Health Equity and Quality Committee Meeting
April 20, 2022
Meeting Summary

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

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

Sellers Dorsey Staff in Attendance:
Sarah Brooks, Project Director
Alex Kanemaru, Project Manager
Dr. Andy Baskin, Quality Subject Matter Expert (SME), MD
Ignatius Bau, Health Equity SME
Janel Myers, Quality SME

Agenda Item 1 – Opening Remarks (Transcript, P. 6-16)

Sarah Brooks called the meeting to order, conducted a roll call, gave an overview of the second Committee meeting, and walked through the agenda, meeting materials, and Committee timeline. Janel Myers reviewed housekeeping notes for in-person and virtual Committee members and members of the public.

An attendee from the public, Reverend Mac Shorty, founder of the Community Repower Movement, said decisions made in this Committee will impact vulnerable communities across California and asked the Committee to address obesity, access to dieticians, and insulin supply.

Agenda Item 2 – Review of the March 24, 2022 Meeting Summary
(Transcript, P. 16-18)

Ms. Brooks asked if there were any changes to the March 24, 2022, meeting summary. There were no changes or objections to the March 24, 2022, meeting summary.

An attendee from the public, Irma Muñoz from Mujeres de la Tierra, commented a priority issue for birthing people and children is health and access to high quality health care. Ms. Muñoz added meetings should occur in various parts of the state and should include community listening sessions.

Agenda Item 3 – Continued Discussion: Data Quality Expert Panel – Current and Future (Transcript, P. 18-31)

Ms. Brooks gave a recap of the March 24, 2022, Data Quality Expert Panel and introduced Dr. Rachel Harrington from the National Committee for Quality Assurance (NCQA) and Dr. Anna Lee Amarnath from Integrated Health Association (IHA) and provided an opportunity for the Committee to continue to the discussion from the previous meeting noting that there was not enough time to get to all of the questions at the last meeting.

Dr. Richard Riggs commented it is important for the Committee to address the technical pieces discussed during the March 24, 2022, Data Quality Expert Panel throughout this process.

Doreena Wong asked if questions may be sent after the meeting. Ms. Wong also asked if the data NCQA, IHA, and RAND is using is disaggregated by race and ethnicity. Ms. Brooks responded questions could be shared after the meeting. Dr. Anna Lee Amarnath responded there would be a benefit to collecting disaggregated data and there is an opportunity to expand in this area. Dr. Rachel Harrington responded the NCQA Healthcare Effectiveness Data and Information Set (HEDIS) is disaggregated at the Office of Management and Budget (OMB) level. NCQA acknowledges the limitations of not disaggregating further.

Rhonda Smith stated while the Committee reviews health equity and other metrics the Committee must consider cause and effect. Kiran Savage-Sangwan stated clarification on what race, ethnicity, and language data health plans have to report on would be beneficial from an accountability perspective. Ignatius Bau responded a first step could be considering these as structural measures to assess completeness of race and ethnicity data.

Silvia Yee asked for clarification on how RAND and NCQA address risk-adjustment. Last month, in the RAND presentation, Dr. Cheryl Damberg spoke of using risk-adjusted measures to distinguish between within-provider disparities and between-provider differences. In the NCQA presentation, Dr. Harrington indicated they excluded risk-adjusted measures as candidates for the five additional measures selected for stratification. Dr. Harrington responded in the first year of stratification risk-adjustment is excluded for ease. Risk-adjustment should not be a barrier in selecting measures.

Dr. Bihu Sandhir encouraged utilizing the Centers for Medicare and Medicaid Services (CMS) Health Equity Index to assist health plans in addressing vulnerable populations.

Dr. Edward Juhn asked if the Committee has defined race and ethnicity and how to address self-reported data. Mr. Bau responded if stratified NCQA measures were utilized we may consider aligning with NCQA's use of OMB categories. However, the Committee may also consider other recommendations. Dr. Amarnath added the measures selected may allow for various sources to identify race. The data may allow for unique ways to identify race and the Committee may think beyond stratification as proposed by NCQA.

