Joint Hearing of the Senate and Assembly Health Committees
Informational Hearing – Health Disparities in California
March 11, 2015 - 1:30 p.m.
State Capitol, Room 4203

Purpose

This joint hearing of the Senate and Assembly Committees on Health will serve to educate the Legislature and the public about what health disparities are, how some Affordable Care Act (ACA) payment reforms might exacerbate disparities, what disparities look like for the majority of Californians, and how the Department of Health Care Services (DHCS), Department of Public Health (DPH), Covered California, and health care partners should be identifying and addressing those disparities.

Health Care Disparities

Broadly, health disparities exist when there are variances in disease frequency, treatment, or mortality among various socio-economic groups, but there is currently no consensus definition. According to the Health Services Research Community of the National Institutes of Health, health *care* disparities refer to differences in access to or availability of facilities and services. Health *status* disparities refer to the variation in rates of disease occurrence and disabilities between socioeconomic and/or geographically defined population groups. Health disparities have been measured between those of a different race, ethnicity, gender, sexual orientation, age, ability, religion, socioeconomic status, language proficiency, and geographic location.

The Institute of Medicine (IOM), in a 2002 report entitled "Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care," found that a consistent body of research demonstrates significant variation in the rates of medical procedures by race, even when insurance status, income, age, and severity of conditions are comparable. This research indicates that U.S. racial and ethnic minorities are less likely to receive even routine medical procedures and experience a lower quality of health services. For example, minorities are less likely to be given appropriate cardiac medications or to undergo bypass surgery, and are less likely to receive

kidney dialysis or transplants. By contrast, they are more likely to receive certain less-desirable procedures, such as lower limb amputations for diabetes and other conditions.

There are many documented health disparities among ethnic groups in California. A 2010 report by the Office of Statewide Health Planning and Development (OSHPD) showed that African Americans were two to three times more likely than other populations to be hospitalized for 14 of the preventable health conditions studied, including diabetes, asthma, and heart disease. They were also more likely to have children with a low birth weight. Hispanics had the second highest rates of hospitalization for 10 of 16 preventable measures, including short-term and long-term complications from diabetes, pediatric and adult asthma, hypertension, congestive heart failure, and urinary tract infections. Hispanics also had the highest admission rate for severe vomiting and/or severe diarrhea in children. Asian/Pacific Islanders had the highest death rates for heart attack, stroke, pneumonia, and cardiovascular treatments of coronary artery bypass graft surgery and coronary artery treatment, whereas whites had the highest mortality rates for congestive heart failure. African Americans and Native Americans have at least twice the rate of diabetes as whites, and Latinos and African Americans have over twice the rate of preventable hospital admissions for diabetes with long-term complications as whites.

Many racial and ethnic minorities, people with disabilities, lesbian, gay, bisexual, and transgender (LGBT) communities face unique health challenges, have reduced access to health care and insurance, and often have poorer health throughout their lives. For example, research suggests LGBT people and families may face significant challenges associated with health disparities in insurance coverage and access to health care services, including preventive care such as cancer screenings. An Institute of Medicine (IOM) report from 2011emphasized the need for collection of gender identity and sexual orientation data on federally supported surveys. Consistent methods for collecting and reporting health data increase understanding of the nature of health problems in the LGBT community.

According to an Asian and Pacific Islander American Health Forum Report in 2010, in California, data available for Asian Americans (AA) and Native Hawaiians/Pacific Islanders (NHPI) lag far behind data on other racial/ethnic groups. In addition, aggregated AA and NHPI data fail to capture the diversity and differences across subgroups. For example, in the 1980s and 1990s, aggregated AA and NHPI data showed that the group had the lowest incidence of breast cancer across races and ethnicities, and the belief at the time was that "Asian women don't get breast cancer". However, subsequent studies showed that Native Hawaiian women had a very high incidence of breast cancer, second only to white women, whereas Korean women had a very low incidence. The high risk for Native Hawaiians was hidden by the aggregation of data. Asian subpopulations also have varying socioeconomic statuses, which is a large predictor of health access. In 2010, the Asian & Pacific Islander American Health Forum stated that support for new primary data collection and longitudinal studies are needed to fully capture the diverse social and health assets and needs faced by all the AA and NHPI communities.

