
HMA

HEALTH MANAGEMENT ASSOCIATES

*NCQA Distinction in Multicultural Health Care:
Assessment of the Benefits and
Recommendation to Require that Issuers
Achieve this Distinction*

PREPARED FOR COVERED CALIFORNIA

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Executive Summary

Background

Covered California's mission is to increase insurance coverage in California and improve quality of care while reducing costs and health disparities. Attachment 7 of the Qualified Health Plan (QHP) Issuer Individual Market Model Contract (Quality, Network Management, Delivery System Standards and Improvement Strategy) lays out Issuer requirements and is designed to hold Issuers accountable for quality care and delivery reform. The guiding principles that underlie Attachment 7 express the goal of assuring effectively delivered quality care and improving population health in ways that are thoughtfully measured, appropriately aligned with other purchasers, promote access to strong provider networks, consumer tools and support, align payment with value and minimize variation in care. Attachment 7, Article 3 of Covered California's model contract (Reducing Health Disparities and Ensuring Health Equity) is designed to help Covered California ensure that its Issuers are committed to and engaged in the mitigation of health disparities. Article 3 requires Issuers to:

- Track quality measures over time based on race and/or ethnicity and gender
- Collect clinical data for population health improvement
- Adopt enhanced data exchange systems
- Collaborate with Covered California to assess ways to expand disparities research and programs to factors beyond race and ethnicity

In addition, Issuers are encouraged to gain National Committee for Quality Assurance (NCQA) Multicultural Health Care Distinction.

Covered California engaged Health Management Associates (HMA) to assess whether achievement of NCQA's Distinction in Multicultural Health Care leads to meaningful adoption of a culture that prioritizes and incorporates equity in goal setting, budgeting, staffing or other businesses processes, in order to determine the benefits and drawbacks of requiring all QHPs to attain the Distinction in Multicultural Health Care.

Methodology

We interviewed four Issuers that have earned Distinction in Multicultural Health Care in at least one line of business. We assessed whether achieving Distinction in Multicultural Health Care promotes meaningful change in Issuer capacity and commitment to reducing disparities and advancing health equity. We also reviewed the Distinction in Multicultural Health Care standards and guidelines with Attachment 7, Article 3, and California's Health Care Language Assistance Act (SB 853) to identify alignment and potential benefits and drawbacks of requiring all QHPs to attain the Distinction in Multicultural Health Care.

Recommendation

Require NCQA Distinction in Multicultural Health Care

A growing volume of research and best practices demonstrate that achieving health equity requires policy-level changes and resource allocation or reallocation. **We recommend that Covered California express its commitment to health equity by changing the language in Article 3.04, requiring Issuers to achieve NCQA Distinction in Multicultural Health Care.** This policy level change can impact Issuers' resource allocation (staffing, funding) to deliberately address disparities and health equity, increasing infrastructure and reinforcing organizational commitment to this work.

Requiring all participating Issuers to achieve Distinction in Multicultural Health Care supports Covered California's desire to catalyze meaningful adoption of a culture that prioritizes and incorporates equity into QHP operations by creating the necessary and consistent infrastructure for improving Culturally and Linguistically Appropriate Services (CLAS) and narrowing disparities across QHPs. It increases Issuers' focus on cultural responsiveness, which complements Covered California's desire to narrow disparities. While some Issuer staff interviewed expressed concern about the burden of data collection, Issuers are already subject to similar data collection and reporting requirements from Covered California and the state Departments regulating commercial and Medi-Cal plans. Many Issuers offering QHPs through Covered California already collect race and ethnicity data on at least 80 percent of members. Additional effort should be relatively modest, and we do not believe it would be enough to discourage Issuer participation in the Marketplace.

There is significant alignment between Covered California's Attachment 7 Article 3 (Reducing Health Disparities and Ensuring Health Equity) and NCQA Distinction in Multicultural Health Care. Even where the alignment is not complete, the Distinction in Multicultural Health Care requirements support the Covered California requirements. Distinction in Multicultural Health Care offers a more detailed and prescribed process and structure for approaching the improvement efforts and sets a stricter standard for identifying the number of languages required for translation.

Finally, interview respondents identified several benefits of the Multicultural Health Care Distinction, including:

