DMHC Health Equity and Quality Committee

July 13, 2022

Housekeeping

For all Committee members:

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

Housekeeping

For all Committee members:

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

Housekeeping

For all Committee members:

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

Housekeeping

For all members of the public:

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

Agenda

1. Welcome and Introductions
2. Review June 22, 2022 Meeting Summary
3. Regulation Process
4. Review Selected Measures for the Final Set
5. Review and Finalize Remaining Measures
6. Break

Agenda

7. State Department Benchmarking Process Presentation
8. Benchmarking
9. Disparities Reduction and Measure Stratification
10. Public Comment
11. Closing Remarks

DMHC Attendees

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

Voting Committee Members

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

Voting Committee Members

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

Voting Committee Members

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

Ex Officio Committee Members

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

Sellers Dorsey Team

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

Meeting Materials

1. Final and Further Discussion Measures Workbook
2. Epidemiologic and Performance Data Handout

Committee Meeting Timeline

- Committee Meeting #7 – July 13
  - Finalize Measure Set, Benchmarking, Measure Stratification
- Committee #8 – August 17
  - Review Draft Report of Committee Recommendations
- Committee Meeting #9 – September
  - To Be Determined

Questions

Review June 22, 2022 Meeting Summary

Sarah Brooks, Project Director

Questions

Regulation Process

Sara Durston, DMHC Senior Attorney

Questions

Review Selected Measures for the Final Set

Sarah Brooks, Project Director
Andy Baskin, Quality SME, MD
Ignatius Bau, Health Equity SME

Legend

^ *Performance data is currently available*

* *NCQA Stratification by Race/Ethnicity*

Final Measure Set

The following measures were voted by the Committee for inclusion in the final recommended measure set:

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

Final Measure Set

The following measures were voted by the Committee for inclusion in the final recommended measure set:

6. Depression Screening and Follow-Up for Adolescents and Adults [NQF Disparities-Sensitive]
7. Prenatal & Postpartum Care [NQF Disparities-Sensitive]^*
8. Well-Child Visits in the First 30 Months of Life^*
9. Child and Adolescent Well-Care Visits^*
10. Childhood Immunization Status (Combo 10)^
11. Immunizations for Adolescents (Combo 2)^*
12. Plan All-Cause Readmissions (PCR)^

Final Measure Set

The following CAHPS measure was voted by the Committee for inclusion in the final recommended measure set:

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

Questions

Review and Finalize Remaining Measures

Sarah Brooks, Project Director

Andy Baskin, Quality SME, MD

Ignatius Bau, Health Equity SME

Measures for Further Discussion

As identified in the June 22 meeting the following seven measures require further discussion:

1. Cervical Cancer Screening (CCS) [NQF Disparities-Sensitive]
2. Follow-Up After Emergency Department Visit for Mental Illness (FUM)
3. Pharmacotherapy for Opioid Use Disorder*
4. Adult Immunization Status*
5. Obesity Prediabetes and Diabetes A1c Control

Measures for Further Discussion

As identified in the June 22 meeting the following seven measures require further discussion:

6. Meaningful Access to Health Care Services for Persons with Limited English Proficiency
7. Patients Receiving Language Services Supported by Qualified Language Services Providers [NQF Disparities-Sensitive]

Process to Narrow Measures to Final Set

For measures that received a 40-59% “yes” vote during the June 22 meeting, another vote will occur (denominator = 17).

