Manifest
MEDEX

January 27, 2022

Dr. Palav Babaria
Chief Quality Officer
Deputy Director, Quality and Population Health Management
California Department of Health Care Services (DHCS)

Re: DHCS 2022 Comprehensive Quality Strategy

Dear Dr. Babaria:

Manifest MedEx (MX) appreciates the opportunity to comment on DHCS' draft 2022 Comprehensive Quality Strategy (CQS) report. We are a statewide, nonprofit health information exchange (HIE) that connects health records for 29 million people among over 400 organizations that care for them, including six Medi-Cal managed care plans. Through our mission and capabilities, we are determined to help DHCS meet the goal expressed in the CQS of "using actionable data to identify gaps in quality and health equity and informing improvement efforts" (p. 78).

We applaud the ambition reflected in this draft CQS, much of which is also embodied in the corresponding rollout of the CalAIM initiative, managed care procurement, and updated Medi-Cal plan contract. We also recognize the CQS is intended to provide an overarching strategy to support DHCS' ten-year vision as opposed to a detailed implementation toolkit. That said, the draft report acknowledges "there are a number of known…gaps, including ensuring that DHCS policies…[support] plan and provider capacity to identify and address disparities and to implement care delivery models that advance high-quality, efficient and equitable care for Medi-Cal members." (p. 77)

The final version of the CQS need not exhaustively catalog such barriers. It should, however, identify the most urgent and pervasive examples so that DHCS and stakeholders may begin to collaborate on ways to overcome them.

CQS should confront the lack of structured clinical data in Medi-Cal

In particular, the draft CQS omits the imperative for Medi-Cal to make substantial progress on harnessing complete, accurate, and timely *clinical* information. We urge DHCS to incorporate this critical missing piece into its final CQS submission, as well as the department's subsequent planning and priorities. All other elements within the strategy—including the choice of measure sets, assessment tools, and risk stratification algorithms—will be hamstrung if Medi-Cal fails to reliably *obtain and organize* clinical data, refine that data into *information*, and *deliver* those insights to providers and plans.

While the 2022 CQS appropriately encompasses all Medi-Cal delivery systems, our comments focus on the causes and consequences of inadequate clinical data for managed care plans, their network providers, and the quality and population health responsibilities that fall upon both.

Today, Medi-Cal plans have little direct access to standardized clinical data or the expertise and tools to manage it. Their efforts to build direct data connections to provider electronic health records (EHRs) are nascent or have not yielded expected results. Health plans with fewer resources have not begun to build these capabilities. Although entities such as HIEs can help establish linkages to clinical data, the draft report is largely silent on both the root problem and the difficulty it creates for the CQS moving forward.

Delaying clinical data impedes population health management and equity goals

Integrating clinical data into Medi-Cal population health management (PHM) will be essential ingredients to the success of the CQS. Yet the draft report does not contain meaningful objectives on this front. One of the PHM Guiding Principles is to "use program and outcomes data to inform policymaking and drive continuous quality improvement efforts across Medi-Cal delivery systems" (p. 59). We are concerned that in the near term "outcomes data" implicitly refers to *administrative* sources—claims and encounters that are most readily accessible to the department. If so, this is a serious shortcoming.

Using only administrative data in PHM is a dangerous and incomplete approach that demonstrates the "streetlight effect." It embeds and exacerbates inequity, as claims and encounters do not reveal underlying clinical or social risk that is not associated with use of services. It also does not support effective care coordination since claims data are not timely enough for this purpose. This is especially problematic for historically underserved populations like those in Medi-Cal.

According to the draft CQS "the [Medi-Cal PHM service platform], which will be procured via a public RFP process in 2022, will integrate multiple sources of data from DHCS, other state departments, health plans, providers, and *clinical data feeds* to provide a comprehensive medical and social assessment of Medi-Cal populations." (pp. 56-57, emphasis added). However, the CQS does not provide a general timeline for establishing these data feeds.