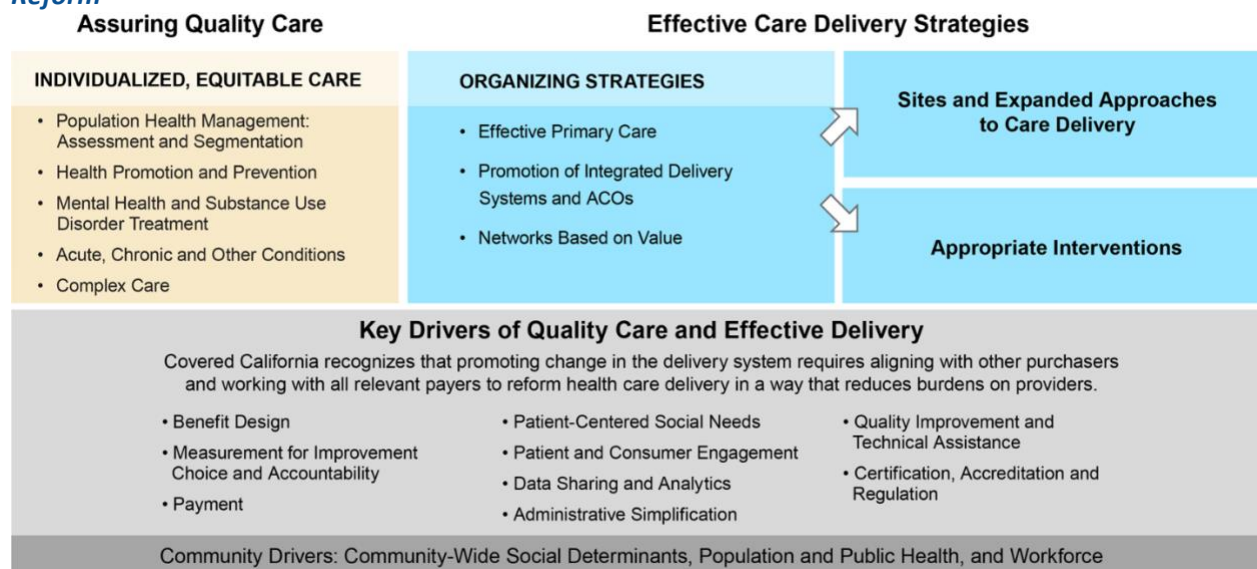
- **Recognizes and Reinforces Commitment.** Allocating resources to addressing disparities and health equity becomes "baked into our organizational structure." Achievement of the Distinction has resulted in stable and ongoing resources (funding and staffing) to advance equity and address disparities.
- **Supports Quality Improvement.** Distinction provides a framework and impetus for plans to push their equity work further.
- **Promotes a Framework for Action.** Having the Distinction formalizes processes, including establishing and maintaining structures for documenting, addressing and eliminating disparities that might not otherwise be prioritized.

Background

Promoting Quality and Value: Covered California’s Contract “Attachment 7”

Covered California’s mission is to increase insurance coverage in California and improve quality of care while reducing costs and health disparities. Covered California has developed a framework for holding plans accountable for quality care and delivery reform, which is expressed in the graphic below and operationalized through its contract with its Qualified Health Plan (QHP) Issuers.

Figure 1. Covered California’s Framework for Holding Plans Accountable for Quality Care and Delivery Reform¹



The contract explicitly recognizes the Issuers’ role in promoting quality and value. Attachment 7 of the Issuer Individual Market Model Contract (Quality, Network Management, Delivery System Standards and Improvement Strategy) lays out Issuer requirements that include management of QHP members and efforts to improve the delivery system as a whole. In addition to addressing traditional Issuer requirements, Attachment 7 is designed to hold Issuers accountable for quality care and delivery reform. Those expectations evolve over time in order to improve quality of care and reform the delivery system based on the best evidence available at the time.

In 2019, Covered California began a deliberative process with stakeholders, through which it is updating the 2022 contract year Attachment 7 requirements based on a set of guiding principles for developing the Marketplace’s expectations for Issuers:

1. Driven by the desire to meet two complementary and overlapping objectives:
 - a. Assuring Quality Care: Ensure our members receive the right care, at the right time, in the right setting, at the right price.
 - b. Effective Care Delivery: Promoting value-enhancing strategies that have the potential to reform the delivery system in the near and long term.
2. Seek to improve the health of the population, improve the experience of care, reduce the cost of care, reduce administrative burden, and reduce health care disparities.
3. Success will be assessed by outcomes, measured at the most appropriate level, in preference to adoption of specific strategies.

¹ Covered California, Attachment 7 Framework, January 2019.

4. We will promote alignment with other purchasers as much as possible.
5. Consumers will have access to networks offered through the issuers that are based on high quality and efficient providers.
6. Enrollees have the tools needed to be active consumers, including both provider selection and shared clinical decision making.
7. Payment will increasingly be aligned with value and proven delivery models.
8. Variation in the delivery of quality care will be minimized by ensuring that each provider meets minimum standards.

Attachment 7, Article 3 of Covered California’s model contract (Reducing Health Disparities and Ensuring Health Equity) is designed to help Covered California ensure that its Issuers are committed to and engaged in the mitigation of health disparities. Article 3 requires Issuers to:

- Track quality measures over time based on race and/or ethnicity and on gender
- Collect clinical data for population health improvement
- Adopt enhanced data exchange systems
- Collaborate with Covered California to assess ways to expand disparities research and programs to factors beyond race and ethnicity

In addition, Issuers are encouraged to gain NCQA Multicultural Health Care Distinction.

Covered California engaged Health Management Associates (HMA) to assess whether achievement of NCQA’s Distinction in Multicultural Health Care leads to meaningful adoption of a culture that prioritizes and incorporates equity in goal setting, budgeting, staffing or other businesses processes. HMA was also asked to assess the benefits and drawbacks of requiring all QHPs to attain NCQA Distinction in Multicultural Health Care as a mechanism for ensuring that QHPs are actively and systematically engaged in improving health equity for all members and the communities they serve.

Methodology

Data Collection

To assess whether achievement of Distinction in Multicultural Health Care results in meaningful change in an Issuer’s capacity and commitment to reduce health disparities and advance health equity, we conducted a literature review and interviewed four Issuers that have obtained Distinction in Multicultural Health Care in at least one line of business. We used the interviews to better understand what drives Issuers to obtain Distinction in Multicultural Health Care, whether and how achievement impacts organizational capacity and commitment, experience going through the process of obtaining Distinction in Multicultural Health Care, and overall impression on the benefits and challenges of obtaining Distinction in Multicultural Health Care. Interviews were conducted telephonically and lasted approximately 30 minutes.

