CAMPAIGN FOR EQUITY IN OBESITY CARE

April 18, 2022

VIA EMAIL
mary.watanabe@dmhc.ca.gov

Ms. Mary Watanabe
Director, Department of Managed Health Care
980 9th Street, Suite 500
Sacramento, CA 95814

VIA EMAIL
publiccomments@dmhc.ca.gov

Social Equity and Health Quality Committee
Department of Managed Health Care
980 9th Street, Suite 500
Sacramento, CA 95814

Re: Health Measures and Obesity

Dear Ms. Watanabe and the DMHC Social Equity and Health Quality Committee:

We write you in your roles supporting California's effort to advance social equity and health quality under the leadership of Governor Newsom. Consistent with the goals established by the Governor in the Summer of 2021, we urge you to take action now on a critical health equity crisis: The growing number of California adults in underserved communities living with obesity, and who lack access to comprehensive care for this chronic disease.

The obesity epidemic is one of the most serious health equity issues impacting our state, affecting 42 percent of Americans. As a top comorbidity for serious cases of COVID-19 and death, obesity disproportionately impacts Black and Latino communities, who are nearly three times as likely to be hospitalized for severe cases of COVID-19 than whites. Obesity is also linked to more than 200 serious health conditions including diabetes, heart disease, high blood pressure, and strokes.

Even though obesity is an epidemic that can lead to additional serious health issues, Black and Latino communities, and those from other underserved communities, can't access the health care needed to treat the disease.

A critical first step is the diagnosis of obesity. A formal diagnosis is the first step toward changing provider and patient behaviors in terms of addressing obesity. Furthermore, a diagnosis of obesity is impacted by bias and stigma among healthcare providers directly impacting the ability of those in underserved communities to seek care for and control their weight.

The **diagnosis of obesity must be included among the developing mandates** for changes in health care to achieve the goal of improved equity in health outcomes across all underserved communities.

Nationally, obesity is associated with nearly $1,900 in excess annual medical costs per person (amounting to over $170 billion in excess medical costs per year). Better access to a range of effective treatment not only could save money but also save lives. Reducing the obesity rate by 25% would have resulted in fewer hospitalizations, fewer ICU admissions, and fewer deaths during the pandemic. Nearly half of those reductions would be among Black people and nearly one quarter would be among Latino people, even though those communities account for 13.4 percent and 18.5 percent of the U.S. population, respectively.

The Campaign for Equity in Obesity Care (CEOC) is a public advocacy and public awareness organization founded in 2021. CEOC is exclusively dedicated to advancing covered health care for obesity, together with better access to, and utilization of, that care in underserved communities throughout California.

We recognize the extraordinary work that lies ahead and believe an important first step is to ensure that our laws and regulations reflect the latest guidelines and standards of care. To that end, we call on DMHC to take action immediately by requiring all health plans in this state to eliminate the disparities in the diagnosis and treatment of obesity.

Sincerely,

The Campaign for Equity in Obesity Care

Select Coalition Members

Reshape LifeSciences
California Psychological Association
California Academy of Nutrition and Dietetics
MedTech Coalition for Metabolic Health
National Kidney Foundation
CoachCare
Seca Precision for Health
Community RePower Movement
Mujeres de la Tierra
Obesity Action Coalition
Redstone Global Center for Prevention and Wellness
Obesity Medicine Association

From: Kristen Tarrell <K.Tarrell@westernhealth.com>
Sent: Wednesday, April 20, 2022 5:45 PM
To: DMHC Public Comments <publiccomments@dmhc.ca.gov>
Subject: Comments for the 4/20/22 Health Equity and Quality Committee

Thank you for this opportunity to provide comments.

1. I shared public comment during the meeting in support of choosing HEDIS measures that are also endorsed by the NQF. Below are thoughts I already shared and additional points I would like to bring forth:
    a. AB 133 is requiring all Commercial plans to have NCQA Health Plan Accreditation (HPA) by 1/2026. Health plans with Exchange line of business are required by Covered CA to have NCQA Health Equity Accreditation (HEA) by 2023. And, health plans with a Medicaid line of business are required to have the HEA by 1/2026. Both the HPA and the HEA require reporting of HEDIS measures.
    b. HEDIS is stratifying disparity sensitive measures by race and ethnicity and that list is expanding to ≥ 15 measures by MY2024.
    c. HEA requires health plans to report on the collection of SOGI data. This is a much needed move toward expanding health equity.
    d. HEDIS measures are robust, validated and established. Many are moving to e-measures which would require data exchange and may lead to even more robust data collection and data sharing.
    e. Choosing HEDIS measures will have less of a burden with data collection and reporting.

