Promoting Equity Across California

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COVERED CALIFORNIA

DHCS

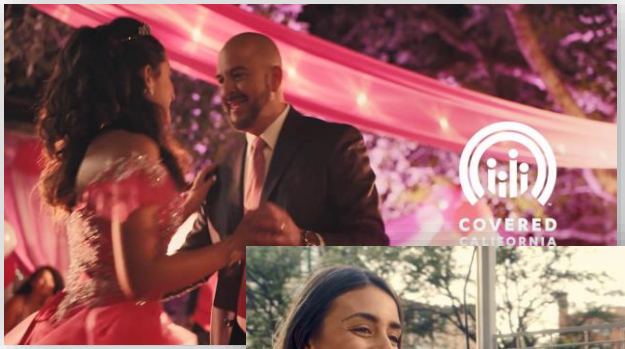
Vision & Mission

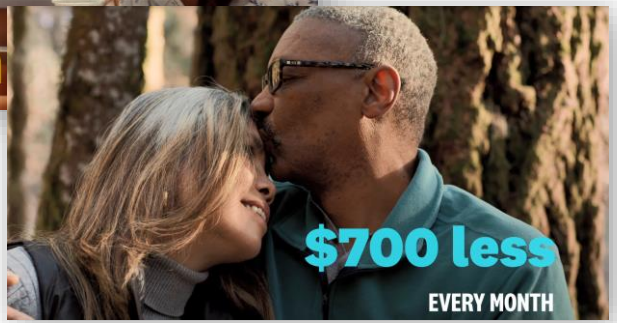
COVERED CALIFORNIA'S MISSION CENTERS EQUITY

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

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

COVERED CALIFORNIA EQUITY LENS





- 1 in 5 enrollees prefer language other than English
- More than 55% enrollees at less than 250% FPL
- More than 90% of enrollees receive subsidies

- Marketing and outreach
- Earned media/ethnic media
- Agent cultural and linguistic diversity

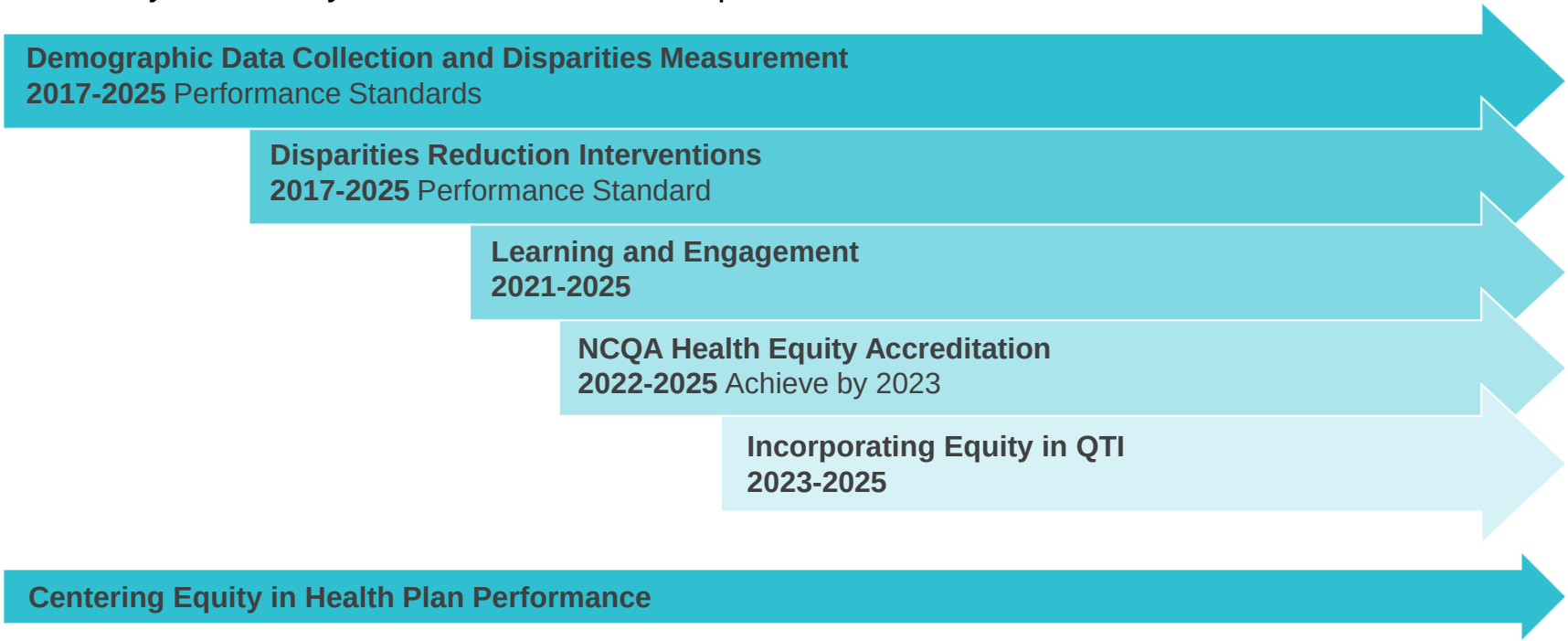
Between 2020 and 2022 enrollment increased by
- 33% for Blacks
- 18% for Latinx
- 14% for whites