We also reviewed NCQA Distinction in Multicultural Health Care Standards and Guidelines, including an overview of the process and a recommended timeline for completion. We conducted interviews with Issuers that have gained Distinction in one or more of their markets and that have a California presence (whether or not they had a QHP with Distinction in Multicultural Health Care). We also conducted a search for scholarly articles related to the impacts of the NCQA Distinction in Multicultural Health Care.

Review of NCQA Distinction in Multicultural Health Care

We assessed the NCQA Distinction in Multicultural Health Care Standards and Guidelines to identify the positive and negative impacts of requiring all participating Issuers to gain the distinction. In considering

whether requiring Distinction in Multicultural Health Care would enhance QHP engagement in and achievement of health equity, we sought to answer two primary questions:

- Does achievement of Distinction in Multicultural Health Care result in meaningful change in an Issuer’s capacity and commitment to reduce health disparities and advance health equity?
- How well do the Distinction in Multicultural Health Care Standards and Guidelines align with Attachment 7, Article 3 (Reducing Health Disparities and Ensuring Health Equity) of Covered California’s QHP model contract, in terms of both overlaps and gaps in the standards and required documentation?

To investigate the level of alignment between the Distinction in Multicultural Health Care standards and Attachment 7, Article 3 of Covered California’s model contract, we compared the five Distinction in Multicultural Health Care standards and guidelines to the requirements and goals in Attachment 7, Article 3:

- 3.01 Measuring Care to Address Health Equity
- 3.02 Narrowing Disparities
- 3.03 Expanded Measurement
- 3.04 NCQA Certification

We also reviewed California’s Health Care Language Assistance Act (SB 853) as it applies to Issuers with health plans licensed by either the California Department of Managed Health Care (DMHC) or the Department of Insurance (DOI).² The crosswalk to SB 853 was included to provide context about how some of the elements required by the Distinction in Multicultural Health Care might already be required by California law, even if not contained within Attachment 7. We assessed whether the Distinction in Multicultural Health Care elements added standards not already contained in either Attachment 7 or SB 853.

² SB 853 resulted in DMHC laws and regulations contained in California Health & Safety Code § 1367.04 and 28 CCR § 1300.67.04; and DOI laws and regulations contained in California Insurance Code § 10133.8 and 10 CCR § 2538.3. http://www.leginfo.ca.gov/pub/03-04/bill/sen/sb_0851-0900/sb_853_bill_20031009_chaptered.html

Findings

This section includes our assessment of whether achievement of NCQA Distinction in Multicultural Health Care leads to meaningful adoption of a culture that prioritizes and incorporates equity in setting goals and objectives, budgeting, staffing or other businesses processes, and the benefits and drawbacks of requiring all Issuers to attain the Distinction in Multicultural Health Care for their Marketplace line of business.

Distinction in Multicultural Health Care

NCQA's Distinction in Multicultural Health Care identifies Issuers, managed care organizations, managed behavioral health organizations, and wellness and population health organizations that provide culturally and linguistically sensitive services and work to reduce health care disparities.³ Distinction in Multicultural Health Care provides a cohesive set of standards for evaluating efforts to improve the provision of Culturally and Linguistically Appropriate Services (CLAS) and to identify and reduce health care disparities. The standards guide Issuers in assessing their organizational efforts and capacity, identifying gaps, and developing improvement efforts to reduce disparities and advance health equity. Additionally, they provide an accountability mechanism and allow organizations to distinguish themselves in their market.⁴ Currently, the NCQA website lists 53 organizations as having achieved Distinction in Multicultural Health Care.

The Process for Achieving Distinction in Multicultural Health Care

Achieving Distinction in Multicultural Health Care takes approximately nine to twelve months. During this period, the Issuer conducts a gap analysis of organizational processes and policies measured against the Distinction in Multicultural Health Care standards and guidelines. The organization then applies for the Distinction in Multicultural Health Care and has an opportunity to bring processes and policies into alignment with standards. Finally, the organization undergoes a final survey and submits required documentation. NCQA scores the entity and determines if the Distinction is granted, which happens within 90 days of the survey and documentation submission. Distinction in Multicultural Health Care is awarded for two years. Applications for renewal require the completion of another complete survey.

The Distinction in Multicultural Health Care Tool

The Distinction in Multicultural Health Care Tool includes standards and guidelines in five key areas with sub-elements:

1. Race/Ethnicity & Language Data
 - a. Collection of Data on Race/Ethnicity
 - b. Collection of Data on Language
 - c. Privacy Protections for Race/Ethnicity/Language Data
 - d. Notification of Privacy Protections
2. Language Services
 - a. Written Documents
 - b. Spoken Language Services
 - c. Support for Language Services
 - d. Notification of Language Services
3. Practitioner Network Cultural Responsiveness
 - a. Assessment & Availability of Information

³ <https://www.ncqa.org/programs/health-plans/multicultural-health-care-mhc/>

⁴ 2010 MHC Standards and Guidelines

- b. Enhancing Network Responsiveness
4. CLAS Standards Program
 - a. Program Description
 - b. Annual Evaluation
5. Reducing Health Care Disparities
 - a. Use of Data to Assess Disparities
 - b. Use of Data to Monitor & Assess Services
 - c. Use of Data to Measure CLAS and Disparities

For each area, NCQA provides information on the intent behind the standards and guidelines and additional information for each set of elements. Information on elements includes:

- Descriptive statements on acceptable performance or results and the importance of the standard and guidelines
- Description of organizational methods, policies, or procedures addressing the element and performance expectations
- Scoring criteria on a continuum of 0 – 100 percent compliance
- Acceptable data sources for documentation purposes
- Information on the scope of review including an explanation and details on the look-back period of assessment
- Examples illustrating performance against an element’s requirements (for guidance purposes only)

Organizations applying for Distinction in Multicultural Health Care submit evidence of meeting the standards and elements within each standard and guideline. Each element is worth a specific number of points and is scored separately. There are 100 possible points and organizations must score a 70 or above to achieve Distinction.

