, Silvia,
13 just to try and think what we might be able to do.
14 MEMBER YEE: Thank you.
15 MEMBER TOPPE: Open the measure workbook and maybe flag
16 those seven and then just sort it so that -- and then share the screen? Oh,
17 maybe that's not allowed.
18 SPEAKER (OFF MIC): (Inaudible.)
19 MEMBER TOPPE: Okay, sorry.
20 MR. BAU: I think you can just repeat the seven measures again
21 and then we will go through them one at a time and say, are they stratified, is
22 there benchmarking data. Maybe that's actually the better question.
23 MS. BROOKS: All right, so I am going to, we are going to do this
24 old school. Thank you, Ignatius. We are going to do this old school. We will go
25 through each measure. We will each write down, or type, you can type if you

1 have your computer, but we will go through what Ignatius just said. Each
2 measure is there a benchmark? Any other kind of specifics? You know,
3 obviously, we went through them before, but. And if they have relationship to
4 any of the other measures that you already voted "yes" for or that might be on
5 the maybe list as well.

6 So the first is cervical cancer screening. And I know, Andy, you
7 spoke to this one before. I don't know if there are comments from you or from
8 others in the Committee with respect to just the benchmarking and the other
9 things that Ignatius referenced just now.

10 DR. BASKIN: Just to reiterate, this is one clearly where there is
11 benchmarking. It's a, you know, an NCQA measure, been around for a long
12 time, so those were not the issues. I mean, managed care organizations have
13 been reporting this for quite some time.

14 MS. BROOKS: Okay. Did anybody have a comment over there?

15 MEMBER TOPPE: I was just going to say it's not stratified; it is not
16 stratified by NCQA.

17 MS. BROOKS: Any questions on -- Doreena, yes, please.

18 MEMBER WONG: Doreena Wong, ARI. Is there, can you go
19 through -- I remember, was it Bihu or somebody was saying if we had data it
20 would be helpful for us to know, for instance, for the cervical cancer screening, I
21 believe that had -- that was one that there were disparities, you know. So I think
22 that would maybe help people decide whether or not we might want to use that.
23 Would it be helpful to kind of go through that? It will be helpful for me, let me put
24 it that way.

25 MS. BROOKS: Doreena is referencing the candidate measures,

1 the epidemiologic and performance data that is included in the handout that we
2 provided to you all. It includes some additional information for measures where
3 data was available. It is not for every single measure because sometimes data
4 was not available, is my understanding.
5 So looking at cervical cancer screening. It looks like, I mean, I
6 don't know, I am trying to think about what is the best -- go ahead, Ignatius.
7 MR. BAU: So this is an Ignatius Bau. So in our April meeting when
8 we presented the disparities data, what the California Healthcare Foundation
9 Disparities Report reported was that the lowest rate of cervical cancer screening
10 was among Asian persons; and that is based on other data. It is not based on
11 the HEDIS measure data for California, it is based on other data that gets
12 reported to the Department of Public Health. So there are disparities for Asian
13 persons, but again, it is not going to be stratified by NCQA in terms of this
14 particular measure.
15 MEMBER TOPPE: This is Kristine. The other thing just to add is,
16 the way that NCQA prioritized the stratification of measures is really to try to kind
17 of get the most bang for the buck, if you will. Not to be crass about it, but really
18 to look at the measures where there is evidence and need. And it is not to say
19 that other measures like this would not be in future, you know, eligible for
20 stratification, but we were trying to build a set. And so this was not in that first
21 initial last year's or those that will be reported on in Measurement Year 2022,
22 which is this year, data reported next year. And then the additional set, which
23 will be reported starting the following year. It is very possible that it will be
24 included in the future but it is not yet now. It is also not to say that California
25 couldn't choose to stratify measures that we are not doing that for so that's just

1 another kind of consideration.

2 MS. BROOKS: Thank you, Kristine. And I see some other hands

3 up so Bihu.

4 MEMBER SANDHIR: Thank you, Bihu Sandhir from AltaMed. So

5 just a couple of things from looking at what you provided to us from a data

6 perspective here. One is actually to Kristine's point is the impact. And that's

7 the -- it is -- actually there is a very nice graph here between the differences

8 between the impact for breast cancer screening, colorectal cancer, cervical

9 cancer screening, the number of new cases.

10 And actually also the other part to look at is how are we actually

11 performing in the, in the past? Is it something that we are really struggling with?

12 It looks like this is a measure set that actually we seem to be doing well on. So I

13 think those are things to take into consideration as we do some of this voting

14 again.