"Portraits" - https://www.youtube.com/watch?v=pLAgFQf-CUc

"Corazon" - https://www.youtube.com/watch?v=FxRfZlbVzf0

2017 – 2025 COVERED CA HEALTH DISPARITIES INITIATIVES

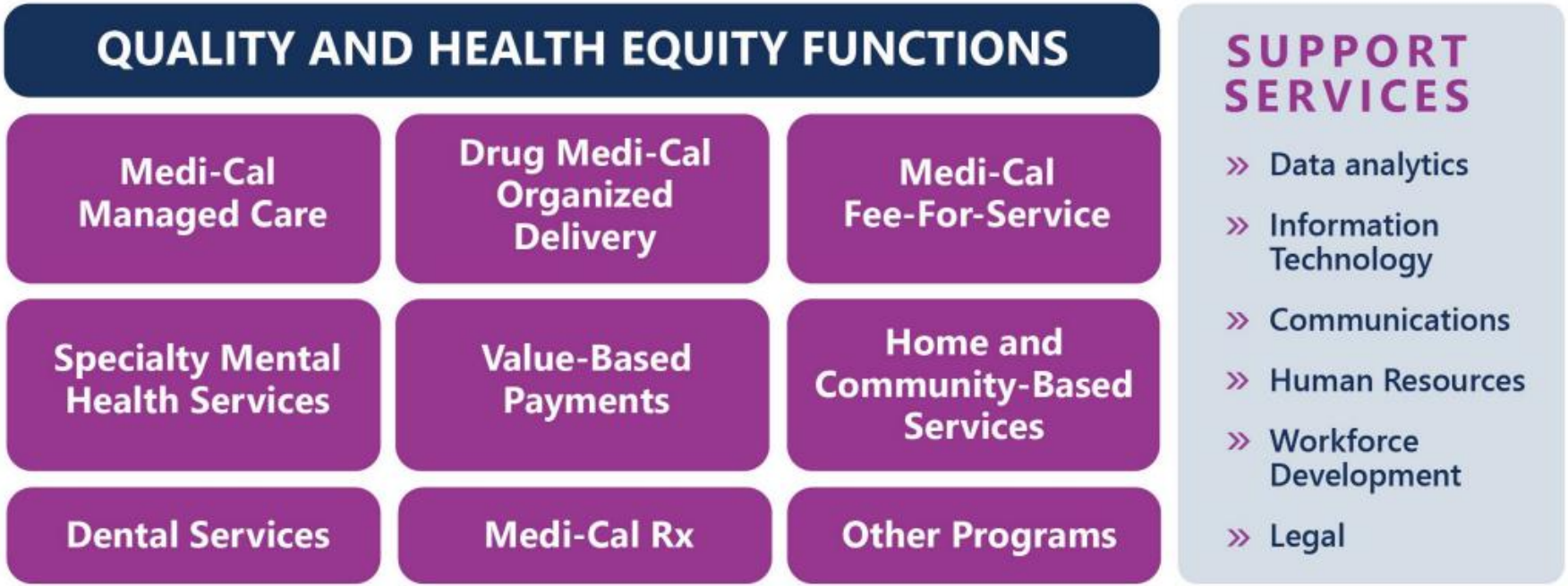
Goal 1: Improve disparity data capture to support measurement
Goal 2: Improve structure and rigor for disparities intervention development
Goal 3: Systematically measure and reduce disparities



