

Improving Collection, Reporting, and Utilization of Beneficiary Demographic Data

Recommendation: Medi-Cal managed care plans (MCPs) and providers can improve health care quality and advance health equity by strengthening self-reported granular data collection, reporting, and utilization of Medi-Cal beneficiary demographic data (e.g. race, ethnicity, language, functional disability, sex, sexual orientation and gender identity) and implementing quality improvement activities to address identified disparities.

Background: The success of DHCS' proposed population health management (PHM) strategy under the Medi-Cal Healthier for all California framework is contingent on the ability of MCPs to improve their demographic data collection and reporting. Under the proposed initiative, MCPs will be required to "identify and assess member risks and needs," and "identify and mitigate social determinants of health." DHCS' own health care disparities reports show that MCPs still have a long way to go to improve beneficiary demographic data collection in order to make the data is actionable.ⁱⁱⁱ Failure to improve demographic data collection could negatively impact health outcomes by exacerbating the disparities Medi-Cal is attempting to address.^{iv}

The California Department of Health Care Services (DHCS) can catalyze improvements in this area through a number of strategies including stricter contract requirements and the availability of financial incentives tied to achievement of specific data collection targets and health disparities reduction goals, such as DHCS' PRIME initiativeⁱ and Covered California's contract with its qualified health plans (QHPs) (Attachment 7).ⁱⁱ These strategies would identify and reduce disparities, and advance health equity.

Problem/Community Evidence

Improving health and health care requires a focus on ensuring equity in access, treatments, and outcomes. Health equity is realized when each individual has a fair opportunity to achieve their full health potential.^v In California, disparities are well-documented and persist by race, ethnicity, language, disability status, sexual orientation and gender identity, among other socio-economic factors. In California, Latinos and African Americans have twice the prevalence of **type 2 diabetes** and are twice as likely to die from the disease.^{vi} **Maternal mortality** rates for Blacks are persistently higher than those for Whites.^{vii} Infant deaths due to **sudden infant death syndrome (SIDS)** and sudden unexpected infant death (SUID) were both three times higher for American Indian Alaska Native (AIAN) infants compared to California infants overall.^{viii}

Despite a growing awareness, communities of color continue to experience persistent disparities in the quality of care they receive. According to a 2018 Agency for Healthcare Research and Quality (AHRQ) report:

- Blacks, American Indians and Alaska Natives (AI/ANs), and Native Hawaiians/Pacific Islanders (NHPIs) received worse care than Whites for about 40% of quality measures
- Hispanics received worse care than Whites for about 35% of quality measures
- Asians received worse care than Whites for 27% of quality measures^{ix}

CPEHN partnered with community based organizations in 2019 to learn more about the experiences of diverse individuals and caregivers in accessing quality, culturally and linguistically appropriate care. The stories people told about their experiences echo well-documented data on disparate treatment:

From CPEHN's consumer focus groups:

“When you speak English they attend to you right away. When you speak Spanish they seem to say they have only limited amounts of appointments.”

– Latin participant

“When I go to XX as a Medi-Cal patient, I feel like they treat me differently. I feel like I can't be honest with them. But when I go to my native health clinic, I tell my doctor everything.”

– Native American participant

“I had a gastritis issue, so I can't eat pork. So I go to the doctor's...but when they took a look at me they started asking if I was on narcotics. They thought I was on drugs.”

– African-American participant

“I had to choose from a list of providers. After meeting with one and telling her my story, she suggested a specific provider that specializes and works well with gay men's health.”

– LGBTQ+ participant

Solution/Best Practice:

To reduce health disparities, Medi-Cal MCPs and providers must explicitly document and measure the existence of disparities and target resources towards eliminating them. Kaiser Permanente's utilization of beneficiary data in its research about the prevalence of diabetes among Asian Americans and Pacific Islanders with lower body mass indexes (BMIs)^x was part of the evidence that resulted in the American Diabetes Association changing its screening guidelines to recommend screening of Asian Americans for diabetes at a lower BMI (of 23).^{xi} A national campaign has been launched to encourage increased diabetes screening among Asian Americans, which will identify

more cases and get those patients into treatment before complications develop.^{xii}

There is also strong evidence that more granular data collection can help to improve health outcomes. An initiative launched by Kaiser Permanente in 2010, called Equitable Care Health Outcomes (ECHO), helped the plan develop targeted, effective interventions aimed at improving hypertension control in African Americans, colorectal cancer screening for Hispanics/Latinos, and diabetes control for both Hispanic/Latinos and African Americans (HgbA1C<8).^{xiii} Not only were gaps in hypertension, diabetes, and colorectal screenings reduced through this project, but the interventions such as culturally tailored communications, that were developed for disparities reduction were adopted system-wide, with benefits for all Kaiser's enrollees.