15 MS. BROOKS: Thank you, Bihu. Anna Lee.

16 MEMBER AMARNATH: Anna Lee Amarnath, Integrated

17 Healthcare Association. I was going to potentially make a suggestion just

18 hearing the conversation and some of the challenges people are having as we

19 need to think about these maybe measures. There are so many different ways

20 we could look at it and we haven't necessarily had --

21 So for some of the measures where there was a clear "yes" vote

22 that to me made me think that what the data showed, the benchmarking, the

23 disparities and other reports, wasn't as much a factor, it is such a clear yes. For

24 measures that seemed like it was a clear "no." But for the maybes perhaps I am

25 suggesting could we come back and vote on those next time and have a,

1 perhaps review each measure, some of what Andy was sharing. Are they being
2 used already in a health plan perspective?
3 To was it Diana or Doreena's question? Is there data or
4 benchmarking available? And that might help. But I am also then suggesting
5 something I don't know if that is difficult for your planning process. I just, I am
6 worried it might be hard to go through each of them in this verbal way and have
7 people keep that in their head to be able to vote well on them.
8 MS. BROOKS: So I think what we could do is, and I don't want to
9 look either direction because, (laughter), is we can come back. But I think what
10 we need to ask you all to do is homework. So we are going to quickly get you
11 information on these measures and then we are going to ask that you all -- and
12 we will share it publicly so that the public, everyone has all the same information.
13 But we are going to ask that you all --
14 Because I don't know that we can review all the data in the next
15 meeting but I think there is opportunity to provide you with that time to look at the
16 information and digest it yourself. Because I do recognize it is difficult to make
17 all these decisions when we aren't able to pull things up on the screen and show
18 you like the list of measures that we picked and compare it to the list of
19 measures that are maybe and, you know, and so on. So I do recognize it's a
20 little difficult. Hopefully that was okay what I just said (laughter). I didn't look
21 at --
22 DR. BASKIN: Sarah?
23 MS. BROOKS: Yes, Andy.
24 DR. BASKIN: Just to add. And I know Sarah said it but once
25 again, there is no mandate that says we have to add any of these seven.

1 MS. BROOKS: Yeah, I think that's right, Andy is correct. I mean,
2 These are the remaining seven measures that are for additional discussion. But
3 certainly, you know, we don't have to move anything forward. These are ones
4 where there just wasn't consensus from the group. So definitely, yes.
5 I see a few hands up. I want to make sure we take those
6 comments and then we will see where we are after we have that discussion. So,
7 Kiran, you have your hand up.
8 MEMBER SAVAGE-SANGWAN: Yeah, thanks. I just want a
9 clarification on the stratification issue because it was my understanding that
10 regardless of whether these are NCQA stratified measures, if they are included
11 in the final measure set they will be stratified in California. But is that not
12 correct?
13 MR. NAU: This is Nathan from the DMHC. So that's something
14 that we could consider doing. I would flag that the data, we would have data
15 challenges, but it doesn't mean that we couldn't mirror the NCQA process and try
16 to obtain the data.
17 MEMBER SAVAGE-SANGWAN: Okay.
18 MS. BROOKS: Ed, you have your hand up.
19 MEMBER JUHN: Hi, Ed, Inland Empire Health Plan. Just adding
20 to what was said earlier. It seems like we have 12 measures that we collectively,
21 you know, pushed through. If I recall, I know there wasn't an exact measure
22 count amount but if I do recall it was somewhere in the 10 to 12 range, possibly.
23 So I guess it's just a question to the entire group or the Committee on, you know,
24 should that factor into how we view these seven maybes?
25 MS. BROOKS: All right, Kristine.

1 MEMBER TOPPE: Thank you, Kristine Toppe, NCQA. I was going
2 to suggest if when we reexamine these if we can, obviously, show them in the
3 domains where they were presented. But maybe if there is a way to show kind
4 of some cross-pollination so that we can look at the 12 and see, do they count in
5 kind of multiple buckets? Do they count in access or utilization? Do you know
6 what I mean? As well as kind of the original domains that they were classified in.
7 I think that would be useful because that was a really big part of our last
8 discussion where I thought that there was, it was very fruitful.
9 MS. BROOKS: Thank you, Kristine. All right, Cheryl, it looks like
10 your hand is up.
11 MEMBER DAMBERG: Okay, thanks. So I think the challenge here
12 is that, you know, as we look across these measures, you know, they are all
13 important things to be doing. But I think we recognize, you know, where it would
14 be difficult to start out of the gate with so many different measures so we are in
15 this world of having to prioritize. And I think one of the challenges for me in this
16 voting process is, you know, there's multiple factors to be considered as we vote
17 and, you know, I don't know that we can go back and revote.
18 But I guess for future, you know, work in this space should the
19 DMHC, you know, pull together this Committee or another Committee in the
20 future, I might suggest something that looks more like a modified Delphi process
21 where you ask panelists to, you know, vote or give ratings based on, you know,
22 different criteria related to each measure so that it's fairly explicit in terms of how
23 people are weighing the different dimensions. So right now I sort of feel like we
24 are all kind of voting from the hip.
25 MS. BROOKS: Great, thanks, Cheryl.