2. Please consider staying away from measures that use surveys as a data source. People are experiencing survey-fatigue as evidence by the continued decrease in the number of returned surveys. We are a small health plan, and using CAHPS as an example, the number of surveys returned by individuals who identify as a race other than "white" is far too few to allow for analysis or comparison.

3. In agreement with a committee member, it is important to ensure, that for each chosen measure, the services and interventions required to "move the needle" and improve health equity are actually covered benefits for all beneficiaries, in all lines of business.

4. I agree with Richard Riggs about the need of obesity focused measures. In addition to the HEDIS WCC measure included on the Mother and Child focus area list, there is also the HEDIS ABA (Adult BMI Assessment) measure. Per the specs it measures the percentage of members 18-74 years of age who had an outpatient visit and whose body mass index (BMI) was documented during the measurement year or the year prior to the measurement year.

5. HEDIS separated indicators for diabetes and individual measures replace the former Comprehensive Diabetes Care (CDC) measure for MY2022. The HbA1c testing measure was removed. The HbA1c control measures were combined and are now the Hemoglobin A1c Control for Patients with Diabetes (HBD) measure. The HBD measure is being stratified by race and ethnicity in MY2022.

Thank you again for your time and effort.

Respectfully submitted,

Kristen Tarrell, RN PHN MS CEN CPHQ
Accreditation Program Manager
Western Health Advantage

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Obesity Action Coalition

4511 North Himes Ave., Suite 250
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(800) 717-3117
(813) 872-7835
Fax: (813) 873-7838

info@obesityaction.org

June 20, 2022

VIA EMAIL
mary.watanabe@dmhc.ca.gov

Ms. Mary Watanabe
Director, Department of Managed Health Care
980 9th Street, Suite 500
Sacramento, CA 95814

VIA EMAIL
publiccomments@dmhc.ca.gov

Social Equity and Health Quality Committee
Department of Managed Health Care
980 9th Street, Suite 500
Sacramento, CA 95814

Re: Health Measures and Obesity

Dear Ms. Watanabe and the DMHC Social Equity and Health Quality Committee:

On behalf of the more than 75,000 members, including thousands of California residents, of the Obesity Action Coalition (OAC), we write you in your roles supporting California's effort to advance social equity and health quality under the leadership of Governor Newsom. Consistent with the goals established by the Governor in the Summer of 2021, we urge you to act now on a critical health equity crisis -- the growing number of California adults in underserved communities living with obesity who lack access to comprehensive care for this chronic disease.

The obesity epidemic is one of the most serious health equity issues impacting our country and the state, affecting 42 percent of Americans. As a top comorbidity for serious cases of COVID-19 and death, obesity disproportionately impacts Black and Latino communities, who are nearly three times as likely to be hospitalized for severe cases of COVID-19 than whites. Obesity is also linked to more than 200 serious health conditions including diabetes, heart disease, high blood pressure, and stroke. Even though obesity is an epidemic that can lead to additional serious health issues, Black and Latino communities, and those from other underserved communities, can't access the health care needed to treat the disease.

A formal diagnosis of obesity is the first step toward changing provider and patient behaviors in terms of addressing this complex and chronic disease. Furthermore, diagnosing obesity is frequently affected by bias and stigma among healthcare providers – often limiting the ability of those in underserved communities to seek

care for and manage their obesity. Therefore, the diagnosis of obesity must be included among the developing mandates for changes in health care to achieve the goal of improved equity in health outcomes across all underserved communities.

Nationally, obesity is associated with nearly $1,900 in excess annual medical costs per person (amounting to over $170 billion in excess medical costs per year). Better access to a range of effective treatment not only could save money but also save lives. Reducing the obesity rate by 25% would have resulted in fewer hospitalizations, fewer ICU admissions, and fewer deaths during the pandemic. Nearly half of those reductions would be among Black people and nearly one quarter would be among Latino people, even though those communities account for 13.4 percent and 18.5 percent of the U.S. population, respectively.