Both Medi-Cal and Covered California have begun to implement pay for performance strategies involving both providers and plans aimed at strengthening the collection and reporting of demographic data with promising results:

Medi-Cal's Public Hospital Redesign and Incentive Medi-Cal (PRIME) 1115 waiver demonstration program:

In 2015, DHCS included requirements for the state's public health care systems to improve the collection and stratification of detailed race, ethnicity, and language (REAL) data and collect sexual orientation and gender identity (SOGI) data as part of California's Medi-Cal waiver.^{xiv} For REAL data, public health care systems had to identify a disparity, implement an intervention to reduce the disparity, and demonstrate year-over-year improvement throughout the five-year PRIME program. Public health care systems have made significant advancements in their ability to collect detailed REAL and SOGI data. PRIME helped advance data collection efforts so that public health care systems could better identify the diversity of their patients and provide more tailored care. By the end of

program year three, **public health care systems collected detailed REAL data for more than 638,000 patients and SOGI data on 279,000 patients. Thirteen out of seventeen DPHs met their annual improvement target for their selected data collection metric and disparity population.**^{xv}

Covered California Qualified Health Plan (QHP) contracts:

Since 2017, health plans in Covered California are required to reduce health disparities and promote health equity by: (1) identifying the race/ethnicity of all enrollees; (2) collecting data on diabetes, hypertension, asthma and depression to measure how quality varies by race/ethnicity; (3) conducting population health-improvement activities and interventions to narrow observed disparities in care; and (4) promoting community health initiatives that foster better health, healthier environments, and promote healthy behaviors. In response to contractual requirements, **93 percent of Covered California enrollees are in plans that were at or above the 80 percent requirement for enrollee self-identification of race/ethnicity.**^{xvi} All 11 insurers are analyzing disparities in care for patients with diabetes, hypertension, asthma and depression for all of their lines of business, not just Covered California, and planning targeted interventions. A new law signed in 2019 clarifies that Covered California plans must provide enrollee data for all of their commercial members including those in the individual and small group markets “in a manner that allows for an analysis by demographic subpopulations.”^{xvii} This new data will help to improve the ability of Covered California and health plans to provide more targeted interventions to address identified disparities.

Moreover, the federal Health Resources and Services Administration has required federally qualified health centers (FQHCs) to collect data about the race, ethnicity, language, sexual orientation, and gender identity of their patients served. Since FQHCs, along with the public hospital outpatient clinics, are important providers in all Medi-Cal MCPs networks, there already is a strong foundation for, and significant experience in, such

demographic data collection.

Considerations:

Through these various initiatives, the health care field is taking important steps towards resolving differences in demographic data collection and reporting across different types of coverage. Not surprisingly, integrated health systems that are able to access more robust data, may have an easier time identifying disparities from which to drive quality improvement interventions. In recognition of the greater effort involved for insurers to collect REAL data, health care purchasers like Covered California and DHCS must emphasize both plan obligations and plan capacity. DHCS should continue to enforce laws and requirements for health plans to provide equitable, patient-centered care while at the same establishing an initial focus upon and ongoing investment in technology that will allow plans, providers, and patients to securely share personal health information, including demographic data, electronically. A centralized method of demographic data collection and sharing will enable plans and providers that are not fully integrated health systems to better track and trend the impact of quality improvement efforts for all Medi-Cal beneficiaries.

Accurate collection of beneficiary demographic data is also important for the successful and unbiased implementation of DHCS’ population health management (PHM) strategy. The PHM strategy requires health plans to manage and assess patient risk in order to target appropriate interventions. While predictive analysis may hold promise, many PHM algorithms for assessing risk are biased when plans and purchasers focus primarily on health care cost and utilization despite known disparities in access to care.^{xviii} Ample data has shown, for example, that African-Americans experience lower access to treatment, both because of provider bias, lack of trust, and other barriers to access.^{xix} PHM strategies that will be effective for diverse Medi-Cal beneficiaries must include adjustments based on demographic data, and

for social and behavioral risks.^{xx,xxi} There are assessment tools such as PRAPARE^{xxii} and trauma screenings^{xxiii, xxiv} that collect data about social and behavioral risk factors that can be used in implementing a comprehensive PHM strategy.

Recommendations:

To improve health care quality and advance health equity, DHCS should:

- Set year-over-year targets and provide financial incentives for MCP self-reported demographic data collection, reporting, and utilization; and elimination of health disparities through MCP Performance Improvement Plans (PIPs).
- Require MCPs to include beneficiary demographic data, and adjust for social and behavioral risks, in implementing population health management (PHM) interventions.
- Require and incentivize provider adoption of the updated 2015 Edition Electronic Health Record (EHR) Certification criteria as part of DHCS' new Value Based Payment program.^{xxv}
- Continue to support a statewide electronic health information exchange that includes electronic exchange of patient demographic data to address drivers of good and poor health; seek federal funds where available to support interoperability and data connections.
- Require MCPs to continue the progress of the Medi-Cal PRIME project through a sustained investment in safety-net data tracking and reporting and efforts to eliminate health disparities.

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Sources:

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