1 All right. So I think given time we are going to push forward and
2 move through the benchmarking section of the presentation. We won't go
3 through a vote or anything of that sort but just to kind of get you familiar a little bit
4 with that information in advance of next meeting as we move forward. So we will
5 move to Slide 66, thank you.
6 All right. So we will begin the conversation around setting
7 benchmarks, approaches and options.
8 As a reminder, there is information in both the candidate measures
9 workbook and the performance epidemiologic handout that may help inform your
10 review of the benchmarking options we will discuss shortly. Next slide please.
11 So each of the described benchmarking approaches we will
12 discuss today has different strengths and considerations that will require careful
13 deliberation before selecting. When benchmarks are set too low or high it can
14 demotivate health plans or providers. Unique to this initiative is that both
15 commercial and Medi-Cal plans are involved, which will require us to consider
16 setting benchmarks across all health plans.
17 As we begin the discussion on benchmarking we ask that you
18 consider the following questions:
19 Which approach or approaches will fit the goals of this initiative
20 best?
21 How do we set benchmarks that are attainable yet motivating for
22 health plans?
23 Will benchmarks change each year or remain fixed?
24 For measures without current benchmarking data, consider using
25 first year results as a benchmark for future years.

1 Set statewide benchmarks for all MCOs. So no separate
2 benchmarks by lines of business. Next slide, please.
3 The benchmarking is used to determine the standards against
4 which performance is assessed. Such benchmarks can be sourced in a number
5 of ways.
6 A common approach is using NCQA's Quality Compass, which
7 provides the results for up to three trended years on HEDIS and CAHPS
8 performance on national, regional, state and plan levels. Although Quality
9 Compass data is available for many measures, for those where data is not
10 available the Committee may need to identify alternative benchmarks through
11 other external sources such as national surveys and measures through
12 recommendations or develop their own benchmarks through internal sources,
13 internal sources. Next slide please.
14 The approaches to benchmarking vary depending on the type of
15 performance improvement desired and data available. The most common
16 methods for benchmarks are Absolute, Improvement based, Relative and
17 Disparity Reduction.
18 An Absolute approach sets the benchmark as a specific value of
19 performance for all entities.
20 A Relative approach, sometimes referred to as an industry
21 standard, sets the benchmark based on performance of similar entities or
22 performance within the industry.
23 An Improvement Based approach sets the benchmark as a specific
24 change, percentage or absolute value in performance to achieve.
25 There could also be a benchmarking approach around Disparity

1 Reduction by setting the benchmark to reduce the gap between the performance
2 of a priority population and the performance of the general population or the
3 highest performing population -- subpopulation, excuse me.
4 Dependent on the goals, certain approaches may be more
5 appropriate than others. For example, an absolute value approach may be used
6 to incentivize providers to achieve a goal. Whereas an improvement based
7 benchmark of a percentage change from baseline may be used to motivate
8 progress. In the case of relative benchmarks, this approach may foster greater
9 competition among participants.
10 Similarly, as mentioned previously, performance data may not be
11 available for all measures, which may limit the feasibility of certain approaches.
12 For example, setting an improvement goal over baseline would require that data
13 be available to determine baseline performance.
14 The Committee is encouraged to be mindful of these
15 considerations, among others, as we prepare to select benchmarks. Next slide
16 please.
17 In this example a baseline is determined and specific target rates
18 are set for each year. So this is an example of an Absolute benchmark. So you
19 can see baseline performance is 50% and then it increases by Measurement
20 Year 1, 2, 3, 4, 5 by five percentile points. Next slide, please.
21 So this slide -- I'm sorry. This approach is most common for
22 measures that a specific performance value is desired or when performance
23 across participating organizations varies little. It is important that the baseline
24 performance is considered so that the benchmark can drive improvement while
25 also being feasible. Because a specific value is set, the benchmark can be the

1 same across payer types. Next slide, please.