Literature Review: Limited Research Available

To determine whether achievement of Distinction in Multicultural Health Care results in meaningful change in an Issuer’s capacity and commitment to reduce health disparities and advance health equity, we conducted a brief literature review and interviewed staff at four Issuers that have gained the Distinction in Multicultural Health Care in at least one of their lines of business. Consistent with the limited scholarly research available on health equity noted in previous HMA research for Covered California, little research has been conducted on the impacts of achieving NCQA’s Multicultural Health Care Distinction. In one paper that specifically addresses the relationship between measurement and health equity, Ng, et. al. conducted semi-structured interviews with a variety of stakeholders, including Issuers that had earned NCQA’s Multicultural Health Care Distinction or were high performers on HEDIS measures. The authors concluded that future work should focus on enhancing the implementation of existing quality measures addressing disparities and CLAS by addressing barriers to adoption.⁵ Requiring Issuers to achieve NCQA’s Multicultural Health Care Distinction addresses the identified need for greater

⁵ Ng, J.H., Tirodkar, M.A., French, J.B., Spalt, H.E., Ward, L.M., Haffer, S.C., Hewitt, N., Rey, D., and Scholle, S.H., Health Quality Measures Addressing Disparities in Culturally and Linguistically Appropriate Services: What are Current Gaps? (2017). Health quality measures addressing disparities in culturally and linguistically appropriate services: what are current gaps. *Journal of Health Care for the Poor and Underserved*, Vol 28(3), pp. 1012 – 1029.

organizational infrastructure and capacity to collect and analyze race, ethnicity, and language data, and requires annual plans to reduce disparities in clinical performance and language access.

Issuer Interviews

We interviewed four Issuers that hold Distinction in Multicultural Health Care in California. Three of the Issuers hold the Distinction for all lines of business while the other holds the Distinction only for its Medi-Cal plan. The following discusses the themes that emerged from the interviews.

Long-term Benefits of Distinction in Multicultural Health Care Align with Covered California Values

Institutionalizing Support. Achieving Distinction in Multicultural Health Care sets a foundation by promoting a common framework and process to address disparities and cultural sensitivity that once obtained, “bake in” a process that is prioritized and leverages resources for collaboration across the organization. Our interviewees saw Distinction as an important tool, noting:

The distinction itself protects resources committed to this work.

* * *

Because there is so much change with leadership, priorities, and service requirements, we live constantly with competing priorities, but this Distinction enables us to maintain resources to meet the standards and thus creates stability around these goals. As leaders come and go, this Distinction keeps things cohesive, especially where it's not necessarily valued or appreciated from all leaders.

* * *

Having this Distinction means we no longer need to justify resources for this work. It is just part of what we normally do now.

Recognizes and Reinforces Commitment. Each organization that pursued the Distinction was motivated by an opportunity to get credit for work already started and consistent with its mission. This was particularly the case for the Medi-Cal line of business, as Medi-Cal has established cultural and linguistic sensitivity requirements. Respondents from each organization said that even though they were already committed to and conducting foundational work, the Distinction moved them forward in important and concrete ways. It has allowed them to address educational gaps (both with providers and internally) and supported concrete steps to make improvements in reducing health disparities and improving cultural sensitivity.

Supports Quality Improvement. Respondents at one organization noted that Covered California already has a prescribed Quality Improvement process. They see the Distinction in Multicultural Health Care process for addressing disparities as fitting with the QI process and do not believe its requirements increase the burden on the organization.

One respondent expressed approval of the NCQA Distinction in Multicultural Health Care process for being stronger and more uniform than California Department of Health Care Services (DHCS) auditing of compliance with Medi-Cal cultural and linguistic access requirements. Her perception was that NCQA had greater depth of expertise and would be more consistent in its approach.

Promotes a Framework for Action. Finally, several respondents discussed sustained changes to how they organize their efforts and staffing to address disparities and advance equity.

The Distinction not only helps with documentation but also creates auditing processes to reflect on actual gaps revealed by the data and a chance to use that to focus on how to do work differently.

* * *

The value Multicultural Health Care Distinction brings is that it asks us to bring structures and processes in place to do this work. That is valuable to the organization.

* * *

It provides an external framework which helps it stay at the front of this work. Without a framework or pressure, this work (addressing disparities) could get deprioritized within the plan.

* * *

Where the Distinction in Multicultural Health Care really provided value was that it allowed us to make it a business case to address health equity, meaning because of Medicaid and SB 853 we had the data on race/ethnicity and language in place, but not necessarily a systematic approach to addressing health equity. Until the Distinction, it had been more project by project. This changed after getting the Distinction as it created a framework for us to address health equity and narrow disparities.

* * *

Because the Multicultural Health Care Distinction process touches all aspects (or departments) of a health plan, it also provided a framework for us to coordinate with other departments and while we may have been doing it before this distinction, this brought a more formal process to it. Now we have cross department teams and people who know we need to renew this distinction every two years, so we all focus on ensuring these processes are up-to-date and being reinforced.