Vision

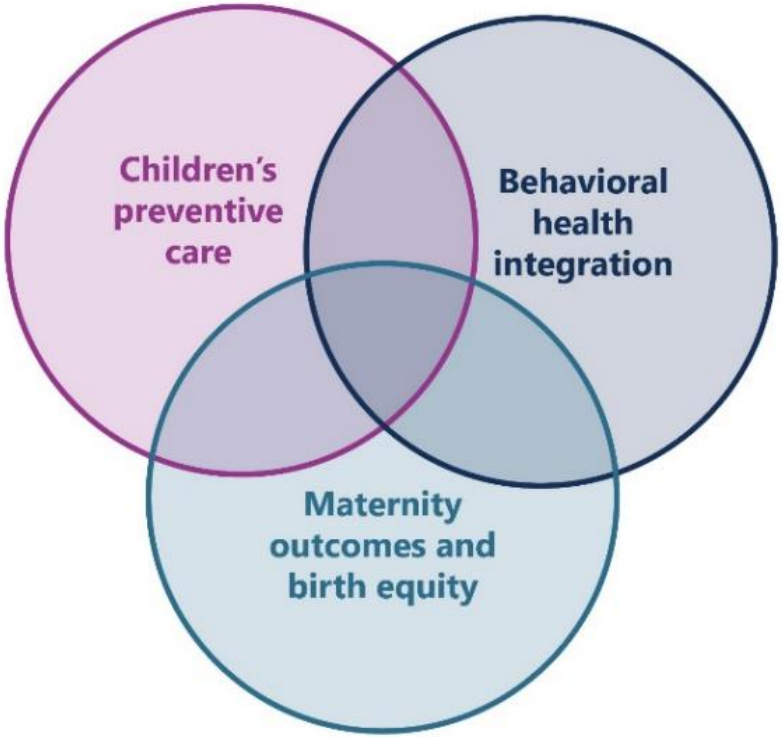

QUALITY STRATEGY GOALS
Engaging members as owners of their own care
Keeping families and communities healthy via prevention
Providing early interventions for rising risk and patient-centered chronic disease management
Providing whole person care for high-risk populations, addressing social drivers of health
QUALITY STRATEGY GUIDING PRINCIPLES
» Eliminating health disparities through anti-racism and community-based partnerships
» Data-driven improvements that address the whole person
» Transparency, accountability and member involvement

Bridging & Aligning Quality



Continuous Quality Improvement Cycle

Clinical Focus Areas



QUALITY/HEALTH EQUITY IMPROVEMENT FRAMEWORK

Driving Change

- Focused initiatives to drive transformation/innovation
- Innovative metrics, process measures, bundles
- Incentives if met (financial or otherwise)
- Example uses: CalAIM incentive programs, COVID19 vaccine incentive program, QIP optional metrics

Foundation:

- Creates a standard across programs/plans
- Fundamental outcome/access measures
- Minimum performance levels & improvement targets
- Penalties if not met
- Example uses: QIP required metrics, MCAS, auto-assignment algorithm

Measuring Disparities

COVERED CALIFORNIA DISPARITIES MEASURES EVOLUTION

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)
- Antidepressant Medication Management (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 (10) 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

2024 COVERED CALIFORNIA STRATIFIED MEASURES

Patient Level Data (PLD) File measures

measures submitted by contracted health plans with member-level race and ethnicity information

1. Controlling High Blood Pressure (NQF #0018)
2. Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Control (<8.0%) (NQF #0575)
3. Colorectal Cancer Screening (NQF #0034)
4. Childhood Immunization Status (Combo 10) (NQF #0038)
5. Depression Screening & Follow-Up for Adolescents & Adults (DSF)
6. Pharmacotherapy for Opioid Use Disorder (POD)
7. Prenatal Depression Screening and Follow-up (PND-E)
8. Postnatal Depression Screening and Follow-up (PDS-E)
9. Prenatal and Postpartum Care (PPC) (NQF #1517)
10. Social Need Screening and Intervention (SNS-E)

Covered California Healthcare Evidence Initiative (HEI) measures

Covered CA-generated measures using claims data and stratified using enrollment demographic data

1. Ambulatory Emergency Room (ER) Visits© per 1,000
2. Breast Cancer Screening (BCS) (NQF #2372)
3. Child and Adolescent Well-Care Visits (WCV)
4. Proportion of Days Covered: Three Rates by Therapeutic Category (NQF #0541)
    a) Diabetes All Class (PDC-DR) (NQF #0541)
    b) RAS Antagonists (PDC-RASA) (NQF #0541)
    c) Statins (PDC-STA) (NQF #0541)

Specific Measures

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

Prenatal and postpartum visits
C-section rates

Prenatal and postpartum depression screening
Adolescent depression screening and follow up

