November 9, 2015

Anne Price, Director

Plan Management

Dr. Lance Lang, M.D.  
Chief Medical Officer  
Covered California   
1501 Exposition Way  
Sacramento, CA

**Re: Prioritizing Health Disparities Reduction in Covered California**

**Qualified Health Plan Contracting**

Dear Ms. Price and Dr. Lang,

The mission of Covered California is “to increase the number of insured Californians, improve health care quality, lower costs, and reduce health disparities.” The California Pan-Ethnic Health Network is committed to eliminating health disparities and to improving health equity for all Californians. We write to ask that in its 2017 Qualified Health Plan contract requirements, Covered California go beyond asking for data and impose contract requirements that require the reduction of health disparities for specified disease conditions. Specifically for the 2017 contract year, we seek year over year reductions in health disparities for specified conditions. For future years, we will ask that contracting health plans meet specified targets consistent with the Let’s Get Healthy California taskforce targets, the California Wellness Plan developed by the California Department of Public Health, and subsequent efforts to improve public health.

Covered California’s membership is 60% communities of color, many of whom experience disproportionate rates of chronic diseases. The 2017 QHP contract is an important opportunity for Covered California to act as Director Peter Lee has stated, “as a catalyst for change in California’s health care system, using its market role to stimulate new strategies for providing high-quality, affordable health care, promoting prevention and wellness, and reducing health disparities.”[[1]](#footnote-1)

We focus in this letter on disparities related to race and ethnicity because this data should be available to the health plans. Medi-Cal managed care has required the collection of data on race and ethnicity for the last twenty years. Similarly commercial plans have been required to collect data on race and ethnicity since

2009. We strongly support reducing other health disparities, including those associated with the LGBTQ community. However, we recognize that due to impediments at the federal level, Covered California and its QHPs currently lack data on sexual orientation and gender identity. We are disappointed by this fact but recognize that the lack of such information impedes the reduction in disparities that should occur for the LGBTQ communities.

We identify four potential areas for quality improvement strategies that will advance health equity in Covered California contracts: diabetes, hypertension, asthma and mental health. In addition, since obesity and tobacco use are co-morbid with each of these, we suggest targeting obesity and tobacco use. In each of these areas, we ask that for the 2017 contract, health plans use 2016 data and be required to demonstrate improvement in managing these conditions over the 2017 contract year.

Below are some additional considerations and information as Covered California considers the adoption of appropriate measures to advance health disparities reduction as part of its 2017 contracts with QHPs:

**Chronic Conditions in California:**

Chronic conditions are the leading cause of death in the United States and the biggest contributor to health care costs. Sociodemographic factors such as income, race, ethnicity and geographic location can impact the prevalence of these types of conditions. According to the California Health Care Foundation (CHCF), about 40% of adults in California — over 11 million people — reported having one or more chronic condition, and about 3 million adults reported having two or more.[[2]](#footnote-2) Adults on public insurance plans were more likely to have one or more chronic conditions compared to those on private plans or the uninsured.

Covered California’s membership shares some similarities with the Medi-Cal program. Beneficiaries are diverse, 60% are communities of color and close to three-quarters (70%) are low-income (earning less than 250% FPL). About 95% of the Covered California enrollment has been adults, ages 19-64. Because of the evolving program standards for pregnant women which now allow pregnant women up to 321%FPL to be enrolled in Medi-Cal with zero premiums and zero cost sharing, we anticipate that few pregnant women will be enrolled in Covered California during the course of their pregnancy. Because the enrollees of Covered California are predominantly low and moderate income, non-pregnant adults from communities of color, we strongly suggest that there be a focus on improving the overall quality of care in areas with clear evidence of health disparities, diabetes, hypertension, asthma and mental health, along with reducing obesity and tobacco use. Focusing on these target areas will assist Covered California in making progress toward meeting the quadruple aim of reducing cost, improving quality and population health while reducing health care disparities.

The Medi-Cal program in its Managed Care Quality Strategy, revised October 2015, is specifically targeting control of hypertension, diabetes care and tobacco cessation for its adult population, which given Covered California’s primary enrollees, low-moderate income adults, many of whom are from communities of color, we highlight to hopefully bring some alignment in health disparities reduction strategies across the state.