The suite of analytic functions envisioned under the PHM service—including dashboards, predictive risk scores, and care management tools—will not achieve the department's care coordination and health quality and equity goals without clinical data. We strongly recommend the final CQS affirm DHCS' intent to establish clinical data feeds *as part of this year's RFP process for the PHM service*.

Electronic clinical data are key to gaining complete picture—and reducing burden—of quality reporting

By describing DHCS' adjustments to quality reporting requirements during the public health emergency, the draft report indirectly references both the importance and burden of collecting clinical data for Medi-Cal providers and plans:

- "Many of the quality measures that [Medi-Cal plans] reported on were hybrid measures that require the *collection (often, in person) of medical records*…the collection of administrative data was also impacted due to delays in provider submission of data as well as delays in the submission of other supplemental data such as from labs and pharmacies." (pp. 170-171, emphasis added)

- "DHCS worked with plans, providers and key partners to implement COVID-19 specific services, provide flexibilities to reduce in-person requirements, and reduce administrative burdens so providers could focus on clinical care, while also maintaining other health care services." (p. 43)

Provider records are primary sources of standard supplemental data for both HEDIS and MCAS. As mentioned earlier, even the most sophisticated health plans have limited ability to access and use standardized clinical data from EHRs. Plans typically employ nurses who manually abstract medical charts to obtain this data, often months after services were rendered.

"Chart chases" and their disruption to care delivery predate the COVID-19 pandemic and are not unique to Medi-Cal. But the burden is especially acute for low-resource providers that care for a disproportionate share of the program's enrollees, and compounds disparities in access. Therefore, the final CQS should more explicitly highlight the inefficiency of manual chart review and solicit ideas for building provider and plan capacity to capture measures using electronic clinical data. Doing so is consistent with DHCS turning toward NCQA for core aspects of its quality and equity agenda.

The CQS states that as part of the Medi-Cal managed care procurement, "plans will also be required to be NCQA-accredited to improve standardization, quality and health equity across the state." (p. 57) Given this intent, DHCS should orient itself with the future direction of NCQA's policies—including assessing the appropriateness of removing the hybrid reporting method from a growing subset of quality measures. An alternative is the Electronic Clinical Data Systems (ECDS) Method, a HEDIS reporting standard that encourages the use and sharing of electronic clinical data across health care systems.

DHCS' final CQS should discuss the extent to which the department will align with NCQA's plans to transition quality measures to ECDS-only reporting—and if so, explore the role of HIEs in reducing the burden of quality reporting through digital services. In a recent issue brief NCQA recommends "[standardizing] data collected in EHRs and aggregated to HIEs to support more efficient sharing and use of clinical data across health care systems…Data aggregators [such as some HIEs] can work to align data formats with quality measure specifications."

Include HIE voices in co-design process

More broadly, we request robust HIE representation in DHCS' upcoming Health Equity Roadmap co-design process. As data utilities and networks that collectively connect thousands of Medi-Cal plans and providers, HIEs bring valuable perspectives to the questions posed by DHCS under "Data Collection and Stratification" (p. 78):

- “While race/ethnicity and sexual orientation/gender identity data collection and standardization efforts are already underway, what opportunities are there to define best practices in collecting these data, and also leveraging data collected outside of DHCS (by plans, providers, and others)?” (*As data curators, HIEs retrieve race/ethnicity and sexual orientation/gender identity information that is more likely to be recorded in clinical data than claims.*)

- “What are the disparities for which we do not currently have good data or ways to measure? How should we begin to define these areas and start to collect data?” (*As we have argued, no disparities are well-measured if the yardstick relies on administrative data alone.*)

- “What data governance and integrity efforts need to exist to ensure that data critical for health equity work is accurate, timely and standardized across programs and delivery systems?” (*Turning data into portable and usable information is an organizing principle of all HIEs’ work.*)

We also propose adding the following question to the conversation:

- *What forms of data infrastructure can be leveraged or expanded to quickly share and use clinical information that is clean, unified, and ready for quality/equity analysis?*

Sincerely,

Felix Su
Director, Health Policy