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

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

BOLD GOALS: 50x2025

STATE LEVEL

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

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

Improve maternal and adolescent depression screening by 50%

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

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

Domains	Measures (MY 2023)
Child & Adolescent Preventative Health	• Child and Adolescent Well-Care Visits (WCV)* • Childhood Immunization Status: Combination 10 (CIS-10)* • Developmental Screening in the First Three Years of Life (DEV) • Immunizations for Adolescents: Combination 2 (IMA-2)* • Lead screening in Children (LSC) • Topical Fluoride for Children (TFL-CH) • Well-Child Visits in the First 30 Months of Life – Well-Child Visits in the First 15 Months (W30)* • Well-Child Visits in the First 30 Month of Life - Well-Child Visits for Age 15 Months - 30 Months (W30)*
Reproductive Health	• Chlamydia Screening in Women (CHL) • Prenatal and Postpartum Care: Postpartum Care (PPC-Pst)* • Prenatal and Postpartum Care: Timeliness of Prenatal Care (PPC-Pre)* • Postpartum Depression Screening and Follow Up (PDS-E) • Prenatal Depression Screening and Follow Up (PND-E) • Prenatal Immunization Status (PRS-E)

Domains	Measures (MY 2023)
Behavioral Health	• Follow-Up After Emergency Department (ED) Visit for Mental Illness – 30 days (FUM)* • Follow-Up After ED Visit for Substance Abuse – 30 days (FUA)* • Depression Remission or Response for Adolescents and Adults (DRR-E) • Depression Screening and Follow-Up for Adolescents and Adults (DSF- E)* • Pharmacotherapy for Opioid Use Disorder (POD)*
Chronic Diseases	• Comprehensive Diabetes Care: HbA1c Poor Control (>9.0%) (CDC-H9)* • Controlling High Blood Pressure (CBP)* • Asthma Medication Ratio (AMR)*
Cancer Prevention	• Breast Cancer Screening (BCS)*—ECDS/Admin • Cervical Cancer Screening (CCS) • Colorectal Cancer Screening (COL)*

DMHC HEALTH EQUITY AND QUALITY MEASURE SET

Health Equity and Quality Committee measures recommendation:

1. **Colorectal Cancer Screening**
2. **Breast Cancer Screening**
3. **Hemoglobin A1c Control for Patients with Diabetes**
4. **Controlling High Blood Pressure**
5. **Asthma Medication Ratio**
6. Depression Screening and Follow-Up for Adolescents and Adults
7. **Prenatal and Postpartum Care**
8. Childhood Immunization Status
9. **Well-Child Visits in the First 30 Months of Life**
10. **Child and Adolescent Well-Care Visits**
11. Plan All-Cause Readmissions
12. **Immunizations for Adolescents**
13. CAHPS Health Plan Survey, Version 5.0 (Medicaid and Commercial): Getting Needed Care

NCQA race and ethnicity stratification effective MY2022 or 2023

Strategies

REQUIREMENTS TO ATTAIN NCQA ACCREDITATION

2023

Covered California requires NCQA Health Equity Accreditation

2024

Covered California requires NCQA Health Plan Accreditation

2026

DMHC & DHCS require NCQA Health Plan Accreditation

COVERED CALIFORNIA DISPARITIES INTERVENTIONS EVOLUTION

Disparities Interventions 2017– 2020

Requirement

- Covered California and health plans jointly select 1-2 disparity measures for intervention

Activities

- Interventions focused on depression, diabetes, and hypertension
- All plans submitted interventions, milestones and outcomes targets

Challenges

- Significant variation in data sources, quality, completeness
- Interventions extremely limited in scope, often not evidence based, with very small denominators