2 In this example of a relative benchmark, the NCQA Quality

3 Compass 50th percentile is used each year. Quality Compass provides

4 benchmarks that are measured as percentiles that show how a plan ranks

5 compared to a proportion of other plans that reported performance on that

6 particular measure for NCQA.

7 For example, if a plan performs at the 75th percentile, that means it

8 performed better than 75% of plans nationwide on that particular measure. As

9 such, these benchmarks would represent performance of NCQA accredited

10 health plans that are either required to report HEDIS measures or opt to publicly

11 report their HEDIS rates, so the HEDIS measures reported to NCQA vary by

12 plan.

13 Also note these plans represent states with and without Medicaid

14 Expansion coverage. Next slide please.

15 This approach is most common for measures where performance

16 should be maintained and may vary greatly from year to year. A couple of

17 comments: This benchmarking methodology assumes Quality Compass or other

18 benchmarking data are currently available. Since Quality Compass is updated

19 annually based on the performance data submitted, the benchmark would

20 change from year to year. And then also noting Quality Compass data are

21 released for each product line at different times of the year so that's a flag as

22 well. Next slide please.

23 So in this first example here for improvement based benchmarks,

24 the benchmark is based on improvement over the baseline with a specified

25 percent of change each year.

1 Okay, we are going to take a quick technology break. One
2 moment, sir. One moment.
3 (Off the record at 4:26 p.m.)
4 (On the record at 4:30 p.m.)
5 MS. BROOKS: Apologies about that. We had a little bit of a
6 technological issue and we are just going to get started again.
7 So we are going to close out a little bit on benchmarking here and
8 then we will go into final public comment for this meeting. And I know, I know we
9 have been here a while and do appreciate everybody's time and commitment.
10 All right, so here we are on Slide 75 talking about improvement
11 based benchmarks. So in this second example the benchmark is set at the
12 NCQA Quality Compass 50th percentile for Year 5; and leading up to that the
13 health plans are required to show improvement toward meeting that goal. Of
14 note, as you get closer to a benchmark there are typically smaller degrees of
15 improvement. Next slide please.
16 This approach to improvement based benchmarking necessitates
17 baseline data and is most common for measures that continuous improvement is
18 feasible and desired, current performance is significantly below targets, or
19 baseline performance among participating entities varies greatly. Both examples
20 allow for improvement to be specific to the health plan's individual performance
21 by setting a benchmark on the degree of change required.
22 The primary difference is that the first example, improvement over
23 baseline, does not specify a final performance rate; whereas the second
24 example, improvement towards benchmark, sets an end goal without specific
25 improvement goals year to year. Next slide please.

1 Another possible approach or add-on to benchmarking is setting
2 disparity reduction goals for subpopulations where disparities exist. For
3 example, an absolute benchmark may set the difference in performance
4 between Black Californians and white Californians to be no larger than 2
5 percentage points. An improvement based benchmark may require the
6 performance of Asian Californians to decrease by 5 percentage points compared
7 to the prior performance year. Next slide, please.
8 It is important to keep in mind the varying degrees of data
9 collection currently available. And as a result the lack of completeness on where
10 disparities exist and where efforts should be focused, which limits the ability to
11 set disparity reduction goals.
12 Likewise, disparities may look different across payer types and the
13 unique member makeup among providers that may create challenges for entities
14 with lower baseline performance to meet benchmarks.
15 These considerations are not meant to discourage disparity
16 reduction, but rather to ensure the appropriate factors are regarded. Next slide,
17 please.
18 So there are a couple of options here. I am not going to go through
19 these because we are going to go through them next time. Actually, Ignatius is
20 giving me a look so I think I am going to go through them. (Laughter.) Yes, he
21 says, go ahead. So I am going to go through these. We are going to vote on
22 these next time. The intent here is to have a vote with respect to we are
23 providing you with options on benchmarking, what the different options may look
24 like. We will vote on the benchmarks. And the vote, similar to the CAHPS
25 survey, the vote that has the highest number will be recommended to the DMHC