Agenda Item 4 – Guiding Principles for Measure Selection (Transcript, P. 31-69)

Ms. Brooks outlined the goal and audience for the measures selected, defined key terms, and the process for measure selection.

Dr. Riggs asked if the measures selected through this process can evolve over time. For example, initially beginning with a process measure like mammography breast cancer screening and then subsequent outcome measure for follow-up for positive diagnosis. Dr. Andy Baskin responded this may be a recommendation for the Committee to consider. Director Mary Watanabe commented the goal is to establish a core set of measures and reminded the Committee recommendations made must be codified into regulation in order to take enforcement action. Dr. Riggs responded a well written regulation would allow for such nuance.

Dr. Juhn commented there may be geographic variances for measures and there may be distinct challenges setting baselines based on region.

Dr. Sandhir agrees with having outcome measures a couple of years into the process and added Committee recommendations must be measurable.

Ms. Brooks reviewed the Guiding Principles for Measure Selection and highlighted the principles are not meant to be limiting and Committee members may consider additional principles throughout the measure selection process.

In response to the Guiding Principles for Measure Selection, Dr. Alice Chen, reiterated the importance of alignment based on the Covered California experience and cautioned the Committee against developing measures.

Nathan Nau asked what the expected timeline for creating measures is. Dr. Palav Babaria responded it is a two to five year process to create a measure, develop measure specifications, and to collect a year's worth of data. Dr. Babaria also commented alignment is important and the value of this work is to create measures across payors and systems so comparisons may be made. Dr. Harrington added timing for developing a simple measure is at least a two year process.

Dr. Juhn added alignment is critical for how information is collected and reported to health plans, for example on 834 files, the race and ethnicity data is often mixed up.

Robyn Strong commented the focus on what is already being collected is a suitable place to start and completeness of existing data is important. Ms. Wong responded to Ms. Strong's comment, existing data on the California Healthcare Eligibility, Enrollment, and Retention System (CalHEERS) could be shared with plans and providers and it may be disaggregated.

Bill Barcellona confirmed the Guiding Principles for Measure Selection are broad enough to use for the purpose of this Committee.

Ms. Savage-Sangwan asked for clarification on the California priority area of focus principle. Ms. Brooks responded this prioritizes what is happening at other state departments and priorities for the Adminisration.

Ms. Yee asked for clarification on what potential for high population impact principle and feasibility principle refer to. Dr. Baskin responded population impact refers to the size of the population the measure impacts (e.g., diabetes). Mr. Bau emphasized impact is really important but oftentimes is hard to measure if the target population is small. Dr. Chen commented from Covered California's experience they began with fourteen measures to stratify. However, once Covered California began stratifying there were challenges getting statistically significant results.

Dannie Ceseña asked if there is going to be a measure on medication adherence. Dr. Baskin responded the Committee will discuss medication adherence when covering the chronic conditions focus area.

Dr. Riggs commented the California priority area for focus principle is an opportunity for measures selected by the Committee to satisfy AB 1204 to include analysis of health care disparities.

Dr. Juhn asked if data sharing is included in the California priority area for focus principle or alignment with other measurement and reporting programs principle. Ms. Brooks responded while this is a critical issue it is outside of the charge of the Committee.

Agenda Item 5 – Focus Areas and Disparities (Transcript, P. 55-69)

Ms. Brooks reviewed focus areas, how disparities would be covered during the discussion on measures and reviewed the most common focus areas. The most common focus areas include health equity, access, prevention, coordination of care, birthing persons and children, chronic conditions, mental health, substance use, population health, specialty, utilization, and patient experience.

Mr. Barcellona asked how many measures this Committee should plan to select. Ms. Brooks responded the number of measures selected is based on the Committee's recommendation and ten to twelve measures would be feasible. Mr. Barcellona commented America's Physician Groups has a standards of excellence program with seven domains or focus areas. Dr. Baskin responded the twelve focus areas are general topics for the Committee's consideration. Ms. Brooks added health equity is included as a focus area because it may be specific to structural measures. Mr. Bau added for the purpose of this Committee there could be stratification and a health equity measure.