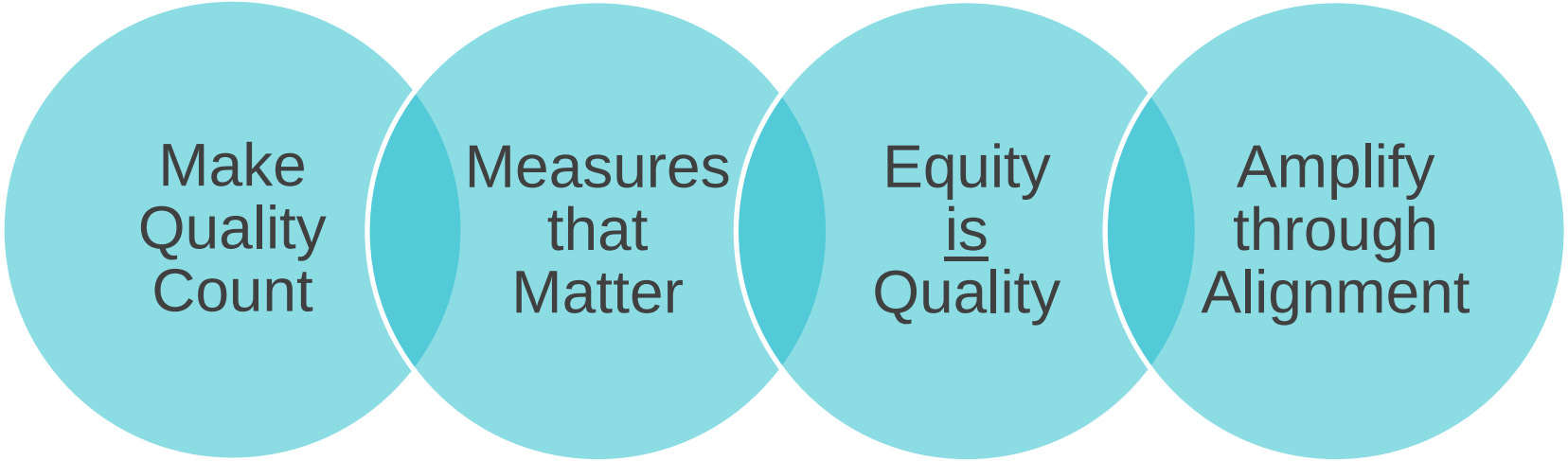
Disparities Interventions 2021– 2022

- Renewed sense of urgency with COVID-19, need for new approach
- Decision to provide more technical assistance and oversight on both data and implementation plan
- Health plans participated in five learning sessions focused on capacity building
  - Introduction, Linking Quality and Equity
  - Best Practices for Engaging with Patients, Providers, and Communities
  - Diagnosing the Disparity: Root Cause Analysis
  - Intervention Design and Implementation
  - Measurement: Data, Performance Metrics, Value-Based Payment
- Health plans submitted revised disparity intervention plans with specific intervention components

COVERED CALIFORNIA CHALLENGES AND LESSONS LEARNED

- Persistent gaps in member race and ethnicity data due to voluntary reporting and issuer dependence on imputation methodology
- Best practice of using DHCS Patient Level Data (PLD) file submission process challenged by vendor arrangements
- Small numbers when stratifying by race and ethnicity means some plans need to use two years of data or combine on and off-Exchange for baseline measurement
- Limitations in use of administrative data for intervention population identification and measurement can be addressed with data completeness thresholds
- Lack of benchmarks for performance measurement can be addressed with implementation of HEDIS measure stratification
- QHP issuers benefit from collaborative learning and technical assistance, though progress remains slow and resource-intensive despite issuer engagement and commitment

AIMING HIGH: QUALITY TRANSFORMATION INITIATIVE PRINCIPLES



0.8% up to maximum of 4% premium at risk for…

...a small set of clinically important measures…

…stratified by race/ethnicity…

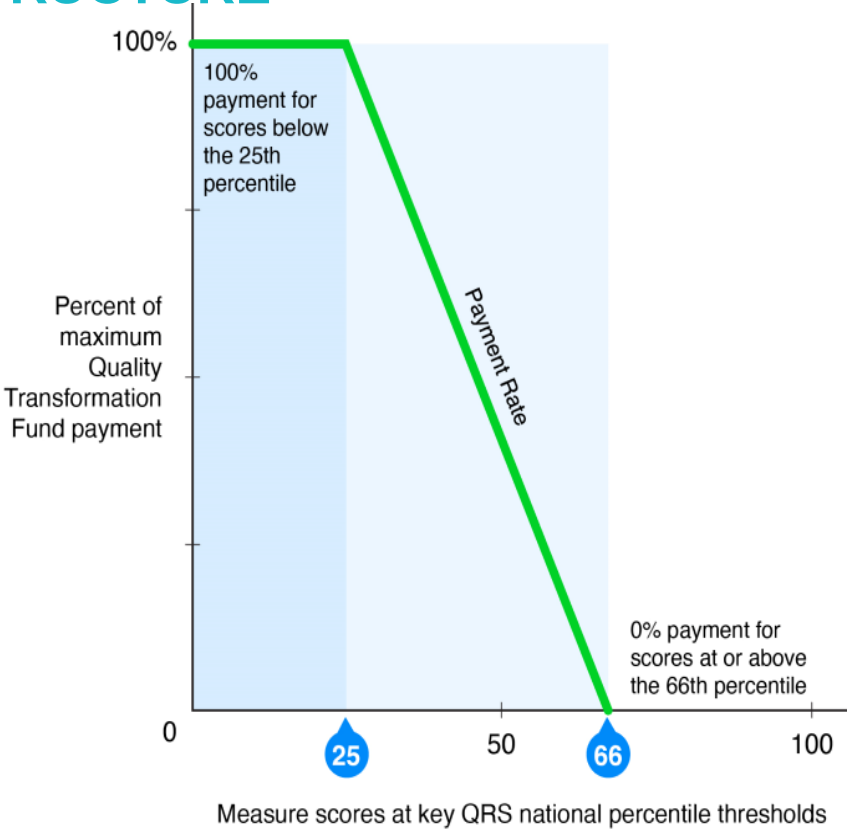
…selected in concert with other public purchasers.