1 with respect to the methodology that should be used. However, if there is
2 something that's close and secondary or something of that sort it will be included
3 in the report as well.
4 All right, so we are on Slide 79. So for benchmarking. Okay. So
5 for benchmarking, Committee Members will vote yes on one of the following
6 options. So we will go through those 1-3 to apply to the final measure set, as I
7 just said.
8 All right, so we will move to Slide 80, which has Option 1. Okay,
9 Option 1 blends the Absolute and Improvement approaches.
10 For measure years that have available benchmark data plans
11 would be required to demonstrate improvement year-to-year towards the overall
12 benchmark set at the NCQA, Medicaid or commercial 50th or 75th percentile.
13 For measures without available benchmark data after a baseline is
14 established, yearly incremental improvement targets would be determined for the
15 remaining program years.
16 So here this option, just to kind of restate it, is saying that for
17 measures where baseline data is available, a percentile would be set in terms of
18 50th, for example, that the health plans have to meet. For measures where
19 baseline is not available, yearly incremental improvement targets would be set.
20 So an example would be you might have a baseline year and you have to
21 improve by, I won't be crazy, by 5% over the baseline year. Maybe that is crazy
22 depending on what the measure is but that is an example. All right, next slide
23 please.
24 Option 2 leverages the Improvement approach for all measures,
25 regardless of if current benchmarks are available, baseline performance would

1 be established. After which incremental improvement targets would be set for
2 the remaining years. next slide.
3 Option 3 blends the Relative and Improvement approaches. For
4 measures with available benchmark data, performance targets would be set in
5 Years 1 and 2 at the higher of Medicaid and commercial 50th percentile.
6 In the remaining years a target would be set to improve at a
7 percentage above the 50th percentile.
8 For measures without available benchmark data, after a baseline is
9 established yearly incremental improvement targets would be determined for the
10 remaining program years. Next slide please.
11 So based on Committee Member feedback and the goals of this
12 initiative, the following concepts will be included in the final report for DMHC's
13 review unless there is objection from the Committee.
14 Disparity reduction goals will also be considered when race and
15 ethnicity data is available.
16 In addition, when more data by race, ethnicity and/or other
17 demographic data becomes available, example: SOGI, disability status, tribal
18 affiliation, and so on, DMHC should consider including disparities reduction
19 approaches to the identified benchmarks.
20 So those are concepts that will be included in the report to make a
21 recommendation. We have heard that from the Committee. If there is concern
22 on that I would ask that you speak up now and express your thoughts on that.
23 Okay. So, with that, looking at the time, I think we have a little bit
24 of time for discussion on benchmarking so let's just see if there are some initial
25 questions or comments from Committee Members on benchmarking specifically.

1 And I have -- Kristine has her hand up.

2 MEMBER TOPPE: Trying to follow the rules. So I think it would be

3 useful to have the state partners, some of whom I know had to step away, share

4 how do they do it? And you know, I mean, we can -- we have talked -- I have

5 offered to have NCQA talk a little bit more maybe about facets of how we do it.

6 But I think it's, frankly, more important for this group to hear about how, you

7 know, DHCS, Covered California and CalPERS have structured their approach

8 as well as IHA you know. I think that would be really useful.

9 MS. BROOKS: I think that's a great comment and we certainly had

10 it in our questions for today. But yes, I know a couple of people had to step

11 away. So we certainly can circle back on that, thank you.

12 Cheryl, your hand is up.

13 MEMBER DAMBERG: Yes. I had a question or a couple of

14 questions. So on, I think it's Slide 75. It says 5% between the plan's prior year.

15 So do you mean 5 percentage points or 5% relative?

16 MS. BROOKS: It could be either one.

17 MEMBER DAMBERG: Okay. So I just -- I think we should be clear

18 on that as we consider it because it could have very different implications in

19 terms of the size of that improvement for any given measure. You know, my

20 observation of performance measures over the years, generally what we are

21 seeing in terms of improvement year-over-year tends to be on the order of 1 to 2

22 percentage points, nothing greater.

23 MS. BROOKS: That is very helpful and just took note on that so

24 thank you so much.