Dr. Riggs commented there may be tension around access and utilization. Dr. Riggs explained while an individual may have access to health care services the individual may not be able to utilize the services.

Diana Douglas commented given the number of focus areas and number of recommended measures, the Committee should ensure measures apply to multiple focus areas and consider which measures will best capture improvements and innovations over time.

Dr. Chen commented there might be feasibility challenges in the health system. Moving forward, the Committee will want to consider things that have historically not improved (e.g., chronic conditions).

Ms. Smith asked if birthing people and children measures will be condensed into one focus area. Dr. Baskin responded while they are considered one focus area they will be separated within the Committee's discussion.

Ms. Savage-Sangwan commented the Committee may want to consider referring to mothers and children as birthing people and children.

Ms. Smith asked if the community representatives would like to make a public comment. Rev. Shorty commented birthing people and children, mental health, and substance use are already being addressed in Los Angeles County. In response to Rev. Shorty's commentary, Ms. Yee added effective communication and health literacy is an important issue to address. Ms. Wong added Rev. Shorty and Ms. Yee's comments can be tied to social determinants of health (SDOH) and the Committee may want to consider a measure focused on SDOH.

Ms. Smith asked if vaccinations are included in the measures. Dr. Baskin answered vaccination status is included in the prevention and birthing people and children focus areas.

Ms. Strong commented COVID-19 vaccinations may be something to consider under the prevention category. Dr. Chen agreed COVID-19 should be considered by the Committee moving forward.

An attendee from the public, Allen Noriega from Illumination Foundation, asked where the reference and resource material may be located. Ms. Watanabe clarified materials are online at HealthHelp.ca.gov.

Agenda Item 6 – Discussion on Measures (Transcript, P. 69-121)

Ms. Brooks commenced the discussion on measures by reviewing the process for identifying the measures for the Committee's review and discussion. Mr. Bau highlighted California specific disparities related to prevention.

Ms. Smith asked why prostate cancer is not included on the preliminary list of prevention measures and added African American men are known to be less likely to be screened and experience disparities in mortality and survival rates. Ms. Smith added for colorectal cancer, younger people are also being diagnosed. Dr. Chen responded the screening mechanism and detection protocols for prostate cancer make it challenging to measure. However, she acknowledged colorectal cancer in African American men is an issue.

Mr. Barcellona asked if the Committee will discuss maternal health during the discussion of birthing people and children. Mr. Bau said it would.

Ms. Savage-Sangwan asked for clarification on the process of selecting ten to twelve measures, measure adjustment, and what the health plans would be held accountable to. Ms. Brooks responded the Committee will utilize technical specifications for each measure or go with adjustments to the specifications as recommended by the Committee. Dr. Baskin added as the process continues we will consider benchmarks and targets for the selected ten to twelve measures.

Ms. Wong asked if this is the time to talk about data disaggregation and other data sets to look at, for example California Health Interview Survey (CHIS) and Office of Minority Health data. Mr. Bau responded there is a lower rate of cervical cancer screening among Vietnamese women may not show up in national or state data.

Dr. Sandhir said she needed more information to make a measure recommendation and from an enforcement perspective the measures need to be covered by insurance.

Mx. Ceseña asked how the Committee will ensure those who identify on the gender spectrum with feminine reproductive organs and identify as male will be identified throughout this process. Dr. Bau responded as gender data is collected in a comprehensive way to account for gender outside of the binary this process will improve. Mx. Ceseña responded there are no ways to collect this data currently and this will cause performance data and measures to be skewed. Furthermore, this will impact how the Committee addresses prevention.

Dr. Juhn commented from an alignment and feasibility perspective the breast cancer screening and cervical cancer screening measures make sense.

Ms. Douglas responded to Mx. Ceseña's comments and urged the Committee to look beyond currently available data. Ms. Douglas added more information is needed regarding disparities, diagnosis, and mortality rates.