AIMING HIGH: QUALITY TRANSFORMATION INITIATIVE MEASURES

Core Measures*	Clinical Context
Blood Pressure	Key risk factor for cardiovascular disease (heart attacks and strokes), the leading cause of death in the United States
Diabetes (A1c control)	~50% Californians have prediabetes or diabetes, which is a leading cause of blindness and amputation and key risk factor for cardiovascular disease.
Colorectal Cancer Screening	Cancer is the second leading cause of death after heart disease, and colorectal cancer is the second leading cause of cancer death after lung cancer. Screening reduces the risk of developing and dying from CRC cancer by 60-70%.
Childhood Immunizations	Childhood immunizations prevent 10.5m diseases annually. For every $1 spent on immunizations, there is as much as $29 in savings.
Reporting only	Depression Screening and Follow-Up for Adolescents and Adults
Reporting only	Medication Treatment for Opioid Abuse

*All measures stratified by race/ethnicity.

AIMING HIGH: QUALITY TRANSFORMATION INITIATIVE PAYMENT STRUCTURE



- Full per measure payment if the measure score is below the 25th national percentile
- Per measure payment at a declining constant rate for each measure score at or above the 25th and up to the 66th national percentile
- No payment if the measure score is at or above the 66th national percentile
- This payment structure will be applied for each reportable QTI core measure

First measurement year 2023
First results assessed 2024
First payments 2025

COVERED CALIFORNIA FUTURE DIRECTIONS

2023 – 2025 model contract implementation

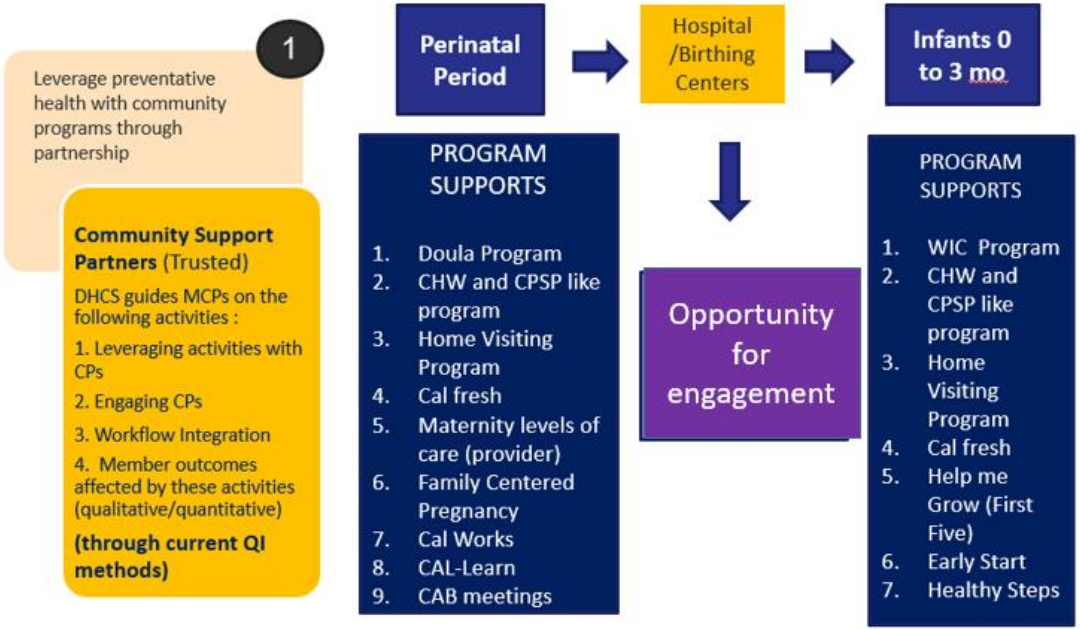
- Quality Transformation Initiative
- Healthcare Evidence Initiative
- Focus on disparities, primary care spend and payment, advanced primary care measure set, behavioral health access and quality
- New oral health measures, enhanced social needs screening