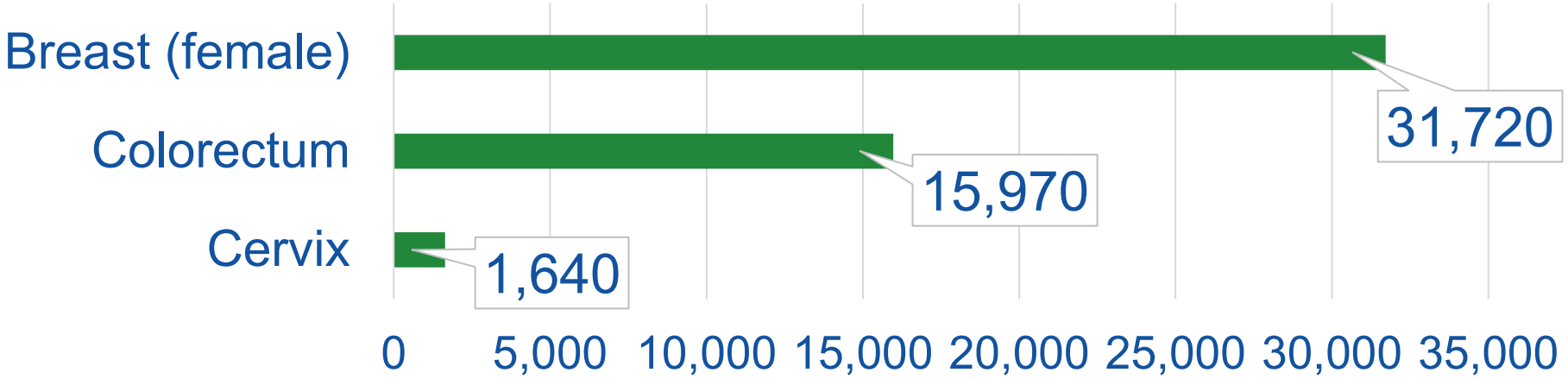
1. If a measure receives a “yes” vote from 60% or more of the Committee, it will be considered for the final measure set.
2. If a measure receives less than 60% of the “yes” vote in this round, it will be removed for consideration from the final measure set.

Cancer Screening Data

- According to State Health Access Data Assistance Center (SHADAC), in California 58.8% of adults received recommended cancer screenings (e.g., including pap smears, colorectal cancer screening, and mammograms) which is lower than the national average 64.1%.
- According to California Health Care Foundation (CHCF), in 2018 Black Californians had higher mortality rates for breast and colorectal cancer when compared to Asian, Latinx, and White Californians in 2017.

Cancer Incidence

California Estimated New Cases, 2022



American Cancer Society 2022 estimate of new cases of breast, colorectal, and cervical cancer in California.

Measures for Further Discussion

- **Measure Name:** Cervical Cancer Screening
- **Reported by:** Medi-Cal, IHA, CMS Core Set, MIPS
- **NCQA Stratified by Race/Ethnicity:** No
- **Performance Data/Benchmark Available:** Yes

Cervical Cancer Performance

Cervical Cancer Screening [NQF Disparities-Sensitive]

	Commercial		Medicaid	
	50th	75th	50th	75th
National	73.17	77.42	59.12	63.93
State	73.93	77.95	60.40	65.41

California commercial and Medi-Cal plans performed above the national 75th percentiles, respectively.

Mental Health Prevalence

- According to Americas Health Rankings 2020, the prevalence of depression nationally for adults was 19.5% compared to California's rate of 14.1%.
- According to Mental Health America 2022, California ranks 15th in the nation (19.86%) for prevalence of mental illness with a rate of 19.49% (or 5.86 million Californians).

Measures for Further Discussion

- **Measure Name:** Follow-Up After Emergency Department Visit for Mental Illness (FUM)
- **Reported by:** Medi-Cal, CMS Core Set
- **NCQA Stratified by Race/Ethnicity:** No
- **Performance Data/Benchmark Available:** Yes

Mental Health Performance

Follow-Up After Emergency Department Visit for Mental Illness

		Commercial		Medicaid	
		50th	75th	50th	75th
30-day	National	61.53	68.52	53.54	64.65
	State	55.95	59.84	30.68	44.79
7-day	National	45.87	53.49	38.6	49.49
	State	41.46	45.24	24.61	33.51