The OAC supports the efforts of the Campaign for Equity in Obesity Care (CEOC), a public advocacy and public awareness organization dedicated to enhancing patient access to, and coverage of, obesity care in underserved communities throughout California and the United States. We recognize the extraordinary work that lies ahead and believe an important first step is to ensure that our laws and regulations reflect the latest guidelines and standards of care. To that end, we call on DMHC to immediately act to require all health plans in California to eliminate the disparities in the diagnosis and treatment of obesity.

Should you have any questions or need additional information, please feel free to contact me or OAC Public Policy Consultant Chris Gallagher at chris@potomaccurrents.com. Thank you.

Sincerely

Joseph Nadglowski, Jr.
OAC President and CEO

Medtronic

Health Care
980 9th Street, Suite 500
Sacramento, CA 95814

VIA EMAIL
publiccomments@dmhc.ca.gov

Social Equity and Health Quality Committee
Department of Managed Health Care
980 9th Street, Suite 500
Sacramento, CA 95814

Re: Health Measures and Obesity

Dear Ms. Watanabe and the DMHC Social Equity and Health Quality Committee:

Medtronic would like to voice its support to include obesity (diagnosis and treatment) as a health equity related measure to evaluate health plans.

Medtronic is a leading global healthcare technology company with over 5,800 employees in the state of California.

Compared to average, prevalence of obesity is disproportionately greater among Blacks and Hispanics. Asians are susceptible to obesity related metabolic diseases at much lower Body Mass Index (BMI) levels compared to non-Hispanic Whites. Women and households with less than 350% of Federal Poverty Level are also disproportionately impacted by obesity.

It is well documented in the medical literature that these underserved communities face greater barriers to get their problem of obesity discussed and addressed. Obesity diagnosis is impacted by bias and stigma among healthcare providers, directly impacting the ability of those in the underserved communities to seek care for obesity. A formal diagnosis is the first step toward changing provider and patient behaviors.

We are a part of The Campaign for Equity in Obesity Care (CEOC), a public advocacy and public awareness organization, which has taken a similar position as Medtronic.

We call on DMHC to act immediately by requiring all health plans in this state to eliminate the disparities in the diagnosis and treatment of obesity.

Sincerely,

Stephanie Wimmer
Vice President, Healthcare Economics, Policy and Reimbursement, Medtronic
Address: 555 Long Wharf Drive, New Haven, CT 06511
Phone: 603-930-2158
Email: stephanie.n.wimmer@medtronic.com

June 16, 2022

VIA EMAIL
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Ms. Mary Watanabe
Director, Department of Managed Health Care
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Sincerely,

Anet Piridzhanyan, MS, RDN
Vice President, Public Policy
California Academy

Brenda O'Day, MS, RDN, CNSC
Immediate Past Vice President Public Policy
California Academy

cc: California Academy Executive Board

June 16, 2022

VIA EMAIL
mary.watanabe@dmhc.ca.gov

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Director, Department of Managed Health Care
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Sincerely,

MedTech Coalition for Metabolic Health Co-Chairs:

Jeffrey Mayes, MCMH
Julie Kofoed, KORR Medical Technologies
Jodi Mitchell, MCMH

From: Tiffany Huyenh-Cho <thuyenhcho@justiceinaging.org>
Sent: Wednesday, June 15, 2022 4:53 PM
To: DMHC Public Comments <publiccomments@dmhc.ca.gov>
Subject: Comments for 6/8 DMHC Equity Measures Meeting

Hello,

Please find some comments for last week's 6/8 meeting.