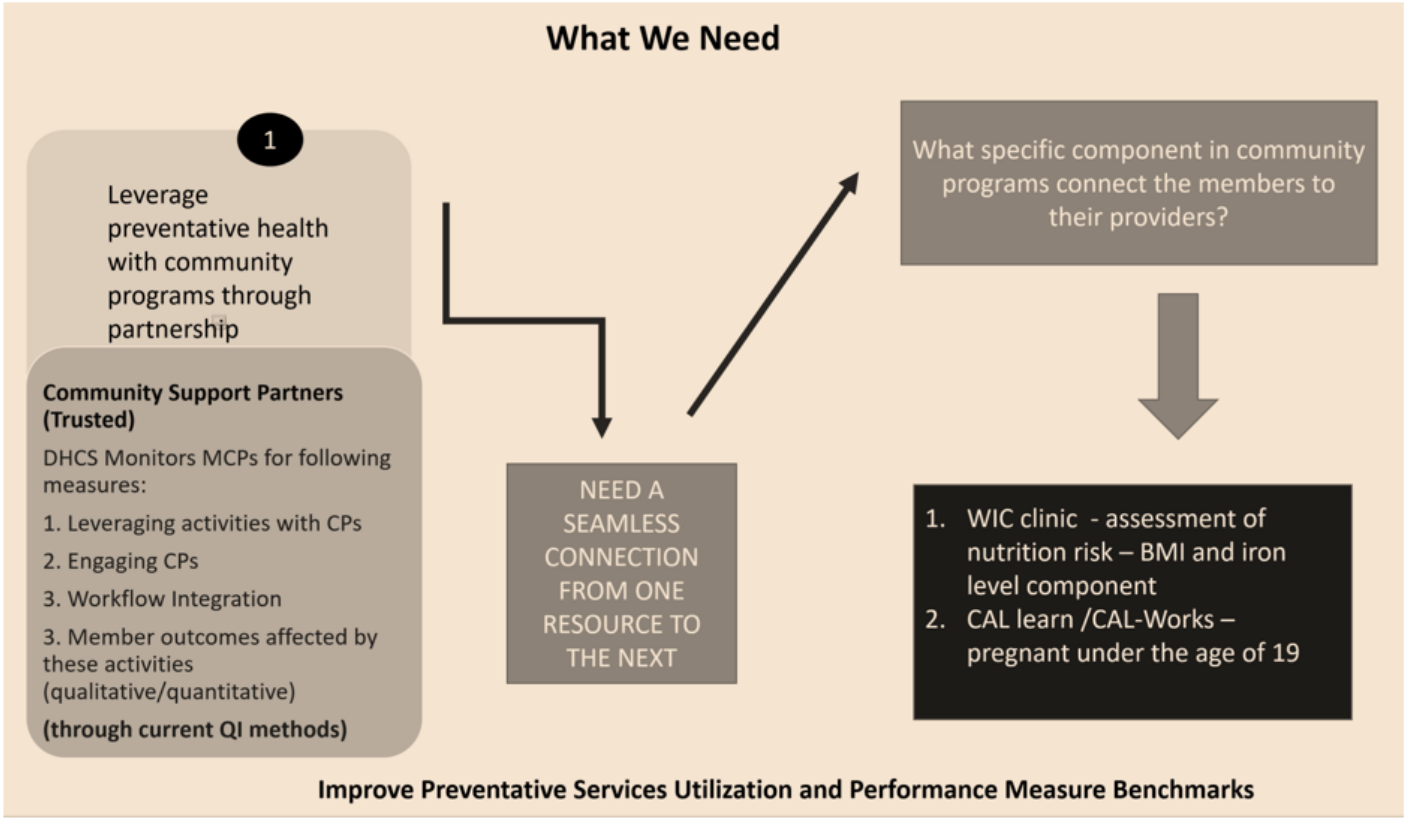
Areas for exploration

- Expanding demographic data collection to sexual orientation, gender identity, disability status
- Alignment with other state departmental efforts on affordability

Multi-Pronged Strategy

Improving Preventive Services Utilization & Performance Measures





Affects the following Domains:

1. Children
2. Reproductive
3. Maternal
4. Cancer Screening
5. Psychotropic and Opioid Management
6. Behavioral
7. Long Term

2

Family / Dyad- based activities/interventions

Family Unit Intervention (trusted)

DHCS monitors MCPs for the following measures:

1. Family unit engagement activities and progress
2. Improving Referral Structures for easy care access
3. Local preventative care and coordination activities

(through current QI methods)

Postpartum and Infants 0 to 3 mo

PROGRAM SUPPORTS

1. WIC Program
2. CHW and CPSP like program
3. Home Visiting Program
4. Cal Fresh
5. Help me Grow (First Five)
6. Early Start
7. Healthy Steps

Postpartum support lacking and only public health county based programs exist

PMAD blue dot program , Father Corps (Alameda county)