Unintended Effects of Some ACA Payment Reforms

The ACA also established the Hospital Value Based Purchasing (VBP) Program, which affects payment for inpatient stays in 2,985 hospitals across the country. Under VBP program, Medicare makes incentive payments to hospitals based on how well they perform in 24 different measures,

or how much they improve their performance compared to a baseline period. The measures fall into four domains: Clinical Process of Care, Patient Experience of Care, Outcome, and Efficiency. Clinical Process of Care measures include timely and appropriate administration of medication, procedures, tests, and prophylaxis, achievement of healthy post-operative serum levels, and delivery of discharge instructions. Patient Experience of Care measures a patient's perception of communication with care providers, the responsiveness of staff, pain management, communication about medicines, the cleanliness and quietness of hospitals, reception of discharge information, and the overall hospital rating. Outcome Domains measure medical complications, infections stemming from central-line placement, and the mortality rate of patients with acute myocardial infarction, heart failure, and pneumonia. The Efficiency Domain measures Medicare spending per beneficiary.

Efforts to reward hospitals for improving quality of care have led to financial penalties at many safety-net hospitals. A 2014 article in *Health Affairs* showed that hospitals treating low-income patients were more likely to be penalized under the VBP program, the Hospital Readmission Reduction Program, and criteria for the meaningful use of electronic health records. The article indicates that safety-net hospitals are likely to remain the provider of choice for uninsured people and possibly those who are newly covered under Medicaid expansion because of the hospitals' historic missions, cultural competencies, and experience serving lower-income populations. Illness severity and social challenges that affect health—an especially important issue at safety-net hospitals—might not be fully captured in the financial models that are designed to reallocate a proportion of payments between hospitals to reward quality, according to the article. Some advocates believe that higher health disparities among patients at safety-net hospitals are largely responsible for reduced quality outcomes, and financial penalties may exacerbate the fiscal pressures these hospitals face.

Disparities and Data in Medi-Cal

The number of individuals enrolled in California's Medi-Cal program has almost doubled, increasing from 6.6 million in Fiscal Year (FY) 2007–08 to 11.9 million in FY 2014-15. Sixty-seven percent of Medi-Cal beneficiaries are from communities of color, and 35 percent speak English less than very well. Approximately 43 percent of Medi-Cal enrollees speak a language other than English. Currently, Medi-Cal managed care plans analyze and report to DHCS on the Healthcare Effectiveness Data and Information Set (HEDIS) measures, a tool used by more than 90 percent of U.S. health plans to measure performance on care and service. Additionally, demographic data, including race, ethnicity, and primary language, is collected at the time of enrollment in the Medi-Cal program. Racial and ethnic health disparities are prevalent and pervasive. A 2013 report by DHCS compared Medi-Cal patients to the general California population in a number of indicators. Medi-Cal patients were more likely to have a higher infant mortality rate, drink sweetened beverages, eat fewer fruits and vegetables, be obese, be readmitted to the hospital due to complications, and acquire hospital-borne (nosocomial) conditions.

DHCS currently reports on a variety of measures, some of which are unique to a specific population or initiative and others that apply more generally. Two of the quality measures are the External Accountability Set (EAS) and HEDIS.

EAS. The federal Centers for Medicare and Medicaid Services (CMS) requires that states, through their contracts with Medi-Cal managed care plans, measure and report on performance to assess the quality and appropriateness of care and services provided to members. In response, DHCS implemented a monitoring system that is intended to provide an objective, comparative review of health plan quality-of-care outcomes and performance measures called EAS. DHCS designates EAS performance measures on an annual basis and requires plans to report on them. DHCS uses HEDIS measures as the primary tool (HEDIS is described below). Currently required HEDIS measures include well child visits, immunizations, comprehensive diabetes care, and annual monitoring of patients on persistent medications. For 2013, Medi-Cal managed care plans will be reporting on 14 HEDIS measures. In addition, DHCS is requiring one customized measure for determining rates of hospital readmissions within 30 days of discharge.