Challenges with Data Requirements

Respondents from two organizations identified data requirements as the biggest challenge with gaining Distinction. Notably, one organization pursued the distinction before passage of SB 853 established data collection requirements. At the same time, one organization noted that the Distinction in Multicultural Health Care requirements for utilizing data from a narrower set of sources (HEDIS or CAHPS survey data) required an investment of additional resources. Even with identified data challenges, respondents from the four organizations approve of the process NCQA uses for Distinction in Multicultural Health Care. NCQA works concretely from data, which provides an important foundation for organizational commitment and collaboration.

A respondent at the Issuer that carries the Distinction only for its Medi-Cal line of business was resistant to extending it to the QHP market because of the volatility of the QHP enrollment, which she reported was less stable than the Medi-Cal population.

Covered California Standards Exceed NCQA's

A respondent at one organization noted that the Distinction in Multicultural Health Care was outdated and not as forward-thinking as Covered California. Covered California requirements include efforts to address disparities that go beyond language, race and ethnicity, such as the efforts to understand and

address disparities based on gender, sexual orientation, and income. This respondent also suggested that intellectual disabilities be considered.

Respondents were Mixed About Whether Distinction in Multicultural Health Care Should be Required

Respondents had mixed reactions when asked whether Covered California should make achievement of Distinction in Multicultural Health Care as an Attachment 7 requirement:

- Respondents at two organizations favor adoption of the requirement because they perceived the distinction as complementary to and supportive of Covered California’s commitment to improving CLAS achievement and addressing disparities.
- Staff at two of the organizations preferred to maintain Distinction as an option as this allows them to “get credit” for the Distinction and to stand out competitively.
- A respondent at one organization said that even if the Distinction were required of QHPs, they would not favor requiring for all lines of business, particularly their non-QHP commercial lines, due to the data collection infrastructure that would be required. In contrast, someone from another organization said that once the Distinction was pursued, it made sense for the company’s accreditation department to use it for all lines of business.
- One organization that did not support making the Distinction a requirement wanted to see another option: allowing Issuers to use the Distinction in Multicultural Health Care as proof that the Issuer meets Attachment 7 requirements related to CLAS and disparities.

While not all interviewees agreed that Distinction in Multicultural Health Care should be required for all QHPs, they all recognized the value add to their organization of obtaining the Distinction. Many interviewees saw Distinction as serving to communicate to their membership the company’s commitment to equity. Many respondents expressed concern that if Covered California made this a requirement for all QHPs, their organizations would lose some of the value they gained by voluntarily pursuing this Distinction. One respondent suggested that Covered California could add value to make up for the loss of a competitive edge by allowing Distinction in Multicultural Health Care to serve as an equivalent for Article 3 of the Issuer contract. This would reduce administrative burden related to contract compliance.

Alignment with and Gaps Compared to Attachment 7

At a high level, the Distinction in Multicultural Health Care standards align with Attachment 7, although in some areas the Distinction in Multicultural Health Care standards are either more or less specific than Attachment 7 requirements. Overall, the Distinction in Multicultural Health Care standards promote a quality improvement program that is complementary to Covered California’s efforts. Notable differences include:

- Covered California follows the Medi-Cal requirements and standards for threshold languages. The Distinction in Multicultural Health Care standard requires translation and language services for any language spoken by the lower of 1 percent of the population or 200 eligible individuals in the service area, for up to 15 languages. The DHCS defines threshold languages as the lower of 5 percent of or 3,000 total mandatory Medi-Cal beneficiaries in the service area who speak a language other than English.
- The Distinction in Multicultural Health Care standards require plans to analyze and identify gaps in meeting member needs for culturally appropriate care, which neither Attachment 7 nor SB 853 require.

- Attachment 7 requires selection and reporting of clinical areas for improvement, with these areas chosen by Covered California. The Distinction in Multicultural Health Care standards allow the plan to choose the clinical areas. Both Covered California and the Distinction in Multicultural Health Care require detailed quality improvement workplans; however, it could be an added benefit to leverage NCQA auditing and scoring to drive implementation and adherence to the workplan.
- The Distinction in Multicultural Health Care standards on reducing health care disparities align with Attachment 7 requirements around reducing disparities. The Attachment 7 requirements at 3.02 are more specific around reporting baseline measurements and establishing targets. Nevertheless, it could be an added benefit to leverage NCQA auditing and scoring to drive implementation and adherence to the workplan.

3.01 Measuring Care to Address Health Equity

Attachment 7, Article 3.01, *Measuring Care to Address Health Equity*, requires contractors to track and trend quality measures by racial or ethnic group, or both, and by gender for their full book of business, excluding Medicare. Item 3.01 is further divided into two main components: 1) Identification; and 2) Measures for Improvement.

Alignment. Distinction in Multicultural Health Care standard 1 (MHC 1) aligns with Article 3.01. MHC 1 includes four elements that collectively address the collection of race, ethnicity and language data, including policies and procedures for ensuring appropriate data storage and retrieval, protection of health information, and permissible and impermissible data use. MHC 1 aligns with Covered California's goal for 3.01 as it requires Issuers to collect and report on member race/ethnicity data. MHC 1 also addresses vital infrastructure elements of data security and privacy practices and requires data collection on language. Both 3.01 and MHC 1 rely on member self-reported data.⁶ The organization may collect data directly at various points of interactions with eligible individuals and through multiple mechanisms. MHC 1 suggests organizations can estimate race and ethnicity using either or both geocoding and surname analysis.

MHC 1 also aligns with the requirements of SB 853. California law institutes collection and reporting requirements related to language preference and limited English proficiency and requires that reporting protects confidentiality and be used only for permissible purposes.