**Diabetes/Hypertension**

Over 2.3 million California adults report having been diagnosed with diabetes, representing one out of every 12 adult Californians, or about 8.3%, a significantly higher proportion than reported by most QHPs.[[3]](#footnote-3) Prevalence is even higher among racial and ethnic groups, Californians with low educational attainment, and poor families, the majority of Covered California’s membership. Latinos and African Americans have twice the prevalence of type 2 diabetes and are twice as likely to die from the disease.[[4]](#footnote-4)

Diabetes is the seventh leading cause of death in California and the underlying cause of death in almost 8,000 people each year. As diabetes is a contributing factor to many deaths from heart disease and stroke, diabetes may be under-represented as a contributing cause of death. The Centers for Disease Control (CDC) estimates as many as 37% of adults in the U.S. have prediabetes and are at risk for developing diabetes. Most are unaware they have the condition.[[5]](#footnote-5)

The cost of diabetes care, if left untreated, is high. Spending associated with adults in Medi-Cal treated for diabetes totaled $3.6 billion or roughly 14% of total spending on non-dual eligibles.[[6]](#footnote-6) The most costly 1% of the diabetes population, just 1,006 individuals, generated roughly 13% of total spending or $248 million. Improving diabetes prevention and symptom management will help to allay treatment costs.

Obesity and smoking are strong risk factors for type 2 diabetes. Obese adults have a four times higher risk of type 2 diabetes compared to normal weight adults in California. Adults with type 2 diabetes are also more likely to have other health problems, including cardiovascular disease and arthritis. One of every two adults with type 2 diabetes also has hypertension.[[7]](#footnote-7)

*Recommended Measures for Quality Improvement Strategies for Diabetes, Hypertension, Tobacco Cessation and Obesity:*

Measures on diabetes control, tobacco cessation, controlling high blood pressure and measuring obesity are currently in use by the Centers for Medicare and Medicaid Services (CMS) and the National Committee for Quality Assurance (NCQA) as part of the Quality Rating System (QRS) for Marketplaces and the Core Set of Adult Health Care Quality Measures for Medicaid.

|  |  |  |  |
| --- | --- | --- | --- |
| **Focus Area for Improvement** | **Recommended Quality Measures** | **2016 QRS Measure** | **Adult Core Set Medicaid** |
| **Diabetes** | Comprehensive/Optimal Diabetes Care:  o   Hemoglobin A1c Poor Control  o   Hemoglobin A1c testing  o   Eye exam  o   Medical attention for nephropathy | 🗸 | 🗸 |
| Medical Assistance with Smoking and Tobacco Use Cessation | 🗸 | 🗸 |
| Aspirin Use and Discussion | 🗸 | 🗸 |
| Controlling High Blood Pressure | 🗸 | 🗸 |
| Adult BMI Assessment | 🗸 |  |

In every instance, Covered California should already have access to stratified data on these measures in 2016, making it easier to hold plans accountable for meeting the rudimentary standard of year over year improvement in diabetes control, tobacco cessation, hypertension control, and obesity. For each of these measures, plans should be expected to show reductions, stratified by race and ethnicity for the 2017 plan year.

**Asthma**

Asthma is a significant public health problem. In California, roughly 1 in 7 people (close to 5 million) has been diagnosed with asthma.[[8]](#footnote-8) Across all measures of asthma burden, there are large disparities by race and ethnicity, income, age, sex, to name just a few. The prevalence of current asthma among American Indians and Alaska Natives is three times greater than the state average. African-Americans have exceptionally higher rates of asthma prevalence (40%), four times higher asthma ED visit and hospitalization rates, and two times higher asthma death rates than Whites.[[9]](#footnote-9)

Low-income populations have higher asthma severity, poorer asthma control, and higher rates of asthma emergency department visits and hospitalizations.[[10]](#footnote-10) Recent Covered California enrollees, particularly those below 250%FPL, are more likely to have asthma that has not been well managed or well controlled. Progress in control of adult asthma is important in reducing mortality, morbidity, lost work days and co-morbidities such as stress on the cardiac system.