- Data that can be stratified and disaggregated is important: by race, ethnicity, language, age, etc. I second the various comments made that we cannot address health equity without understanding where the disparities lie.
- Access to care measures must reflect the lived experience of the consumers served by DMHC regulated plans, which iznclude most of the Medi-Cal managed care plans. Dual eligibles in 7 counties are part of Medi-Cal managed care plans regulated by DMHC and the entire statewide dual eligible population will be in Medi-Cal managed care as of January 1, 2023. The final set of measures selected by DMHC will soon apply to a broader swath of dual eligible beneficiaries. The dual eligible population generally have chronic conditions and account for a higher amount of Medi-Cal expenditures due to high needs. This group is also more likely to be women, people of color, and have limited English proficiency.
- I would also support methods that use the CAHPS survey more effectively. If the return rate is low, is there room to brainstorm how to better use this survey. Are there ways to improve the return rate, such as the method in which these surveys are returned, should the surveys go out to a larger random sample of health plan enrollees, or the entire plan membership. Granted, there is more to learn about the CAHPS survey but it would be helpful to know if the surveys are helpful to plans if the return rate is so low.
- From my recollection of last week's DMHC meeting, the CAHPS survey is not available in all languages except Spanish, English, and maybe written Chinese. All other languages are accessed via a telephone interpreter. I strongly support the CAHPS survey be required to be sent in all languages, or at least the 14 Medi-Cal threshold languages to improve language access and advance health equity.
- I also support the coordination of care measures (Plan All Cause Readmissions) remain as coordination of care measures on slide 62. There was discussion of whether some of these measure might be better characterized as quality measures but the measures as I understood them, focused on whether that person received the appropriate, and timely, follow-up care that could have prevented another hospital admission.

Thank you!

Tiffany Huyenh-Cho
(TI-fuh-nee WIN Choh)
Pronouns: she/her/hers
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We're celebrating 50 years of impact in 2022. *Check out our 50 for 50 Video Project featuring the voices of partners, clients, policymakers, funders, thought leaders, and others talking about all we've accomplished together.*

From: David Lown
To: DMHC Public Comments
Subject: Health Equity_Measurement for VBP_technical issues
Date: Friday, June 24, 2022 8:52:53 AM
Attachments: Health Equity_Measurement for VBP_technical issues_2022v4.docx

DMHC Health Equity and Quality Committee,
My name is David Lown, and I am the Chief Medical Officer for the California Health Care Safety Net Institute (SNI), which is the partner organization of the California Association of Public Hospitals and Health Systems (CAPH).
Based on the discussion of benchmarking and target setting that began towards the end of the last Committee meeting, we felt that the Committee members may benefit from the attached technical review that we at SNI wrote.
The document reviews technical topics relevant to the Committee's discussion:

- Identification of Disparities
    - Statistical Methodologies
    - Reference Population selection
- Target Setting
    - Absolute Targets
    - Gap Closure Targets (which employs two forms of relative methodologies)
- Geographic level of Reference Population
    - Discusses the interplay between Disparity Identification and Target Setting for Program Design

During this past week's discussion, one committee member requested a summary of the pros and cons of the various approaches, and this document does just that.
I'm happy to answer any questions the committee may have on the document.

David

David Lown, MD
Chief Medical Officer
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Preferred pronouns: he/him/his
Living on the unceded ancestral lands of the Coast Miwok

From: Linnea Koopmans
To: DMHC Public Comments
Subject: LHPC Feedback - DMHC Health Equity and Quality Measure Set
Date: Wednesday, July 20, 2022 9:06:29 PM

Hello,

On behalf of LHPC, which represents the 16 local, not-for-profit Medi-Cal managed care plans, please see the below feedback on the measures being considered by the DMHC Health Equity and Quality Committee for inclusion in the final measure set.

LHPC Feedback: DMHC Health Equity and Quality Measure Set

- Overall, the local plans support the 12 measures recommended by the committee for inclusion in the final measure set. We are supportive of the alignment between these measures and measures on the DHCS Managed Care Accountability Set (MCAS) and other Medi-Cal priorities (e.g., the DHCS "Bold Goals"). Additional comments on the final measures:
    - There are concerns regarding data collection and completeness regarding the depression screening measure. Screening results are reported by LOINC codes, which cannot be submitted through claims. Further discussion is needed, particularly regarding approach and process for establishing a benchmark for this measure.
    - Asthma Medication Ratio may be impacted by the Medi-Cal pharmacy carve-out, as MCPs do not have the ability to adjust formulary or authorization processes to promote use of controller medications versus emergency relief.
- With respect to the seven measures that were in the category of "for further discussion," LHPC recommends that these measures *not* be included in the final measure set for several reasons:
    - It is important that the final measure set is limited to a small number of measures (twelve or fewer) so that they can be prioritized by plans and providers for performance, improvement, and disparities reduction. These efforts will not be effective if there are too many measures. Therefore, we are supportive of eliminating all the measures in this category.
    - The measures in this category are not a part of the CMS Core Sets (or DHCS MCAS) so would be new measures beyond the nearly 40 measures already required in Medi-Cal managed care as a part of the MCAS.
    - Because of benefit carve-outs in Medi-Cal, particularly for SUD and SMHS, there would be challenges with data completeness and with comparing performance with commercial plans if some of these measures were to be included.