Ms. Strong said race and ethnicity data for multiracial individuals is limiting. In claim forms there are multiple spaces a person can self-identify. Sexual orientation and gender identity (SOGI) data is not readily available in claim forms, but standards can be put in place to align with United States Core Data for Interoperability (USCDI) SOGI standards to update claim forms. The Centers for Disease Control and Prevention (CDC) also references race and ethnicity categories.

Ms. Yee stated the Office of the National Coordinator for Health Information Technology (ONC) has an interoperability workgroup and has done work to address SOGI and individuals living with disabilities data.

Dr. Amarnath recommended against using the medical assistance with smoking and tobacco use cessation measure to try to eliminate a Consumer Assessment of Healthcare Providers and Systems (CAHPS) measure. Dr. Chen commented Covered California selected this measure and had an extremely hard time getting complete data for reporting.

Lishaun Francis commented well child visits and dental visits are not captured in the prevention measure list. Mr. Bau responded this is covered in birthing people and children focus area.

Dr. Sandhir and Mr. Barcellona agreed the colorectal cancer, breast cancer, and cervical cancer screening measures should move forward.

Ms. Yee asked when cervical cancer screening is recommended. Dr. Sandhir and Dr. Chen answered at age twenty-one.

Ms. Douglas noted the DMHC serves individuals 65 and younger, but some measures go up to ages 74 and 75 and may not be applicable.

Dr. Amarnath and Dr. Chen commented adult immunization is a gap in the measures presented and should be addressed. Dr. Riggs said the requirements for COVID-19 immunization is changing and may be hard to address. Dr. Chen said NCQA's changing guidelines could support this.

Ms. Savage-Sangwan asked if there is a measure for all adult vaccinations. Dr. Babaria responded there is a new HEDIS measure for adult vaccination status.

Dr. Juhn said data capture, data sharing, and data exchange is needed to operationalize these measures and urged the Committee to consider this throughout the process. Dr. Chen noted this effort could accelerate data exchange between public health and health care systems.

Ms. Wong asked for clarification on the process for measure selection. Ms. Brooks responded for each focus area the Committee will identify two to three measures (candidate measures) and then the Committee will filter the measures from there. Dr. Sandhir commented the Committee is short-listing the measures, but more data would be useful before making final recommendations. Director Watanabe asked for clarification on the additional information the Committee members would like to be able to make a recommendation. Dr. Sandhir responded additional information would be beneficial for the candidate list of measures. Director Watanabe added written comments will be accepted from the public and the Committee. Mr. Bau added the benchmarking data will be examined when reviewing the candidate measure list.

An attendee from the public, Kristen Tarrell from Western Health Advantage, pointed out that AB 133 requires all commercial plans to have NCQA Health Plan Accreditation by January 2026 and Covered California and the Medicaid line of business in California are requiring the Health Equity Accreditation. Ms. Tarrell urged Committee members to consider the use of HEDIS measures.

Ms. Brooks summarized the Committee members agreement on measures to move forward in the prevention focus area, which included breast cancer screening, colorectal cancer screening, cervical cancer screening, and an adult vaccination measure.

Ms. Brooks transitioned to begin the discussion on the California specific disparities related to chronic conditions. Mr. Bau added this is general California data about the prevalence of chronic conditions and it varies based on race and ethnicity. Dr. Baskin introduced the measures within the chronic conditions focus area.

Dr. Sandhir commented diabetes is an important chronic disease and needs to be included. She asked if it is possible to have a diabetes control measure and additional sub-measures. Dr. Baskin added this could be included in the recommendations.

Dr. Riggs asked about the lab report figures the health plan may receive and if this is currently being collected. Dr. Sandhir responded that health plans know what the range for a particular measure is, for example Hemoglobin A1c (HbA1c). Dr. Sandhir added codes are based on the range and these are based on Current Procedural Terminology (CPT) II codes.