25 MEMBER DAMBERG: Yeah. And then --

1 MS. BROOKS: Go ahead.
2 MEMBER DAMBERG: I guess the other thing that we need to be
3 mindful of is, so I certainly support disparities reduction. But, you know, as we
4 look at any given measure there may not be a current measure in our priority set
5 but, say, in future years, where performance could be low, very low across all
6 categories. So I think we kind of have to think hard about, you know, are we
7 really trying to reduce, you know, a sort of 1 to 2 percentage point gap or are we
8 trying to raise performance overall? So, I think as, you know, we gain more
9 information in terms of the actual differences between subgroups we may need
10 to kind of revisit how we think about setting these thresholds.
11 MS. BROOKS: That is great, thank you, Cheryl for contributing
12 that. I think excellent point. Kiran.
13 MEMBER SAVAGE-SANGWAN: Thanks, Sarah. I am not sure
14 what exactly is planned for the next meeting but I think in order for the many of
15 us on this Committee who are not data or quality improvement experts to weigh
16 in meaningfully on this, more information would be helpful. Like, what are the
17 pros and cons of each approach? What does the research show about the
18 impact?
19 And I also, I appreciate Kristine's suggestion about understanding
20 what other departments are doing. Although I will also say like I understand
21 DMHC is in a different position because you are not a purchaser and so you
22 don't have the same financial levers on these. So I don't know if there's any
23 information that can be brought to the Committee about like what regulators in
24 other states might be doing. Just something that's maybe more comparable for
25 this purpose. I think that would just be really helpful. Thanks.

1 MS. BROOKS: Thank you, Kiran. I appreciate those comments
2 and have taken note of them so thank you so much.
3 All right. So I think, Silvia, you had your hand up; go ahead, please.
4 MEMBER YEE: This is Silvia at DREDF. I appreciate Kiran's
5 remarks. I was also thinking, I mean, when you were talking through the
6 benchmark discussion, it seems that at the point when looking at race and
7 ethnicity information and plans, DMHC would be thinking about benchmarks as
8 plans started collecting more data. And it just seems like it's in the control of the
9 plans whether -- as they decide what they think they want to collect or whether
10 they want to stratify in different ways? Is that how it will work? Like the plans
11 sort of consider, well, maybe we will start collecting some of this or get -- that
12 that's how it will be coming into play or? What are the incentives then that will,
13 that will encourage plans to collect data beyond race and ethnicity is what I --
14 that's my question, thank you.
15 MS. BROOKS: Yeah, no, I think you are asking an excellent
16 question. Do you have some comments, Ignatius?
17 MR. BAU: So as we tried to -- this is Ignatius Bau. As we tried to
18 mention in the presentation, the future of what both disaggregated race and
19 ethnicity data beyond the broad Office of Management and Budget categories,
20 as well as other demographic data specifically on language, sexual orientation,
21 gender identity, and disability are going to be dependent on the data exchange
22 framework, which will be mandatory and required for health plans. So it's not
23 going to be optional, Silvia.
24 As that data exchange framework gets implemented then all
25 entities in California, hospitals, health plans, providers, will need to begin

1 collecting, and more importantly, sharing that information so that these kinds of
2 quality measures can be calculated. The timing of that is still part of the
3 challenge for this process for DMHC. Because those requirements won't go into
4 effect until 2023 at the earliest and DMHC has to do its regulations before that.
5 So that's where we are toggling to try to put in a pathway to take advantage of
6 that additional data collection but not having clarity about what that pathway
7 might look like all the way into the future.
8 MS. BROOKS: Thank you, Ignatius.
9 Silvia, hopefully that clarified your question. I see your hand has
10 gone down so I believe so. And it was helpful information and a great question.
11 Ed.
12 MEMBER JUHN: Ed from Inland Empire Health Plan. So as we
13 think about these important measures I think it is also worth mentioning that as
14 health plans, you know, we are, you know, we need also guidance as to how to
15 collect some of this information. Because depending on what the measures are,
16 and depending on how those measures are stratified, some of those pieces that
17 we have to collect information on would be new, whether they are new tools, you
18 know, better ways to standardize and adjust the information. The way that, for
19 example, for Medi-Cal the state provides us information.
20 So I think that's something maybe we can consider when we go
21 through the benchmarking piece because, again, you know, for plans that are
22 held accountable, they all want to do the right thing, you know. It's just how do
23 we, how do we process and make sure that we have the right information so that
24 we can better understand, you know, what those gaps are and how we can
25 reduce that.