HEDIS. HEDIS is a standardized set of performance measures used to provide health care purchasers, consumers, and others with a reliable comparison between health plans. HEDIS data are often used to produce health plan "report cards," analyze quality improvement activities, and benchmark performance. The National Committee for Quality Assurance classifies the broad range of HEDIS measures across eight domains of care: effectiveness of care; access/availability of care; satisfaction with the experience of care; use of services; cost of care; health plan descriptive information; health plan stability; and informed health care choices. DHCS and plans use plan-specific data, aggregate data, and comparisons to state and national benchmarks to identify opportunities for improvement, analyze performance, and assess whether previously implemented interventions were effective.

Prior to being transitioned to the Medi-Cal program, the Healthy Families Program (HFP) was administered by the Managed Risk Medical Insurance Board (MRMIB). MRMIB required its HFP-health and dental plans to ensure that access to quality health care was provided to enrollees and used HEDIS data in annual reports. MRMIB provided HEDIS results subscribers in enrollment materials, including the program handbook, so that families could use the information to compare health plan performance in areas important to them. HEDIS results were also used by MRMIB to monitor plan performance and to inform decision-making regarding quality improvement activities and health plan participation in HFP. Medi-Cal does not analyze and report the HEDIS data from its contracting plans in the same way and does not require the plans to report the data in a way that would allow similar analysis. Requiring Medi-Cal managed care plans to analyze utilization, quality, and outcome data by race, ethnicity, gender, and primary language may help these plans better understand the specific needs of their members, allowing them to develop culturally and linguistically appropriate interventions, to allocate resources more effectively, and ultimately to reduce historic health disparities that communities of color face.

California's Efforts

Let's Get Healthy Task Force

In May 2012, Governor Jerry Brown established the Let's Get Healthy California Task Force (Task Force) to develop a 10-year plan for improving the health of Californians, controlling health care costs, promoting personal responsibility for individual health, and advancing health equity. The Executive Order directed the Task Force to issue a report with recommendations for

how the state can make progress toward becoming the healthiest state in the nation over the next decade. In the report, issued in December 2012, the Task Force developed an overarching framework, identifying six goals, organized under two strategic directions: Health Across the Lifespan and Pathways to Health. The Report states that the framework makes clear that health equity should be fully integrated across the entire effort. Many of the recommendations relate to the collection of additional data and refer to metrics similar to those used in HEDIS data.

DHCS Strategic Plan

In the fall of 2013, DHCS updated its Strategic Plan and released the *DHCS Strategy for Quality Improvement in Health Care*. DHCS also produced a set of fact sheets, *Health Disparities in the Medi-Cal Population*, to explore potential inequalities in various health indicators among Californians. DHCS used the 39 health indicators presented in the *Let's Get Healthy California Task Force Report* as a starting point for the fact sheets. According to DHCS at the time, more health topics would be examined, such as smoking among adolescents and adults, nonfatal child maltreatment, diabetes prevalence, and hospice enrollment. DHCS also stated that other social strata and groups would be explored.

DHCS recently indicated that, beginning in FY 2015-2016, it will stratify quality measures by demographic factors. Their goal is to focus quality improvement efforts to eliminate heath disparities and improve quality overall. DHCS is in the process of identifying initial measures to conduct this analysis. Another demographic analysis currently conducted by DHCS is the use of managed care plan grievances and appeals data. DHCS is able to determine if an over-prevalence of grievances and/or appeals exists among a specific demographic group. DHCS has previously collected race and/or ethnicity data when conducting the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey. This survey is a measure of beneficiary satisfaction. DHCS reports they will continue to conduct this analysis by race and/or ethnicity and use the CAHPS survey to collect additional demographic factors.

1115 Waiver Renewal

As part of the 1115 Waiver, the Delivery System Reform Incentive Pool (DSRIP) program is a pay-for-performance incentive program for the 21 designated public hospitals in California. The current DSRIP program, ending October 2016, offers designated public hospitals incentive for the collection of Race, Ethnicity, and Language (REAL) data for purposes of addressing health disparities in the hospital system. DHCS is in the process of developing a new1115 Waiver renewal, which will include a DSRIP 2.0 and other measures-focused concepts that will require measurement and monitoring of Medi-Cal plans and providers, including safety net hospitals.