2

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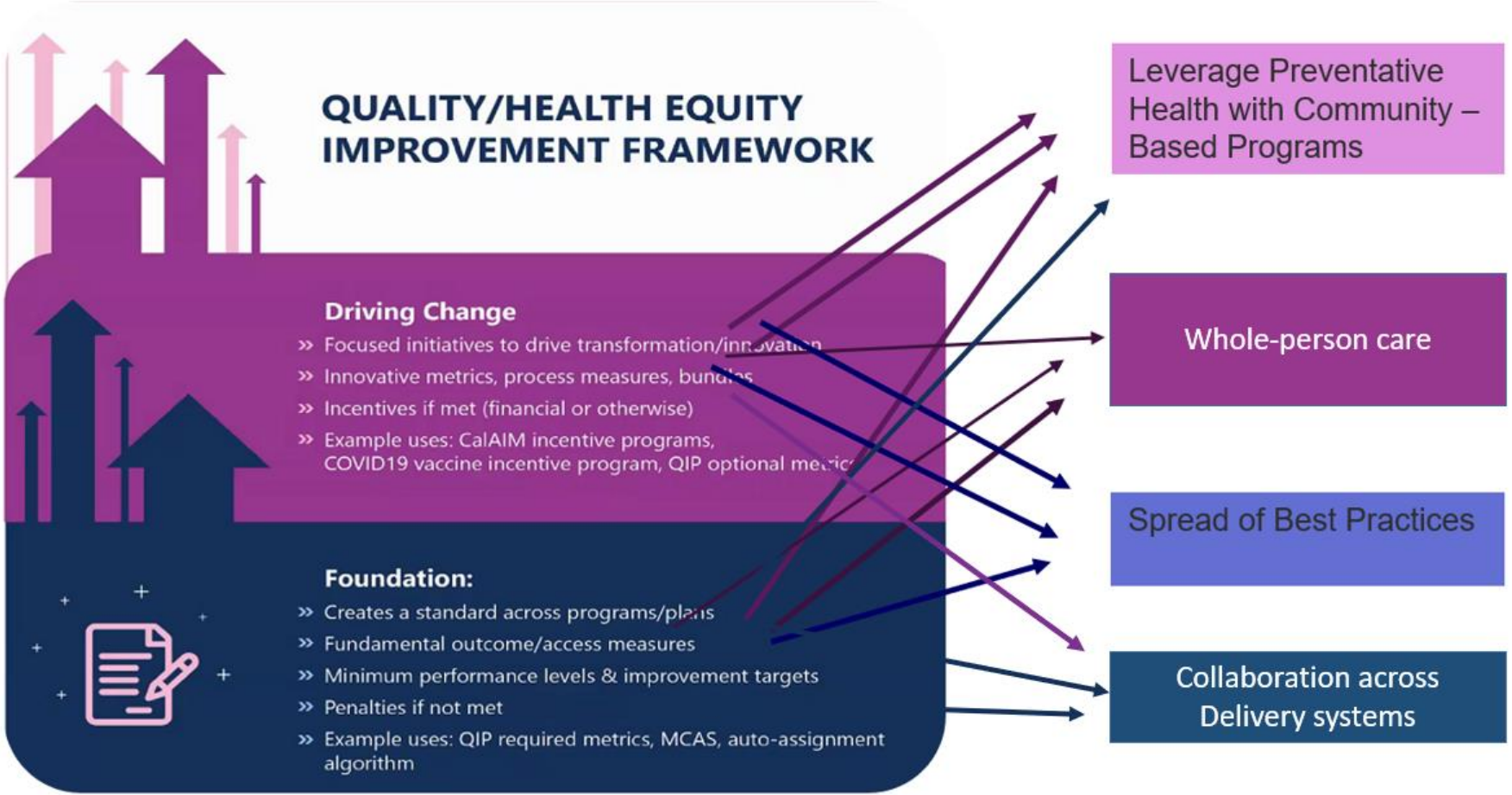
Postpartum and 0 to 3 mo.

Data support: Are hard-to-reach members (frequent gap in care appearances) receiving ECM or CM?

CHW Utilization: Specific wrap around care approach

Bundling of measures: Orchestrated approaches that allow members to seek and receive preventative care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Leverage Preventative Health with Community – Based Programs
Whole-person care
Spread of Best Practices
Collaboration across Delivery systems

Statewide Alignment

Discussion Questions

- How is your organization aligning efforts with the state partners' identified clinical focus areas and health equity goals?
- How are you driving whole-person care for your Members?
- What are some areas where you would like the state partners to focus?
- How can we collaborate to align our focus areas with your organization's in promoting higher quality and equitable services?