1 MS. BROOKS: Thank you, Ed. Cheryl.
2 MEMBER DAMBERG: I need a reminder from the folks at the
3 DMHC in terms of how to think about this because my understanding is that what
4 is in play is a penalty. I think one of the things that my team thinks hard about in
5 any of these kinds of quality improvement/quality incentive programs is trying to
6 avoid creating cliff effects as well as trying to avoid misclassification, say, of
7 plans as being sort of high-performers versus low-performers.
8 And, you know, as I kind of think about structuring. So if we are
9 creating some penalty that says, you know, if you fall below the 50th percentile of
10 performance statewide then you will pay a penalty. That essentially creates a
11 cliff effect, which is not sort of a desirable measurement property. Versus having
12 something that looks more like a continuous scale and where you fall along
13 some continuum and potentially the penalties. So I am having to think about
14 penalties as opposed to rewards, you know, are modulated across that
15 continuum.
16 So, you know, I think it's, you have to kind of think a little bit
17 broader than just like setting the threshold in terms of how this is going to play
18 out. But I would encourage staff and, you know, again, happy to talk offline
19 about some of the issues related to structuring these incentive and penalty
20 programs and kind of how to set cut points and ensure you are not misclassifying
21 people or organizations.
22 MR. NAU: Cheryl, this is Nathan from DMHC, thank you for those
23 comments. There's definitely some positive aspects that come from a regulator
24 and a purchaser working on quality. We have talked about a lot of it. So from
25 the DMHC's perspective, we really have corrective action plan and enforcement

1 authority. And one thing to consider that we will probably talk about in the
2 beginning of next meeting is our, our benchmarks are going to be in regulation,
3 they are not going to be in a contract, like a purchaser, so that should factor into
4 the discussions as well. We are also not in a position to do an incentive
5 program.
6 And although we could have corrective action plans where we are
7 not going to do heavy quality improvement activity like a purchaser would as well,
8 but we are going to have to be cognizant of the points that you brought up and
9 not to be overly aggressive and create a disincentive and to create more
10 challenges. I know Mary is on, I think she may have something to add to that as
11 well.
12 MS. WATANABE: Yeah, no, Cheryl, and I appreciate your
13 feedback too because, you know, that cut point can be just a matter of, you
14 know, fractions of a percentage point and you are below it.
15 I think, you know, the goal here is this is a, this is a very different
16 approach than the carrots and the incentives and paper performance; this is
17 really an indication that this administration takes very seriously like it's time to
18 address disparities and move the needle and so this is a very different approach.
19 I think I mentioned this in the beginning, we knew that the
20 benchmarking conversation was going to be the most challenging one. I think
21 something for everybody to think about is, is it a bright line? Is it based on a
22 national percentage or something else? Or is it a range and as long as you are
23 in that range, you know, you are good? Maybe you continue to work on a
24 corrective action plan to improve things.
25 But at some point you are really a poor performer and you are at

1 the bottom and that's where I think this regulatory approach of having our, you
2 know, penalties, and the other enforcement actions that we can take are really
3 critical. But a corrective action plan is in play starting Year 1 because we really
4 want the plans to start thinking about what are those interventions.
5 I appreciate the Reverend's participation in all these meetings
6 because I think he has really talked about the importance of engaging at the
7 community level to understand what the community needs. What's that
8 messaging. It is maybe not a 40 question survey but it's come and talk to us,
9 educate us about what we need to do.
10 So I think it's a really important point that everyone should do some
11 thinking about. I think we have thrown out some options. But really
12 understanding this will be in regulations probably for several years. Five is kind
13 of the time period when we would revisit this. But yeah, this is, this is the big
14 question.
15 MEMBER DAMBERG: Yeah. So that's helpful, Mary. I mean, I
16 am trying to get my head on this to kind of think the flip of like a positive incentive
17 program so this is kind of the opposite end of the spectrum. So I do think that it
18 would be helpful for all of us to think hard about whether there's some range
19 across which sort of you are kind of modulating your response. And I recognize
20 you have to put it in statute. You know, I see this go on all the time as CMS
21 issues regulations.
22 But, you know, again, I would try to think carefully about how to
23 avoid cliff effects and this misclassification of plans. And so this is all the more
24 reason you may have seen on some of the slides about measures having
25 reliability of .7 or higher. This is going to give greater confidence around being

1 able to distinguish a particular plan's performance relative to that benchmark.
2 And so it will have more signal, less noise and lower risk of misclassification.
3 MS. BROOKS: Thank you, Cheryl.
4 So I see, Ed, your hand is up. We are going to take one last
5 comment from you and then we need to move to public comment. But go ahead,
6 Ed.
7 MEMBER JUHN: Ed, Inland Empire Health Plan. You know, for
8 the experts in the room for measurement and evaluation, is there ways to also
9 consider benchmarking from a regional perspective, given that some of the
10 regional nuances may potentially impact sort of the performance for this, you
11 know, soon-to-be regulation? Or is the standard approach just having more of a
12 national benchmark?
13 MS. BROOKS: It's a great question you are asking, Ed, and I think
14 we will explore that in our next meeting a little bit more.
15 All right, so I am going to move to public comment. Public
16 comments may be submitted to public comments. So we are, sorry, moving
17 ahead to Slide 97, and hopefully nobody gets sick. Thank you.
18 Public comments may be submitted to public
19 comments@dmhc.ca.gov until 5:00 p.m. on June 29.
20 Members of the public should refrain from reaching out to
21 Committee Members directly and email the DMHC inbox should you have
22 comments or questions. Next slide, please.
23 So the July 13 Committee meeting will be held in-person at
24 DMHC's downtown office here. We will make sure to include that physical
25 meeting location in the ten day meeting notice. And of course, the public is

