DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-25-26
Baltimore, Maryland 21244-1850

State Demonstrations Group

December 20, 2023

Michelle Baass
Director & State Interim Medicaid Director
California Department of Health Care Services
1501 Capital Avenue, 6th Floor, MS 0000
Sacramento, CA 95814

Dear Director Baass:

The Centers for Medicare & Medicaid Services (CMS) completed its review of the Global Payment Program (GPP) Health Equity Monitoring Metrics Protocol, which is required by the Special Terms and Conditions (STC), specifically, STC #14.9, of the California section 1115 demonstration, "California Advancing and Innovating Medi-Cal (CalAIM) Demonstration" (Project No: 11-W-00193/9), effective through December 31, 2026. CMS determined that the GPP Health Equity Monitoring Metrics Protocol, which was submitted on March 29, 2022 and revised on November 7, 2023, meets the requirements set forth in the STCs, and thereby approves the state's GPP Health Equity Monitoring Metrics Protocol.

The Protocol is approved for the demonstration period through December 31, 2026, and is hereby incorporated into the demonstration STCs as Attachment M (see attached). In accordance with STC #16.11, the approved GPP Health Equity Monitoring Metrics Protocol may now be posted to your state's Medicaid website.

We look forward to our continued partnership on the CalAIM section 1115 demonstration. If you have any questions, please contact your CMS demonstration team.

Sincerely,

[redacted]

Danielle Daly
Director
Division of Demonstration Monitoring and Evaluation

cc: Cheryl Young, State Monitoring Lead, CMS Medicaid and CHIP Operations Group

Attachment M

GPP Health Equity Monitoring Metrics Protocol

A. Health Equity within GPP

GPP provides support to Public Health Care Systems (PHCS) for the delivery of more cost-effective and higher value care for indigent, uninsured individuals. PHCS are comprised of a designated public hospital and its affiliated and contracted providers. Each PHCS participating in the GPP is listed in Attachment C. Where multiple designated public hospitals are operated by the same legal entity, the PHCS includes multiple designated public hospitals, as set forth in Attachment C. In alignment with federal and state equity goals, PHCS will work with DHCS to advance equity through a Health Equity Monitoring Metrics Protocol that improves reporting for equity-related metrics and initiates evaluation of disparities within the GPP program, as described in detail below.

B. Expanded Reporting of Equity-Related Data Fields

PHCS will strengthen data reporting to allow for more robust stratification and improved evaluation of disparities. In the GPP reporting structure, PHCS currently report gender, race (one field), ethnicity, and zip code.[1] However, PHCS generally have the ability to collect more data than they are currently being asked to report in GPP. PHCS, in collaboration with DHCS, will implement the following changes in encounter-level data reporting in order to improve the ability to stratify and evaluate disparities within GPP.

1. The GPP reporting structure will be updated to:
   a. Add fields for multiple race categories, transitioning from the current structure that only allows for reporting of a single race category.
   b. Add a new field for Preferred Language.
   c. Add a new field for Sexual Orientation.
   d. Expand the values allowed for reporting of gender identity (to be determined) that align with other State data collection approaches for gender identity.[2]
2. PHCS will begin reporting these updated and new data fields beginning in 2023 for PY 8 and continuing through PY 12 on an annual basis as part of the existing GPP encounter data reporting process.
3. DHCS will work with PHCS to determine the detailed reporting specifications and update GPP reporting guidance accordingly. DHCS will monitor implementation of these changes in encounter-level data reporting and adjust data specifications as needed.

[1] Full RUCA coding requires complete addresses to determine census tracts and, from there, delineation of rural/urban status. GPP reporting includes only zip codes. However, there is a zip-code version of RUCA that approximates census tracts, which could be used in analyzing GPP zip codes data. DHCS can explore this option as part of the demonstration evaluation.

[2] The DHCS proposed stratification methodology for sexual orientation and gender identity (SOGI) is based on federal data standards for SOGI established by ONC during Meaningful Use (2015 Final Rule on Certified EHR Technology, pp 496-7) and approved by ONC in 2021 as part of (USCDIv2, pp12-13). This approach also aligns with the State's standards. DHCS will take into account any future guidance from CMS, as feasible.

C. Initiating Evaluation of Disparities

DHCS will begin exploring evaluation of disparities in GPP with the aid of more robust data reporting as described in Sections 1 and 2 below.