Gaps. Where member self-identification of race or ethnicity is not possible, Covered California allows the estimation of race/ethnicity using indirect proxy identification methods based on zip codes and surnames. NCQA does not prescribe a method for estimating race/ethnicity, but rather requires organizations to *have* a method and to be able to validate its estimation method. Additionally, while Covered California's 3.01(1) states a requirement to track and trend quality measures by race, or ethnicity, or both, and *by gender*, MHC 1 does not reference gender. Finally, MHC 1 does not include a percentage goal for self-identification of race or ethnicity nor an annual reporting requirement for certification.

Documentation. NCQA allows the organization to show compliance with MHC 1 using documented processes, reports, and materials supporting evidence of data collection practices. Organizations are required to submit documented processes to demonstrate meeting this requirement.

Additional Information. Beyond the requirement to collect race and ethnicity data, MHC 1 includes processes to roll up race/ethnicity to federal Office of Management and Budget (OMB) categories,

⁶ Members provide race and ethnicity on a voluntary basis, but the organization must attempt to collect it.

systems for data storage and retrieval of individual-level data, and reporting HEDIS Diversity of Membership measure (race/ethnicity component), if applicable. Additional elements include: collection of data on language, an assessment of the population's language profile at least every three years, and thresholds on languages spoken and impacts on member materials and access; privacy protection requirements for race/ethnicity and language data including controls for physical and electronic access to data, permissible and impermissible uses of data including underwriting and denial of coverage benefits; and Notification of Privacy Protection requirements.

3.01(2) Measures for Improvement

Item 3.01(2) requires annual reporting of disparities in care by racial and ethnic identity and by gender for measures specified by Covered California (Diabetes, Hypertension, Asthma control and associated hospital admission rates, and Depression).⁷

Alignment. MHC 5 (Reducing Health Care Disparities) requires organizations to use race, ethnicity and language data to improve services and reduce disparities and includes three key elements that collectively address the use of race/ethnicity and language data to assess disparities by clinical measures, monitor and assess utilization and experience with language services, and identifying, addressing, and evaluating health care and CLAS disparities. MHC 5 aligns with Covered California's goals of ensuring Issuers utilize member race/ethnicity data to identify health disparities, develop plans to address them, and evaluate their progress. It extends beyond CCA goals by including addressing disparities related to member language and CLAS.

Gaps. Attachment 7 is more specific, identifying clinical measures for improvement and outlining steps for developing annual intermediate milestones in the reduction of disparities. NCQA does not prescribe clinical measures to be analyzed for disparities by race/ethnicity, but instead requires organizations to stratify one or more HEDIS or other clinical performance measures using individual-level data. Additionally, as noted in 3.01(1), gender is not included as a specific requirement. Despite this, on the whole MHC 5 provides the infrastructure to support Covered California's requirements for race/ethnicity data stratification, disparity analysis, and reporting.

Documentation. As evidence of compliance for MHC 5, NCQA accepts reports supporting evidence of use of data to assess, monitor, and evaluate disparities in health care and language and CLAS.

Additional Information. In addition to identifying whether the Issuer uses data on race/ethnicity to assess health disparities, MHC 5 also includes factors assessing whether language data are used to assess health disparities. Elements of MHC 5 support assessment, monitoring, and improvements in language access and experience and achievement of CLAS standards.

3.02 Narrowing Disparities

Item 3.02 requires Issuers to collect data on clinical measures in order to assess progress toward reducing health disparities, including developing and adopting systems for enhanced information exchange. Together MHC 5 Standards and Guidelines and the data collection requirements and standards from MHC 1 align aligned with 3.02. In addition, MHC 4: Culturally and Linguistically Appropriate Services Programs includes substantive input from the community in developing and monitoring programs to improve CLAS programs and services contributing to narrowing disparities.

Alignment – 3.02(1) Baseline Measures. Article 3.02(1) references contractor reported baseline measurements from plan years 2015, 2016, 2017, and 2018 as listed in the Measurement Specifications document and cites that this baseline data may be incomplete. MHC 1 addresses this identified issue by

⁷ SB 853 also includes requirements to monitor and assess language access.

requiring Issuers to develop the necessary data infrastructure and capacity to capture individual level data by race, ethnicity, and language.

MHC 5 requires organizations to use that infrastructure to analyze clinical performance by race/ethnicity and language to assess the existence of disparities and to focus quality improvement efforts towards improving the provision of culturally and linguistically appropriate services and decreasing health care disparities. This element includes requirements on how the organization uses data to analyze:

- one or more valid measures of clinical performance, such as HEDIS, by race/ethnicity;
- one or more valid measures of clinical performance, such as HEDIS, by language; and
- one or more valid measures of eligible individual experience, such as CAHPS, by race/ethnicity or language.

The Distinction in Multicultural Health Care requirement is less specific than Attachment 7 and does not include Covered California's specificity regarding required baseline clinical measures for improvement (diabetes, hypertension, asthma, and depression) or required targets for 2020 or annual disparities reduction milestones to be established by Covered California based on national benchmarks, analysis of variation in California performance, best existing science of quality improvement, and effective engagement of stakeholders. Distinction in Multicultural Health Care allows organizations to pick from any one or more valid measures of clinical performance.

As outlined in the 3.02(1) Measurement Specifications, MHC 5 can ensure alignment with the overall goal of enhancing information exchange.

Gaps – 3.02(1) Baseline Measures. No specific gaps were discovered.

Documentation – 3.02(1) Baseline Measures. Acceptable evidence of compliance for MHC 5 includes reports supporting evidence of data collection practices. Organizations are required to submit documented processes to demonstrate they meet this requirement.