1 welcome to join us in-person for those meetings. We will continue to offer the
2 public an opportunity to participate remotely and will include information about
3 the remote options in the agenda.
4 Before ending the meeting today I wanted to check to see if there's
5 any additional public comment online first to see if there -- we don't have hands
6 raised online.
7 SPEAKER (OFF MIC): Actually we do.
8 MS. BROOKS: Oh, they are raised now. Oh, so we are able to
9 see hands online now?
10 SPEAKER (OFF MIC): Yes. David Lown.
11 MS. BROOKS: Okay. All right, David, we can -- he is open?
12 Okay, David, we can hear you if you would like to go ahead with your comments,
13 please.
14 DR. LOWN: Sure. Thank you. David Lown, from the California
15 Health Care Safety Net Institute/California Association of Public Hospitals and
16 Health Systems. I will keep this super short because I probably have about 45
17 minutes to an hour of comment/feedback on the various benchmarking target-
18 setting options as we have been thinking about this quite deeply, probably for 5,
19 10 years.
20 I think Kiran's suggestion of having pros/cons for the different
21 approaches is very important.
22 To I think it was Cheryl's comments or others, the state, DHCS has
23 quite extensive experience in using both absolute and relative target setting
24 through the DSRIP PRIME waiver programs and now the QIP Quality Incentive
25 Pool, which uses a minimum threshold of performance, then a sort of gap

1 closure. To your question, Cheryl, it is what is your prior your performance
2 compared to the 90th percentile national benchmark, close that gap by 10%.
3 And then it caps out at 90th percentile. So if you are doing at or above that, you
4 are all good.
5 And there's just lots of other nuances around how these kinds of
6 benchmarks, which benchmark use national -- to Edward's comment, you know,
7 national versus state, how they are used in a state-specific program.
8 The last thing I will just quickly say, again, there's a million things to
9 discuss here, is that setting disparity reduction targets, operationally is very, very,
10 very, very difficult. Because you are talking about, even if you are just talking
11 about changes in disparity between two populations; given quality improvement,
12 both populations are moving. They are both changing. And unless you want to
13 be inappropriately incentivizing your higher performing population to be worse to
14 reduce your disparity it's a challenging thing. Also, you can have hardly any
15 disparities between two populations and yet both populations are performing
16 pretty poorly compared to lots of others. There are systems out there who have
17 really minimal disparities between all their populations, yet overall their
18 performance is nothing to be proud of.
19 So I will end there but this topic should probably spend a lot of time
20 because all the details, and even in the mathematical sense, get very, very
21 important. Thank you.
22 MS. BROOKS: Thanks, David.
23 Do we have other public comments online?
24 SPEAKER (OFF MIC): That is all.
25 MS. BROOKS: Do we have any public comment in the room?

1 Okay, so with that we are going to adjourn this meeting. And just
2 want to thank everyone again for your contributions today and ongoing dialogue,
3 it has been very much appreciated. And have a wonderful day.
4 (The Committee meeting concluded at 4:56 p.m.)
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1 CERTIFICATE OF REPORTER

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3 I, JOHN COTA, an Electronic Reporter, do hereby certify that I am

4 a disinterested person herein; that I recorded the foregoing California

5 Department of Managed Health Care Health Equity and Quality Committee

6 meeting and that it was thereafter transcribed.

7 I further certify that I am not of counsel or attorney for any of the

8 parties to said Committee meeting, or in any way interested in the outcome of

9 said matter.

10 IN WITNESS WHEREOF, I have hereunto set my hand this 30 day

11 of June, 2022.

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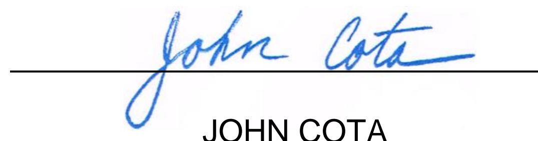
14 

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