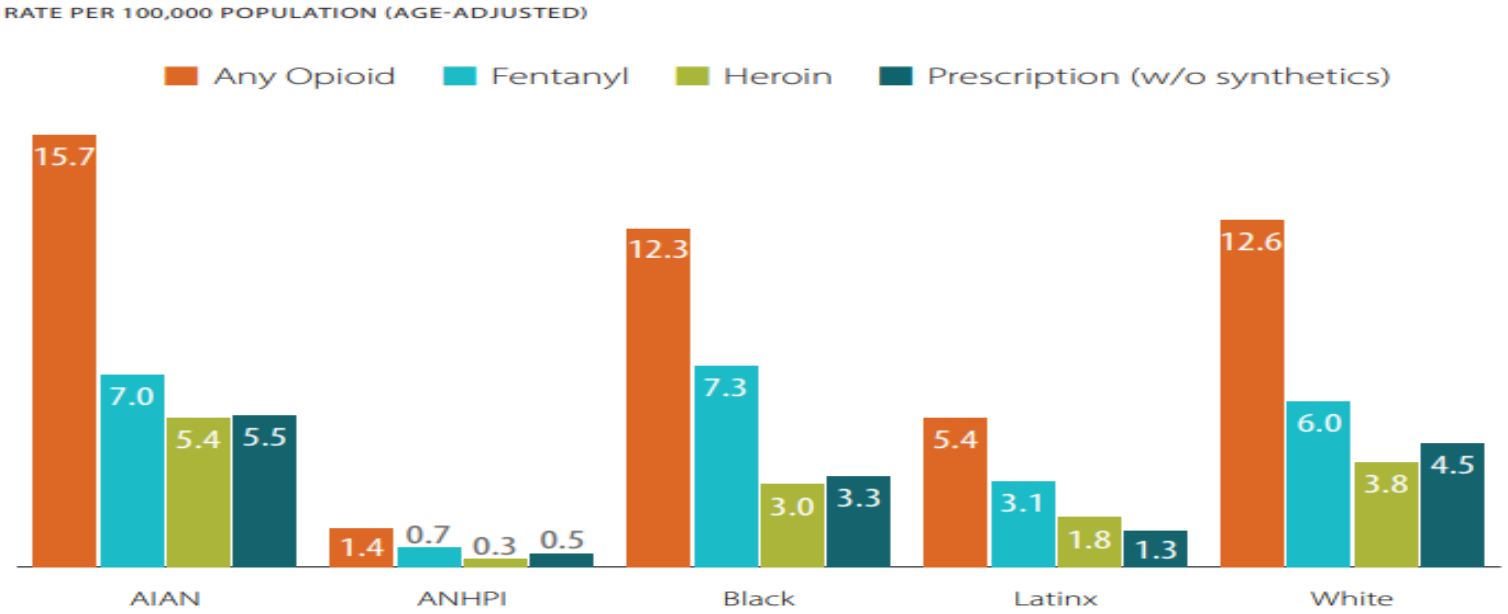
California commercial and Medi-Cal plans performed below national 75th percentiles, respectively.

Opioid Use Prevalence

- According to “Substance Use in California” by CHCF (2022):
  - Nearly 9% (2.9 million) of Californians ages 12 and older reported a substance use disorder in the past year.
  - American Indian and Alaska Native Californians had the highest rate of opioid overdose deaths, followed by White and Black Californians.

Opioid Overdose Mortality Rates

Opioid Overdose Deaths
by Race/Ethnicity, California, 2019



Measures for Further Discussion

- **Measure Name:** Pharmacotherapy for Opioid Use Disorder
- **Reported by:** Medi-Cal, CMS Core Set
- **NCQA Stratified by Race/Ethnicity:** Yes
- **Performance Data/Benchmark Available:** Yes

Substance Use Performance

Pharmacotherapy for Opioid Use Disorder*

	Commercial		Medicaid	
	50th	75th	50th	75th
National	29.81	37.11	30.52	38.93
State	19.57	24.37	11.64	17.68

California commercial and Medi-Cal plans performed below national 75th percentiles, respectively.