Additional Information – 3.02(1) Baseline Measures. MHC 5 requires organizations to demonstrate that it is using data to monitor and assess services regarding language services, including:

- utilization of language services for organization functions;
- eligible individual experience with language services for organization functions;
- staff experience with language services for organization functions; and
- eligible individual experience with language services during health care encounters.

It also requires organizations to use data to measure CLAS and disparities and requires organizations to:

- identify and prioritize opportunities to reduce health care disparities;
- identify and prioritize opportunities to improve CLAS;
- implement at least one intervention to address a disparity, implement at least one intervention to improve a CLAS;
- evaluate the effectiveness of an intervention to reduce a disparity; and
- evaluate the effectiveness of an intervention to improve CLAS annually.

Alignment – 3.02(2) Targets for Year End 2020. We did not assess this specific article against the Distinction in Multicultural Health Care Standards and Guidelines as it did not apply. However, Covered California's goal to establish targets for year end 2020 and annual milestones in the reduction of disparities would be supported by the infrastructure requirements of MHC 1 and 5.

Gaps – 3.02(2) Targets for Year End 2020. Not Applicable.

Documentation – 3.02(2) Targets for Year End 2020. Not Applicable.

Additional Information – 3.02(2) Targets for Year End 2020. Not Applicable.

3.03 Expanded Measurement

3.03 of Article 3, Attachment 7 (Expanded Measurement) requires contractors to partner with Covered California to assess the feasibility and impact of extending the disparity identification and improvement program over time. Suggested areas include income, disability status, sexual orientation, gender identity, and limited English proficiency.

Alignment. Of the five suggested areas for extending disparity identification, only limited English proficiency (LEP) is addressed in the Distinction in Multicultural Health Care Standards and Guidelines.

- MHC 1 addresses data collection of member language including LEP.
- MHC 2 focuses on access and availability of language services including in-person and written translation services as well as interpreter services.
- MHC 3 includes elements of addressing LEP through a focus on practitioner network cultural responsiveness including assessing practitioner language options and making that information available to members. It also includes a requirement to assess the capacity of the network in meeting member language needs and to develop a plan to address gaps identified every three years.
- MHC 4 focused on developing, implementing, and evaluating annual work plans to address CLAS inclusive of LEP.
- MHC 5 requires organizations to use language data to analyze at least one clinical performance measure by language.

Gaps. Specific gaps noted include the other four suggested areas of focus for expanded measurement (income, disability status, sexual orientation, and gender identity). However, the infrastructure and capacity required to comply with NCQA’s Distinction in Multicultural Health Care, combined with organizational experience of coming into compliance, could likely provide a roadmap for expanding measurement into mutually agreed upon areas between Issuers and Covered California.

Documentation. Providing evidence of compliance includes documented processes, reports, and materials supporting evidence of data collection. Organizations are required to submit documented processes to demonstrate meeting this requirement.

Additional Information. Not Applicable.

3.04 NCQA Certification

3.04 of Article 3, Attachment 7, NCQA Certification, requires contractors who have met the standards and guidelines for Multicultural Health Care Distinction to submit this information to Covered California during their annual application for certification.

Alignment. Once an organization receives the Distinction in Multicultural Health Care, it is good for two years. A renewal process that includes submitting a Renewal Survey before the organization’s status expires is required every two years. Issuers with the Distinction in Multicultural Health Care should be able to submit certification to Covered California through their annual application.

Gaps. Not Applicable.

Documentation. Upon organizational success of Distinction in Multicultural Health Care, NCQA provides a Certificate of Distinction to the organization with applicable dates of distinction status and a final version of the Survey Tool Report with the organization’s final scores on the standards and elements.

NCQA reserves the right to publish the names of the organizations with Distinction in Multicultural Health Care. The Certificate of Distinction and Full Survey Tool report could serve as documentation for Covered California's needs.

Additional Information. Not Applicable.

Additional Impacts and Considerations

Language Access Requirements in MHC 2 and SB 853

MHC 2 aligns with SB 853's requirements regarding language access services, except that the threshold for requiring translation services is stricter under MHC 2. MHC 2 requires written translations whenever 1 percent of the population or 200 enrollees, whichever is less, needs translation services, with a maximum of 15 languages. The MHC 2 elements include: written documents; spoken language services; support for language services; and notification of language services.

Practitioner Network Responsiveness

MHC 3 requires the organization to maintain a practitioner network that is capable of serving its diverse membership and is responsive to member needs and preferences. MHC 3 has two elements: (A) assessment and availability of information; and (B) enhancing network responsiveness. The linguistic access requirements align in part with SB 853, which ensures enrollees' language preferences are reported to providers, providers have access to free interpretation services offered by the plans, and providers' language capacities are shared with enrollees through the provider directory.