LHPC is still discussing the various benchmarking approaches being considered by the committee with the local plans. Acknowledging that the next meeting of the committee on August 17th will include a review of a draft report, what is the timeline for providing feedback or recommendations

on benchmarking?

Thank you,
Linnea

Linnea Koopmans • Chief Executive Officer
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DMHC Health Equity & Quality Committee: LHPC Recommendations

August 24, 2022

As DMHC concludes its Health Equity and Quality Committee process, the Local Plans of California (LHPC), which represents the 16 local Medi-Cal managed care plans serving over 8.5 million Medi-Cal enrollees provides the following recommendations regarding a benchmarking approach, measure stratification, and other important process considerations. Local plans are committed to providing high quality and equitable health care for the Medi-Cal populations they serve. They also understand firsthand how the challenges of poverty, geography and social factors impact care, and what's necessary to make an impact on health outcomes. For example, improving health outcomes for unhoused populations or individuals without full immigration status is more challenging than doing so for commercial or Medicare populations that have less of those barriers. With this in mind, we believe it's important for DMHC to adopt standards that will enable plans serving the most vulnerable populations to drive equity and improvement without negative impacts like sanctions which will reduce resources that could otherwise be invested in under-resourced communities to address health inequities. LHPC thanks DMHC in advance for considering our recommendations.

1. *Benchmark approach and percentile.* We understand that the Committee intends to recommend that DMHC establish an absolute benchmark for both Medi-Cal and commercial plans. Assuming this is the approach adopted by DMHC, LHPC recommends that DMHC utilize national Quality Compass Medicaid percentiles. Although there may be some measures where national Medicaid performance exceeds commercial plan performance, overall, we know that Medicaid performance is lower in large part due to poverty and related social drivers of health. If DMHC were to adopt a commercial standard, it would likely result in Medi-Cal plans being disproportionately penalized, thus reducing the available resources to invest in quality improvement. In short, adopting a commercial standard may not achieve the quality or equity outcomes that California seeks through this effort.

   Additionally, given that DMHC is establishing a single standard for all measures (i.e., there will not be a separate standard for the measure in aggregate versus for stratified subpopulations) we recommend the MPL be the 25th percentile based on the annual national Quality Compass data. It is important to recognize that the 25th percentile is actually a high standard to set as a minimum and we expect that most plans would not meet this percentile for a subset of measures or subpopulations. Were DMHC to adopt this standard, it would mean that for all measures and subpopulations, every plan would outperform a quarter of plans nationally. We would be concerned if the 50th percentile was used, as this would mean that all plans in California would be above average compared to all other Medicaid plans in the country for all subpopulations, which is an impossibly high standard statistically and would mean failure for most, if not all, plans. Additionally, as improvement occurs, California's plans will actually increase the bar for performance as we would drive increases in the percentages associated with the national percentiles.

2. *Measure stratification.* We support DMHC's alignment with NCQA stratification requirements. However, given that sometimes the denominators may be very small for certain subpopulations or measures, DMHC guidance should specify that for measures where there is not statistical significance due to a small denominator, the stratified measure will be removed from reporting. Additionally, while not in the purview of DMHC, there are longstanding challenges with the completeness of Medi-Cal demographic data. We understand that as a part of CalAIM DHCS will be working to improve these data (currently approximately 20% of Medi-Cal enrollees are of unknown race or ethnicity) however this work has not yet begun. That lack of data for 20% of the population could both skew results upward or downward and means that plans are unable to intervene for members in specific sub-populations that are not identified in the group. DMHC consideration for data improvement efforts should consider DHCS timing and process, as plans are reliant on state and county eligibility systems for such information.