Flu Vaccine Prevalence

- According to SHADAC, for adults who received a flu vaccine in the past 12 months:
  - Fewer Californians (37.7%) received a flu vaccine when compared to the national average (38.7%).
  - Among Californians and the national average, the percent of individuals with one or more chronic disease that received a vaccine was similar, 49.0% and 49.1%, respectively.

Measures for Further Discussion

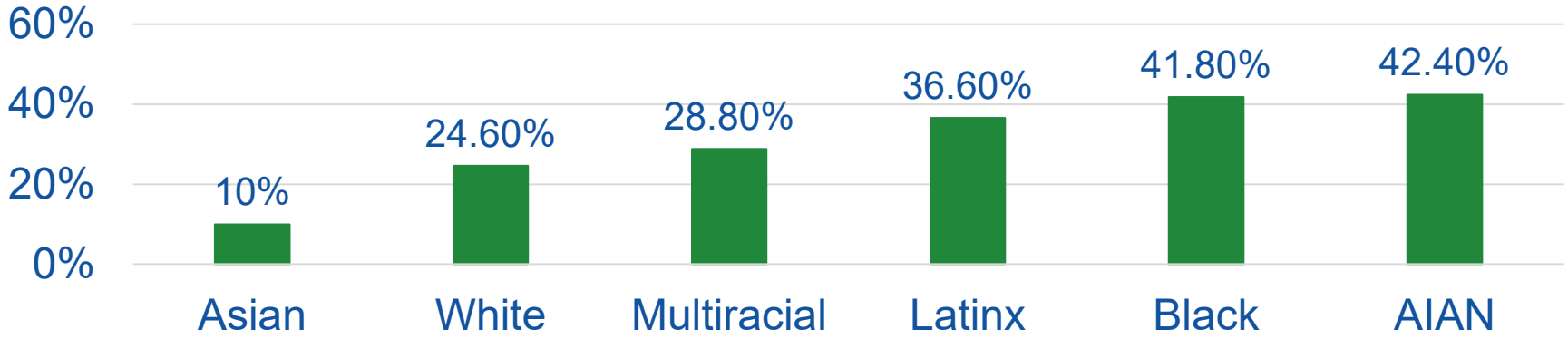
- **Measure Name:** Adult Immunization Status
- **Reported by:** N/A
- **NCQA Stratified by Race/Ethnicity:** Yes
- **Performance Data/Benchmark Available:** No

Obesity Prevalence

- In 2018, 27.1% of Californians were obese. The state could save an estimated $81.7 billion in obesity-related health care costs if adult BMI were reduced by 5% by 2030.

Obesity Prevalence

Obesity, by Race/Ethnicity
California, 2020



According to CHCF, in 2020 the prevalence of obesity was highest among American Indian and Alaskan Natives and Black Californians.

Measures for Further Discussion

- **Measure Name:** Obesity Prediabetes and Diabetes A1c Control
- **Reported by:** N/A
- **NCQA Stratified by Race/Ethnicity:** No
- **Performance Data/Benchmark Available:** No

Measures for Further Discussion

- **Measure Name:** Meaningful Access to Health Care Services for Persons with Limited English proficiency
- **Reported by:** N/A
- **NCQA Stratified by Race/Ethnicity:** No
- **Performance Data/Benchmark Available:** No

Measures for Further Discussion

- **Measure Name:** Patients Receiving Language Services Supported by Qualified Language Services Providers [NQF Disparities-Sensitive]
- **Reported by:** N/A
- **NCQA Stratified by Race/Ethnicity:** No
- **Performance Data/Benchmark Available:** No