1. Stratified GPP Utilization Rates and Trends – PHCS and DHCS will evaluate stratified utilization rates and trends over time to determine whether care is shifting from acute settings to primary and preventive services, including non-traditional services – a key objective of the program and the subject of the initial GPP evaluation.
    a. The following two utilization metrics will be examined:
        i. Annual Utilization in selected GPP service categories stratified by race, ethnicity, language, sexual orientation, and/or gender identity
        ii. Annual Utilization trended over time (by GPP program year) in selected GPP service categories stratified by race, ethnicity, language, sexual orientation
    b. PHCS will be required to report utilization, stratified by race, ethnicity, and preferred language spoken (REAL) and sexual orientation and gender identity (SOGI), for selected GPP service categories of interest,[3] including but not limited to:
        i. Physical health: Inpatient, ER and Outpatient
        ii. Behavioral health: Inpatient, ER and Outpatient
        iii. Non-traditional services
        iv. Equity-enhancing services that will be added to GPP beginning in 2023[4]
    c. DHCS will analyze the stratified PHCS annual utilization data by comparing patterns by REAL and SOGI characteristics (within and across GPP service categories). DHCS will trend utilization over time to identify any desirable or undesirable changes. The types of analyses that DHCS conducts may change over time as DHCS becomes more familiar with the data and identifies patterns of interest.
    d. The list of utilization measures is subject to change, based on lessons learned in the initial years of reporting and other factors. Changes to the measures will be uniformly treated for all PHCS and is subject to DHCS approval.
2. Stratified Clinical Quality Measures
    a. PHCS and DHCS will work to identify five clinical quality metrics that are applicable to the GPP and that align as much as possible with goals outlined in the DHCS Comprehensive Quality Strategy submitted to CMS on February 4, 2022.

[3] The initial GPP evaluation identified these service categories as categories of interest to track, looking at whether acute care services (such as inpatient and emergency) utilization declines over time and outpatient (including non-traditional) utilization increases over time.

[4] The addition of the equity-enhancing services category was approved by CMS on 2/16/23 (Attachment L, Table 1). The equity-enhancing services category is effective beginning in Program Year 9 (2023); systems will first report these services in 2024, based on 2023 utilization. The equity-enhancing services were selected to mirror the new Medi-Cal Enhanced Care Management and Community Supports benefits that are available as part of CalAIM. Now that these benefits are available to Medi-Cal beneficiaries, the intention was to add these benefits as GPP services to make access to new benefits /services equitable across both populations.

b. Initial clinical quality measures that DHCS and PHCS have identified include:
    i. Colorectal Cancer Screening: CMS130v10 (UDS)
    ii. Controlling High Blood Pressure: CMS165v10 (UDS)
    iii. Diabetes: HbA1c Poor Control (> 9%): CMS122v10 (UDS)
    iv. Preventive Care and Screening: Screening for Depression and Follow-Up Plan (CMS2v11) (UDS)
    v. Coronary Artery Disease (CAD): ACE/ARB Therapy - Diabetes or LVSD (LVEF < 40%) QPP #118 MIPS CQM 2021 (MIPS)
c. The five quality of care measures were selected to align with the quality strategy goals of providing early interventions for rising risk and patient-centered chronic disease management as well as keeping families and communities healthy via prevention. These goals are outlined in the DHCS Comprehensive Quality Strategy (CQS) Report. In addition, although the measure addresses depression for the broader population, the Preventive Care and Screening: Screening for Depression and Follow-Up Plan measure aligns with the state level Bold Goal to improve maternal and adolescent depression screening by 50%.
d. The data used in reference to state and national disparities in these measures come from the DHCS 2021 Health Disparities Report, DHCS Health Disparities in the Medi-Cal Population Fact Sheets, AHRQ 2022 National Healthcare Quality and Disparities Reports, U.S. Department of HHS Office of Minority Health, National Center for Health Statistics, and other peer reviewed publications.
e. The list of clinical quality measures is subject to change, pending changes made to measures at the national level and other factors. Changes to the measures will be uniformly treated for all PHCS and is subject to DHCS approval.

3. DHCS will work with PHCS to develop reporting guidance for all measures, including adjusting metric specifications and identifying which stratifications will be reported for each measure. DHCS will also work with PHCS to interpret performance rates on the measures listed above, considering the challenges with applying national measures and benchmarks to a program like GPP, monitor performance and trends over time, and discuss improvement strategies, if needed, at the end of the waiver period.
4. PHCS will begin reporting these utilization rates and trends and clinical quality measures beginning in 2024 for PY 9 and continuing through PY 12 on an annual basis after the encounter data reporting process with specific dates to be determined. PHCS will report the measure rates to DHCS in a form and manner to be specified by DHCS.
5. The state may retain flexibility on two distinct aspects of the quality of care measures: a) The selection of the composition of the measure set, and b) the selection of benchmarks that will be utilized to determine the level of quality performance.
    a. Measure selection flexibility is due to the nature of the GPP population and the limitations of denominator sizes, which are further limited by measure specification requirements (e.g., age restrictions, diagnosis established, etc.). To ensure that meaningful data is reported the state requests flexibility to identify and select measures with sufficient denominators that also meet the alignment to the Quality Strategy Report discussed above.

b. The state may retain flexibility in the selection of comparison data/benchmarks. The state may select the most appropriate benchmark for each measure based on the closest approximation to the GPP population. DCHS will describe the benchmarks selected in the annual monitoring report.

6. DHCS will report on the progress of the Health Equity Monitoring Metrics Protocol to CMS on an annual basis as part of its Annual Monitoring Report.