Asthma management can achieve year over year improvements. There are well demonstrated efforts for pediatric asthma patients in reducing emergency room visits and achieving better control of their asthma. Conversely, the cost of not treating asthma is high. Adults with asthma had higher emergency department visit rates than the overall California adult population (34% vs. 19%). Among adults with asthma, one-third of emergency department visits in the past year were asthma-related. Some of these visits might have been prevented through appropriate and accessible primary care, regular medications, and good asthma management.

CMS is recommending the use of an additional measure: Medication Management for People with Asthma as part of the 2016 QRS survey which Covered California should adopt for 2016. Neither the 2016 QRS nor the Medicaid Adult Core Set includes a comprehensive/optimal measure set for asthma. However some states, most notably Minnesota has adopted a measure: Optimal Asthma Care, as part of their quality measurement and related reporting of payment approaches of the state’s Medicaid Accountable Care Organizations. The National Quality Forum (NQF) endorsed measure is an all-or-none, Composite (“optimal” care) measure of the percentage of pediatric and adult patients who have asthma and meet specified targets to control their asthma. Since this is not currently part of CMS’ 2016 QRS, this would be an additional asthma measure we would encourage Covered California to consider adopting.

In addition, being obese and smoking are major risk factors for asthma. Among California adults with asthma, 16%, or an estimated 340,000 people, reported being current smokers. A larger percentage of adults with asthma were obese (33%) compared to the general adult population (25%). Measures on obesity (Adult BMI Assessment) and smoking (Medical Assistance with Smoking and Tobacco Use Cessation) as referenced above, are currently in use by the Centers for Medicare and Medicaid Services (CMS) and the National Committee for Quality Assurance (NCQA) as part of the Quality Rating System (QRS) for Marketplaces and Core Set of Adult Health Care Quality Measures for Medicaid.

Covered California should ask CMS to align its asthma measures with those in the Medicaid adult core set. Specifically, the QRS measures should include admission rates for older adults with asthma and asthma in younger adults’ admission rates. Adoption of these measures would help to better align quality strategies between the two programs, Medi-Cal and Covered California.

|  |  |  |  |
| --- | --- | --- | --- |
| **Focus Area** | **Specific Quality Measures** | **2016 QRS Measure** | **Adult Core Set Medicaid** |
| **Asthma** | Medication Management for People with Asthma | 🗸 |  |
| NQF #1876 Optimal Asthma Care\* |  |  |
| Chronic Obstructive Pulmonary Disease (COPD) or Asthma in Older Adults Admission Rates (age 40 and up) |  | 🗸 |
| Asthma in Younger Adults Admission Rate |  | 🗸 |

\*This composite measure reflects the percentage of adults and children who have optimally managed asthma with all of following components met: a) Asthma is well-controlled; b) Patient is not at increased risk of exacerbations; and c) Patient has been educated and has a current, written asthma action/management plan.[[11]](#footnote-11)

*Recommended Measures for Quality Improvement Strategies*

While Covered California will have only one asthma measure in place in 2016, medication management for people with asthma, showing year over year improvement in medication management for people with asthma as well as reduction in disparities associated with race and ethnicity would be progress in meeting the quadruple aim. For future years, we would hope that Covered California would set asthma management targets comparable to what have been achieved in other efforts in California.

**Mental Health**

According to the California Health Care Foundation (CHCF), 2.2 million Californians are experiencing severe psychological distress. Notable disparities exist in mental health by income, race and ethnicity. For example, serious psychological distress was more than two times greater among lowest income adults overall (138% FPL and lower) than those in the highest income group (400+% FPL). Additionally approximately 1 in 10 American Indians and Alaskan Natives, African Americans, and Latinos experienced serious psychological distress in the past year. The prevalence of serious psychological distress was more than twice as high among those with Medi-Cal or other public insurance (14%) and nearly 1.5 times greater among the uninsured (9%) than among those with private insurance.

Mental health is frequently co-morbid with other chronic conditions. The 2007 California Health Interview Survey (CHIS) found that adults with mental health needs were 1.5 times more likely to have high blood pressure, heart disease, or asthma – or to have two or more of these select chronic conditions – compared to other adults.[[12]](#footnote-12) Without appropriate preventive measures, these patients are often the most costly to treat. In California’s Medi-Cal program individuals treated for diabetes and serious mental illness or alcohol and drug dependency produced an acute care hospital inpatient rate of 795, a rate that was nearly 3 times greater than those treated for diabetes only.