Questions

Vote

Break

State Department Benchmarking Process Presentation

Julia Logan, CalPERS

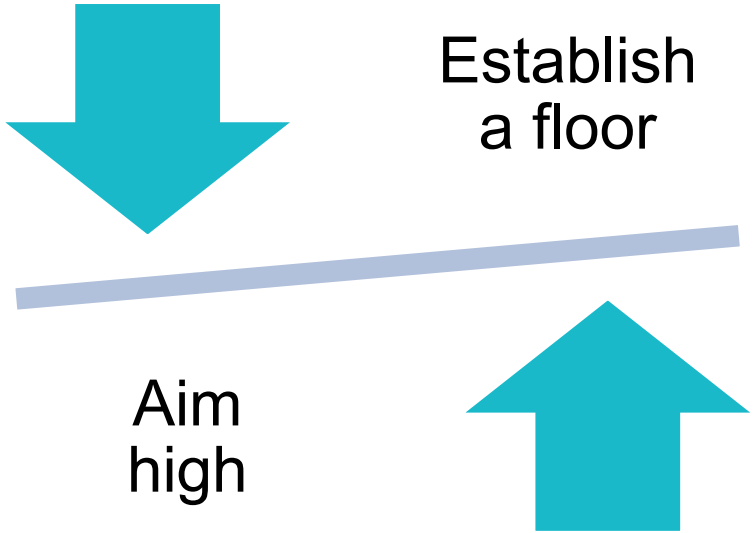
Dr. Alice Chen, Covered California

Dr. Palav Babaria, DHCS

DMHC Equity and Quality Committee

Considerations for Benchmarking and Disparities

Covered California Example: Floor Versus Target



Persistent performance below 25th percentile national performance is unacceptable – **penalize** by removing from marketplace.

Quality should be aspirational – **"incentivize"** continuous performance improvement up to 66th percentile national performance.

Significant Variation Across Plans and Measures

Benchmark:	≥ 90th Percentile	50th - 90th Percentile	25th - 50th Percentile	< 25th Percentile

Measure Title	Year	A	B	C	D	E	F	G	H	I	J	K	L	M	N
Colorectal Cancer Screening	2020	48	49	49	49	54	51	34	69	46	33	29	71	44	52
Comprehensive Diabetes Care: HbA1c Control (<8.0%)	2020	52	62	54	63	61	76	61	62	52	56	54	69	60	51
Controlling High Blood Pressure	2020	54	55	46	39	58	56	50	56	53	57	43	76	44	58
Childhood Immunization Status (Combination 3)	2020	63	71	64		63		61	85	82	57	22	87		

Note: national benchmarks are static for the duration of contract (2023– 2025).

Significant Differences Across Lines of Business

Measure Name	Medicaid 50th PCT (NCQA MY2020)	QRS 50th PCT (QRS MY2020)	Commercial 50th PCT (NCQA MY2020)
Diabetes Care: HbA1c Control < 8.0%	46.8	56.2	54.8
Controlling Blood Pressure	55.5	57.8	54.6
Childhood Immunization Status Combo 3	68	75.8	77.1
Immunizations for Adolescents Combo 2	36.5	27.1	29.4
Postpartum Care	76.4	80	78.8
Prenatal Care	85.9	84.7	82.5
Child and Adolescent Well-Care Visits Age 3-21	45.6	36.0^	53.3
Colorectal Cancer Screening	--	57.4	62.2

^ Limited to California QHP results (1st year measure)

50th percentile represents a range of performance.

Large performance improvement opportunities across most measures.