3. *Reassessing benchmarks and measures.* Although the statute allows the measures and standards to remain in place for up to five years before they sunset, we recommend that DMHC reassess the measures and standards after three years. After three years, there will be sufficient data and experience to evaluate the selected measures and benchmarks, particularly for the stratified measures, and determine whether changes may be appropriate. There should also be a mechanism or process to determine whether there were any unintended consequences related to the measure standards and benchmarks. One example could be lowering of quality measure scores for subpopulations that initially had higher scores due to greater interventions with lower scoring subpopulations.

4. *Timeline for establishing new benchmarks.* Where benchmarks do not exist today, we recommend a minimum of two years before those measures are subject to DMHC enforcement and accountability activities. This is the standard approach for new quality measures or benchmarks given that the first year is data capture with results mid-year the next year, which allows setting of the benchmark for year 3. This will also enable plans to design interventions and make any needed adjustments to their quality efforts before accountability and enforcement activities begin.

A Public Entity
Inland Empire Health Plan

August 18, 2022

Ms. Mary Wantanabe
Director, Department of Managed Health Care
980 9th Street, Suite 500
Sacramento, CA 9581

VIA EMAIL: mary.watanabe@dmhc.ca.gov
publiccomments@dmhc.ca.gov

RE: Public Comment – August 17, 2022, Meeting of the Health Equity and Quality Committee

Dear Director Wantanabe,

On behalf of Inland Empire Health Plan's (IEHP) Executive Team, thank you for the opportunity to offer feedback following the August 17- meeting of the Department of Managed Health Care (DMHC) Health Equity and Quality Committee ("Committee"). Having served on the Committee since its inception, it truly has been a privilege to represent IEHP and work with DMHC, Sellers Dorsey and my fellow Committee members to help shape recommendations that will inform the equity and quality measures that DMHC is developing and ultimately mandating.

As the local-initiative Medi-Cal managed care plan for Riverside and San Bernardino counties, IEHP is proud to coordinate the health care for more than 1.5 million Medi-Cal beneficiaries. As Chief Quality Officer for IEHP, I am committed to ensuring that the care they receive is of the highest quality and is provided as expeditiously as possible. It is because of this commitment that I feel compelled to offer additional feedback for DMHC's consideration on the conversation that was offered at the last meeting of the Committee on August 17. While there was considerable support for the equity and quality initiatives, there was a divergence of opinion on two key considerations that I wish to offer an additional perspective on:

(1.) IEHP recommends that DMHC adopt the 25th percentile benchmark. It is understood and recognized that the 25th percentile is an ambitious target that will challenge health plans but also be more achievable in the near-term for plans to meet. The importance of the "achievability" of DMHC's initial benchmark cannot be understated. I agree that ensuring that the goals of increasing quality and equity will require a pragmatic and thoughtful approach that allows plans the flexibility to effectively design and ramp up their quality efforts. This also ensures DMHC flexibility as it positions its management and compliance infrastructure to hold plans accountable to these initial measures and benchmarks. It is for this reason that IEHP believes the 25th percentile is the more appropriate benchmark to set for the initial phases of this important effort.

(2.) IEHP recommends DMHC adopt the alternative two-year timeframe versus a one-year lag time on when quality and equity benchmarks will be released and updated. Like the feedback stated

A Public Entity
Inland Empire Health Plan

previously, IEHP supports the aims of DMHC's equity and quality efforts, and we want those efforts to succeed. However, success will only be achievable if the Department and health plans have the flexibility to effectively plan and prepare to meet the benchmarks that are adopted, both in the early phases of the program, and when those targets are updated based on new data that is provided. By adopting the two-year lag time, this will allow plans the additional time needed to make effective adjustments to their equity and quality improvement efforts.

Thank you for the opportunity to offer the comments above and if you have any questions about the recommendations therein, please don't hesitate to reach out to me personally at (909) 890-2930 or by email at Juhn-E@iehp.org.

Sincerely,

Edward Juhn, MD, MBA, MPH
Chief Quality Officer, IEHP

CC: Jarrod McNaughton, IEHP CEO

P.O. Box 1800, Rancho Cucamonga, CA 91729-1800
Tel (800) 440-IEHP (4347) • TTY (800) 718-4347 • Fax (909) 890-2003
Visit our website at: www.iehp.org