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

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info@obesityaction.org

June 20, 2022

VIA EMAIL
mary.watanabe@dmhc.ca.gov

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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

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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

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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

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Sincerely,

MedTech Coalition for Metabolic Health Co-Chairs:

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

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

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