Race/ethnicity Data Collection is Foundational

Contract Year	% Complete	Data Source	Performance Guarantee	Issuer Performance
2016	n/a	plan report	n/a	52% - 94%
2017	n/a	plan report	n/a	51% - 99%
2018	n/a	plan report	n/a	67% - 99%
2019	negotiated	plan report	2%	66% - 99%
2020*	80	plan report	2%	62% - 92%
2021	80	plan report	2%	69% - 99%
2022	80	claims database	7.5%	TBD

*Addressed incorrect data mapping of non-respondents to “Other” which counts towards completeness

Complexity of Patient Level Data Submissions - Ethnicity

Covered CA Race and Ethnicity Categories for PLD File and Summary Data Preparation June 2021

	Office of Management and Budget (OMB) [1]	CalHEERS	834 File	Covered California Race & Ethnicity Codes
Responses for ethnicity	**Hispanic or Latino**	Hispanic or Latino Indicator Yes	Hispanic or Latino Indicator Yes	Hispanic or Latino Indicator 01-Hispanic or Latino
		Cuban Guatemalan Mexican/Mexican American/Chicano Other Hispanic, Latino, or Spanish Origin Puerto Rican Salvadoran	2182-4 Cuban 2157-6 Guatemalan 2148-5 Mexican/Mexican American/Chicano/a 2135-2 Other Hispanic/Latino/Spanish 2180-8 Puerto Rican 2161-8 Salvadoran	100-Cuban 120-Guatemalan 200-Mexican, Mexican American/Chicano 300-Other Hispanic, Latino, or Spanish Origin 400-Puerto Rican 500-Multiple Ethnicities 110-Salvadoran
	Not Hispanic or Latino	Hispanic or Latino Indicator No	Hispanic or Latino Indicator No	Hispanic or Latino Indicator 00-Not Hispanic or Latino
No response for ethnicity		Null (no response)	Null (no response)	999- Unknown Ethnicity 99-Unknown Hispanic or Latino Indicator

Complexity of Patient Level Data Submissions – Race

Covered CA Race and Ethnicity Categories for PLD File and Summary Data Preparation June 2021

	Office of Management and Budget (OMB) [1]	CalHEERS	834 File	Covered California Race & Ethnicity Codes
Responses for race	**American Indian or Alaska Native**	**American Indian or Alaska Native**	**1002-5 American Indian or Alaska Native**	**01-American Indian or Alaska Native**
	Asian	Asian Indian Cambodian Chinese Filipino Hmong Japanese Korean Laotian Other Asian Vietnamese	2029-7 Asian Indian 2033-9 Cambodian 2034-7 Chinese 2036-2 Filipino 2037-0 Hmong 2039-6 Japanese 2040-4 Korean 2041-2 Laotian 2028-9 Other Asian 2047-9 Vietnamese	02- Asian Indian 24-Cambodian 04-Chinese 05-Filipino 25-Hmong 07-Japanese 08-Korean 23-Laotian 12-Other Asian 15-Vietnamese 26-Mixed Asian
	Black or African American	**Black or African American**	**2054-5 Black or African American**	**03-Black or African American**
	Native Hawaiian or Other Pacific Islander (NHOPI)	Native Hawaiian Samoan Guamanian or Chamorro	2079-2 Native Hawaiian 2080-0 Samoan 2086-7 Guamanian or Chamorro	10-Native Hawaiian 14-Samoan 06-Guamanian or Chamorro 13-Other Pacific Islander 27-Mixed Pacific Islander
	White	**White**	**2106-3 White**	**16-White**
	Other	**Other**	**2131-1 Other**	**11-Other**
				09-Multiple Races

Disparities Measures Evolution and Learnings

Disparities Measure Set 2017 - 2020

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

Disparities Measure Set Learnings

- Developed through stakeholder process 2015 – 2016
- Combination of AHRQ PQI (9) and HEDIS (4) measures
- Performance aggregated across QHP issuer lines of business except Medicare
- Despite aggregation, population sizes still too small for certain measures (particularly AHRQ PQI condition-specific complications)
- Missing access and prevention measures

Disparities Measure Set 2021 – 2022

4 HEDIS measures based on patient level data

- Diabetes control A1c <8
- Diabetes nephropathy screening
- Diabetes retinopathy screening
- Blood pressure control