Element B, which is focused on cultural sensitivity and gaps in meeting members' needs, is an area not otherwise addressed by Attachment 7 or SB 853. This element focuses both on language access and providers' capacity to meet members' needs for "culturally appropriate care." Element B is not contained within Attachment 7 and is broader than the SB 853 requirement that staff be trained in "understanding the cultural diversity of the plan's enrollee population and sensitivity to cultural differences relevant to delivery of health care interpretation services." According to MHC 3, an organization has an ongoing obligation to determine unmet need for culturally appropriate care and demonstrate how it will meet it with very specific planning requirements that document actions and permit assessment. Examples of areas of assessment include:

- Attitude toward working with people from different cultures
- Awareness of health beliefs and health-related behaviors among people from prevalent cultures in the service area
- Ability to determine language or cultural barriers interfering with communication
- Skills in assessing patient understanding
- Participation in continuing medical education cultural competence training

Culturally and Linguistically Appropriate Service Programs

MHC 4 requires organizations to continually improve their services to meet the needs of multicultural populations. It requires a written program description and an annual evaluation. As noted above, this standard aligns with Attachment 7, Sections 3.02 (narrowing disparities) and 3.03 (expanding measurement). While Attachment 7 is more specific in identifying clinical areas for improvement, MHC 4 contains more specific requirements for community engagement and provides a uniform framework for its internal annual evaluation. Under MHC 4, the organization must provide a written program for improving delivery of culturally and linguistically appropriate services, which must include a list of measurable goals for improving CLAS and health care disparities.

While Covered California is more specific in setting the clinical areas for improvement, and SB 853 is clear in addressing deficiencies related to reporting of linguistic data, neither Covered California nor SB 853 requires a quality improvement plan that specifically addresses cultural competence and sensitivity. Additionally, MHC 4 requires community engagement with participation by members of the culturally diverse community in identifying and prioritizing opportunities for improvement in CLAS goals and reduction of health care disparities. Neither Attachment 7 nor SB 853 specify this level of participation.

MHC 4 sets out specific criteria for its annual evaluation of its CLAS services which includes trending of measures to assess performance; analysis of initiatives, including barrier analysis; and a community engagement piece under which community representatives must review and interpret the results. These requirements are more specific than those contained within Attachment 7 or SB 853.

Reducing Health Care Disparities

MHC 5 requires organizations to use race, ethnicity and language data to improve services and reduce disparities. Its requirement to use data to assess health care disparities closely aligns with Sections 3.01 (measuring care to address health equity) and 3.02 (narrowing disparities). However, MHC 5 also requires the use of data to monitor and assess delivery of CLAS and to measure CLAS and health care disparities. MHC 5 moves beyond measuring and monitoring disparities by requiring interventions to address a disparity and to improve CLAS.

While SB 853 provides comprehensive language assistance requirements and standards, MHC 5 addresses the use of data for monitoring and assessing staff experience with language services for organization functions. SB 853 requires Issuers demonstrate an ability to provide timely interpretation services whenever Issuer staff have routine contact with members and health care providers (and their front office staff). While SB 853 requires Issuers to report on their compliance, MHC 5 identifies more specific standards for using this data for monitoring.

Recommendation: Require NCQA Distinction in Multicultural Health Care

There is significant alignment between Covered California's Reducing Health Disparities and Ensuring Health Equity (Article 3) section of Attachment 7 and NCQA Multicultural Health Care Distinction. The five Distinction in Multicultural Health Care standards and guidelines either directly align or support the four discrete elements of Article 3. Additional alignment exists with the California Language Assistance Act, adopted as SB 853. Even where the alignment is not complete (for example, specifying areas for action regarding chronic care, setting a numerical baseline for collection of data, and expanding the specific data elements to be collected), the requirements of Distinction in Multicultural Health Care support the Covered California requirements. Additionally, Distinction in Multicultural Health Care offers a more detailed and prescribed process and structure for approaching the improvement efforts and sets a stricter standard for identifying the number of languages required for translation. As noted above, this process fits with Covered California's Quality Improvement requirements and does not add burden.

The main benefit of requiring all QHPs to achieve Distinction in Multicultural Health Care is to support the creation of a necessary and consistent infrastructure for improving CLAS and narrowing disparities across Issuers. This would help ensure the plans' long-term capacity to prioritize support for this infrastructure. The process of gaining Distinction in Multicultural Health Care would trigger NCQA surveying and auditing resources that could reduce Covered California resources necessary to ensure compliance.

In addition, Distinction in Multicultural Health Care fills a gap in Covered California's Attachment 7 requirements by focusing on cultural responsiveness. If addressed in the context of closing disparities, this is fully complementary to Covered California's goals around narrowing disparities. For Issuers that also participate in Medi-Cal, this would reinforce existing state requirements.

Concerns about data challenges may be overstated in that data collection and reporting are already required by Covered California, the regulating agencies over SB 853 (DMHC and DOI), and DHCS for Medi-Cal. Many Issuers already capture self-reported race and ethnicity data for at least 80 percent of members.⁸ Any additional investment should be relatively modest, and we do not believe it would be enough to discourage QHP participation.

A growing volume of research and best practices demonstrate that achieving health equity requires policy-level changes and resource allocation or reallocation. Article 3 provides evidence of Covered California's commitment to improving the care and health outcomes for its most vulnerable members. The Article 3 requirements 3.01 (measuring care to address health equity), 3.02 (narrowing disparities) and 3.03 (expanded measurement), and 3.04 (encouraging Distinction in Multicultural Health Care), support QHP achievement of the necessary infrastructure and planning Issuers require to effectively address health disparities and increase equity.

We recommend that Covered California take the opportunity to strengthen its commitment to health equity by changing the language in Article 3.04 to "requiring health plans achieve the NCQA Multicultural Health Care Distinction." This policy level change can impact Issuers' allocation or reallocation of resources in the form of staffing and funding to deliberately address disparities and health equity, increasing infrastructure and reinforcing organizational commitment to this work.

⁸ Attachment 7, Article 3 requires QHPs to report on the percent of members for whom they have race and ethnicity identification. Covered California plans to eventually require QHPs submit member-level race and ethnicity data to the Marketplace but does not do so at present.