Also, as part of the state's 1115 Waiver renewal stakeholder process, the California Pan-Ethnic Health Network, SEIU, and Health Access have developed a proposal to pay for reductions in significant health disparities impacting people of color on Medi-Cal, which would require the identification and development of incentive payments for improvements to reduce disparities by health plan within six target areas of known racial or ethnic-related disparities:

- Diabetes care (e.g. to address racial disparities related to amputations)
- Child and maternal health (e.g. to address infant and maternal mortality rates)
- Asthma (e.g. to address avoidable emergency room visits)
- Hypertension and congestive heart failure (e.g. to reduce avoidable admissions)

- Behavioral health (e.g. to address lags in screening)
- Readmissions (e.g. to eliminate disparities in avoidable readmissions and hospital acquired infections)

Another waiver proposal would make better use of nontraditional providers (community health workers, navigators, promotoras, advanced IHSS workers, and peer counselors) to free up more time for provider visits; teach newly covered or assigned patients how to use their coverage or navigate the health system; conduct home visits and provide frequent follow-up and support; and attend clinical visits with patients to help understand and reinforce care plans. The proposal would also improve culturally and linguistically competent care by hiring a workforce from within the communities they serve. Advocates hope that approaches such as these will also bring a health disparities and equity focus to a broader cross-section of policy discussions (such as Triple Aims, payment reforms, data collection and reporting, quality monitoring) and improve transparency around disparities, such as requiring payers, plans, and providers to collect sociodemographic data; requiring public payers to stratify plan quality reporting by sociodemographic factors; and requiring DHCS and Covered California to develop a plan and mechanisms to target the identification and elimination of addressable disparities.

DPH Office of Health Equity

The Office of Health Equity (OHE) was established within DPH in 2013 to focus on those who have experienced socioeconomic disadvantage and historical injustice, including vulnerable communities and culturally, linguistically, and geographically isolated communities. According to the OHE website, a priority of OHE is the building of cross-sectoral partnerships. OHE consults with community-based organizations and local government agencies to ensure that community perspectives and input are included in policies and any strategic plans, recommendations, and implementation activities. Aligning state resources, decision making, and programs, OHE is charged with the following:

- Achieve the highest level of health and mental health for all people, with special attention focused on those who have experienced socioeconomic disadvantage and historical injustice, including, but not limited to, vulnerable communities and culturally, linguistically, and geographically isolated communities.
- Work collaboratively with the Health in All Policies Task Force to promote work to prevent injury and illness through improved social and environmental factors that promote health and mental health.
- Advise and assist other state departments in their mission to increase access to, and the quality of, culturally and linguistically competent health and mental health care and services.
- Improve the health status of all populations and places, with a priority on eliminating health and mental health disparities and inequities.

Covered California

Covered California has stated that one of its missions is to reduce health disparities, and that it recognizes the diverse cultural, language, economic, educational, and health status needs of those they serve. Their ongoing outreach initiatives include efforts to enroll underserved beneficiaries. Covered California runs the Community Outreach Network, which partners with local organizations across California to provide information, resources, and training. Community

Outreach Network partners include organizations devoted to serving at-risk populations, including African Americans, Asians and Asian sub-populations, LGBT, immigrants, Mexican Americas, HIV and AIDS patients, and Native Americans. Partners distribute materials, provide outreach and enrollment assistance, and are compensated by Covered California for each application that leads to a purchase. Covered California has also awarded $43 million in grants to organizations that have trusted relationships with culturally and linguistically diverse uninsured markets.

Conclusion

California's implementation of the ACA has increased access and affordability for a large portion of our poorest communities. However, disparities and inequities among all populations, through gaps in coverage, cultural barriers, and implicit biases, prevent many Californians from becoming and staying healthy. Efforts to reward hospitals for high quality care can unintentionally penalize institutions that treat underserved patients, further exacerbating the problem. More stringent and detailed data collection will help identify health disparities so they can be addressed effectively. Continued efforts by public and private institutions will be necessary for identifying and addressing health disparities in California.