Disparities Measure Set 2023 – 2025

6 QTI measures + perinatal depression screening and follow up

- Diabetes control A1c <8
- Blood pressure control
- Colorectal cancer screening
- Childhood immunizations
- Depression screening and follow up
- Pharmacotherapy for opiate use disorder

Benchmarking

Sarah Brooks, Project Director

Andy Baskin, Quality SME, MD

Ignatius Bau, Health Equity SME

Potential Benchmark Sources

- Benchmarks are value(s) to assess performance standards
- External benchmark sources
  - Quality Compass (e.g., National 50th percentiles)
  - National surveys and surveillance systems
  - Other (e.g., NQF, Healthy People 2030)
- Internal benchmark sources
  - Electronic health records, claims data
  - Annual reports
  - Other data-generating activities

Benchmark Approaches

- **Absolute:** sets the benchmark as a specific value of performance for all entities
- **Relative:** sets the benchmark based on performance of similar entities or performance within industry
- **Improvement based:** sets the benchmark as a specific change (percentage or absolute value) in performance to achieve

Absolute Benchmark

Example

- Baseline performance is 50%
- Achieve performance of 55% in Measurement Year 1
- Achieve performance of 60% in Measurement Year 2
- Achieve performance of 65% in Measurement Year 3
- Achieve performance of 70% in Measurement Year 4
- Achieve performance of 75% in Measurement Year 5

Absolute Benchmark

Strengths

- Could be the same across payors
- Appropriate for measures where performance across participating organizations varies a little

Challenges

- Establishes common minimum performance for all without recognizing variations in baseline
- The benchmark should be informed by performance

Relative Benchmark

Example

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

Relative Benchmark

Strengths

- Allows the benchmark to fluctuate from year to year based on external mitigating factors (e.g., a pandemic).
- Benchmark can be set to maintain performance or move above a standard (e.g., national average).

Challenges

- If the benchmark uses a state standard that is the average performance (50% percentile) or above, then some health plans will meet or exceed that average, but some health plans will fall below that average each year

Improvement Based Benchmark

Example

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

Improvement Based Benchmark

Example

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

Improvement Based Benchmark

Strengths

- Recognizes baseline performance may vary greatly

Challenges

- Most appropriate for measures that continuous improvement is possible and desired
- Requires data be available to determine baseline performance
- If baseline performance is already high, future improvements could be negligible or small

Recommendations for Benchmarking

- The following recommendations for measures with available Quality Compass data will be discussed and voted on.
- For those measures without available Quality Compass data, the Committee will discuss and make recommendations for DMHC to consider.

Voting for Benchmarking

- For benchmarking, the following voting methodology will be applied to the recommendations on subsequent slides:
  1. Committee will vote on the Quality Compass percentile to apply to all applicable measures. The percentile with the most votes will be applied to applicable measures.
  2. Committee will vote on scenario a) or b), the scenario with the highest number of votes will be applied to applicable measures.

Recommendations for Benchmarking

1. **What Quality Compass percentile does the Committee recommend as a benchmark?** Available percentiles for voting purposes: 5th,10th, 25th, 33.3rd, 50th, 66.67th, 75th, 90th, or 95th

Recommendations for Benchmarking

2. **Based on the Quality Compass percentile voted on by the Committee, should benchmarks be:**
   a) The lower of the national Commercial and Medicaid performance, or,
   b) An average of the national Commercial and Medicaid performance based on what is recommended by the Committee in Question 1.

Benchmarking Example

a) The lower of the national Commercial and Medicaid performance

Breast Cancer Screening [NQF Disparities-Sensitive]*

	Commercial		Medicaid	
	25th	50th	25th	50th
National	66.57	70.56	48.07	53.93
State	67.91	69.63	53.24	56.29

For example, if the Committee decided to set the benchmark at the national 25th percentile for all measures, this measure's benchmark would be 48.07%.