Ms. Douglas stated a preference for clinical outcome measurements such as the HbA1c measures rather than medication reconciliation measures. Dr. Baskin clarified medication reconciliation measures typically report on if the medication is filled which is used as a proxy for adherence. Ms. Douglas added there are concerns regarding adherence where people may unequally pick up their medication across distinct categories. Dr. Chen agreed with Ms. Douglas' concerns about medication reconciliation measures.

Dr. Chen commented a diabetes measure must be included in the measure set and confirmed NCQA is bundling the greater than 9% and less than 8% HbA1c measure but if one needed to be selected, her preference is for greater than 9%.

Ms. Smith commented there may be African American and Latinx persons who are pre-diabetic and unaware. Ms. Smith asked if there is a pre-diabetes measure to include with the candidate measures. Dr. Baskin commented he is not aware of a formal or widely used pre-diabetes measure. Ms. Smith asked if family history contributes to diabetes diagnosis. Dr. Baskin responded family history contributes to a diagnosis of diabetes. Dr. Sandhir added there is guidance on pre-diabetes screening but it changes every year as the American Diabetes Association guidelines come out which is challenging.

Ms. Wong commented the Asian category includes Native Hawaiian and Pacific Islanders. However, there are some populations like Pacific Islanders with very high prevalence of diabetes. Ms. Wong agrees it would be good to include a diabetes measure. Mr. Bau responded if the greater than 9% or less than 8% HbA1c measure is selected then NCQA is requiring stratification by race and ethnicity by OMB categories.

Ms. Savage-Sangwan agrees with including the diabetes measures and suggested the controlling high blood pressure measure based on impact. Ms. Savage-Sangwan commented it is important to consider the physical health for people with serious mental illness and suggested the diabetes screening for people with schizophrenia or bipolar disorder who are using antipsychotic medications measure. She asked about the magnitude of the impact of this measure and if there are measures in other focus areas focused on mental health. Dr. Baskin responded when the Committee gets to the mental health focus area measures, there are a number of measures related to

depression because it is the most common mental health condition. Dr. Baskin added this is a small sub-population for which there is a higher prevalence of diabetes.

Dr. Juhn agreed with comments regarding utilizing outcome measures. Dr. Juhn also pointed out for Medi-Cal Managed Care Plans the pharmacy benefit has been carved out via Medi-Cal Rx.

Ms. Yee commented for the diabetes screening for people with schizophrenia or bipolar disorder measures it is measuring symptoms the individual is feeling. Dr. Sandhir clarified there is a subset of patients with bipolar disorder who have high blood pressure due to their medications. However, depression is more common in patients with diabetes.

Ms. Yee added disparities among measures must be considered for race, ethnicity, sexual orientation, and disability. Mr. Bau commented many of these measures are standards of care, so if an individual is diagnosed with diabetes clinical actions should happen including annual eye exam, foot exam, and regular HbA1c testing. Ms. Yee responded a lot of a diagnosis involves if the individual's symptoms are believed. Dr. Chen responded she understood and gave the examples of the disparities in diagnosing cardiovascular disease in women or long bone pain treatment for African American and Latinx persons. Dr. Chen also clarified for the diabetes screening for people with schizophrenia or bipolar disorder the individual is supposed to be screened for diabetes and hyperlipidemia. Second, this measure is disproportionately owned by MediCal because of the structure of the mental health system.

Dr. Riggs commented an obesity measure is not included in this set and acknowledged obesity is difficult to measure. Dr. Sandhir commented there is a Uniform Data System (UDS) obesity measure for adults.

Agenda Item 7 – Public Comment (Transcript, P. 122)

Ms. Brooks asked if there was anyone who wanted to give public comment. There was none. Ms. Brooks noted members of the public may submit comments until 5 p.m. on April 27, 2022, to publiccomments@dmhc.ca.gov.

Agenda Item 8 – Closing Remarks (Transcript, P. 122)

The meeting adjourned at 4:59 p.m. The next meeting is scheduled for May 18, 2022.