Benchmarking Example

b) An average of the national Commercial and Medicaid performance Breast Cancer Screening [NQF Disparities-Sensitive]*

	Commercial		Medicaid	
	25th	50th	25th	50th
National	66.57	70.56	48.07	53.93
State	67.91	69.63	53.24	56.29

For example, if the Committee decided to set the benchmark at the average of the national 25th percentile for Commercial and Medicaid plans for all measures, this measure's benchmark would be 57.32% ([66.57+ 48.07]/2).

Vote

Benchmarking for Measures without Quality Compass Data

- For measures without Quality Compass data, the Committee will discuss alternative recommendations.
- This is the case because there is no comparative state or national data for Medicaid and Commercial plans to use for benchmarking purposes.
- These recommendations will not be voted on but rather included in the report for consideration by the DMHC.

Discussion Questions

1. Does the Committee have any recommended approaches to set benchmarks for measures without Quality Compass data?

   For example: Year 1 (2023) or more years may be used for collecting baseline data. In subsequent years, benchmarks may be set.

   Recommendation: Measures without Quality Compass data will be report-only for ___ year(s) (how many years)?

Questions

Disparities Reduction and Measure Stratification

Sarah Brooks, Project Director

Andy Baskin, Quality SME, MD

Ignatius Bau, Health Equity SME

Measure Stratification

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

NCQA Stratification

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

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

NCQA Stratification

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

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

Voting for Measure Stratification

- If a measure stratification recommendation receives a “yes” vote from 60% or more of the Committee it will be applied to the final measure set (denominator=17).
- If a measure stratification recommendation receives less than 60% of the “yes” vote it will not be applied to the final measure set.

Recommendations for Measure Stratification

1. Does the Committee recommend that measures identified (starting in MY 2022, and already identified for 2023) by NCQA for stratification by race and ethnicity should also be stratified in the final DMHC measure set?
2. For NCQA HEDIS measures not yet identified for stratification through 2023, does the Committee recommend waiting to align with NCQA (see measures workbook)?

Recommendations for Measure Stratification

3. If the measure is not currently stratified by NCQA or is not an NCQA measure, does the Committee recommend stratifying the measure (see measures workbook)?

Vote

Committee Discussion

1. As language, sexual orientation, gender identity, disability, tribal affiliation, health-related social needs data, and ability to disaggregate data by race and ethnicity become more readily available due to evolving state or federal requirements, including the CA Data Exchange Framework, how and when should DMHC include requirements for stratification by these additional demographic data?

Disparity Reduction Benchmark

- **Disparity reduction:** sets the benchmark to reduce gap between the performance of a disparity subpopulation(s) and the performance of the general population or the highest performing subpopulation

Disparity Reduction Benchmark

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

Absolute Example

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

Improvement Based Example

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

Disparity Reduction Benchmark

Considerations

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

Options for Disparities Reduction

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

- DMHC should consider requiring minimum reductions in race and ethnicity disparities.
- DMHC should consider whether regional rather than statewide race and ethnicity disparities reduction requirements are feasible and appropriate.

Disparities Reduction: *CAHPS Measure*

- CAPHS measure stratification would need to be reported to the health plan from the CAPHS survey vendor based on the member's self identified race and ethnicity from the survey itself. This information may or may not align with racial/ethnicity data collected directly by the health plan.

Committee Discussion

1. As disparity reduction methodologies improve, what other recommendations would the Committee like to propose for the DMHC's review?

   For example: DMHC should consider requiring all stratified race and ethnicity subgroups that represent 10% or more of the health plan's population achieve the benchmark recommendation (e.g., National Quality Compass 50th percentile).

Questions

Public Comment

Public comments may be submitted until 5 p.m. on July 20, 2022, to publiccomments@dmhc.ca.gov

Closing Remarks

Public comments may be submitted until 5 p.m. on July 20, 2022, to publiccomments@dmhc.ca.gov

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

Next Health Equity and Quality Committee meeting will be held on August 17.