Excessive alcohol consumption and smoking have been identified as risk factors associated with serious psychological distress among adults. Among Californians who reported serious psychological distress in the past year, the prevalence of binge drinking and current smoking was higher than the state average.[[13]](#footnote-13)

Measures on the initiation and engagement of alcohol and other drug dependent treatment are currently in use by the Centers for Medicare and Medicaid Services (CMS) and the National Committee for Quality Assurance (NCQA) as part of the 2016 QRS and the Core Set of Adult Health Care Quality Measures for Medicaid. Additionally, CMS’ 2016 QRS will include a measure on follow-up after hospitalization for mental illness. Medicaid currently measures screening for clinical depression and follow-up plan.

|  |  |  |  |
| --- | --- | --- | --- |
| **Focus Area** | **Specific Quality Measures** | **2016 QRS Measure** | **Adult Core Set Medicaid** |
| **Mental Health** | Screening for Clinical Depression and Follow-Up Plan |  | 🗸 |
| Follow-Up After Hospitalization for Mental Illness | 🗸 |  |
| Initiation and Engagement of Alcohol and Other Drug Dependent Treatment | 🗸 | 🗸 |

*Recommended Measures for Quality Improvement Strategies:*

Covered California should have access to stratified data on two out of three measures in place in 2016, Follow-up After Hospitalization for Mental Illness and Initiation and Engagement of Alcohol and Other Drug Dependent Treatment. For future years, we would hope that Covered California would ask for access to data on the third measure, Screening for Clinical Depression and Follow-Up Plan to ensure consistency between programs. Covered California should require it’s contracting QHPs to show year over year improvement from 2016 to the 2017 plan year. For future years, it should hold plans accountable for meeting specified benchmarks to be developed during 2016.

**Patient Experience of Care**

Standardized consumer surveys like the Consumer Assessment of Health Plan (CAHPS) survey is another important tool to measure the progress of QHPs towards reaching concrete disparities reduction goals. Thus we were keenly disappointed to learn of the impact of small sample size requirements on the validity of data gleaned from this year’s CAHPS surveys. With an ambitious disparities reduction strategy, Covered California cannot wait till 2017 for consumer information that more accurately reflects the unique experiences of the exchange’s diverse enrollees.

We strongly support Covered California’s request that CMS require plans to survey larger sample sizes and allow for big states like California to move towards regional surveys in 2016 and beyond. Additionally, although CAHPS can be a useful tool for measuring overall quality of care, the sample size for consumer surveys as saw this year, is often too small to support generalizations about the experiences of people from smaller ethnic, racial, and language subgroups within each individual plan. Below are some recommendations for steps Covered California can take to overcome some sample size challenges so 2016 data can be used effectively to reduce disparities for the exchange’s diverse enrollees. Specifically Covered California should:

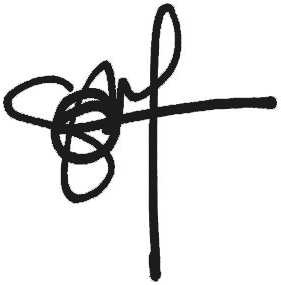
* Pool survey data by demographics across plans to have an understanding of the diverse experience of Covered California enrollees.
* Work with plans to boost response rates to surveys, especially among limited English proficient communities, This could include providing technical assistance and resources such as marketing dollars to educate consumers about the importance of CAHPS surveys and incentivizing QHPs to use translated, validated CAHPS surveys in other languages besides English, Spanish and Chinese.
* Develop alternative methods for capturing experiences of diverse enrollees by conducting supplemental surveys or focus groups.

**Conclusion**

As a leading exchange in the nation, Covered California should move forward in reducing the health disparities of its members by directing its QHPs to meet concrete disparities reduction goals in specific target areas starting in 2017. Additionally the exchange should work with QHP partners to develop valid measures of patient experience of care for your diverse membership. Once again, California has the opportunity to lead the nation by ensuring that health equity is not only important but central to your quality improvement strategy and to the exchange’s ability to achieve its mission of reducing health disparities in our state.

We strongly urge you to take action now to ensure the 2017 QHP contract requirements provide an important and meaningful step towards reducing persistent health disparities. Please contact myself or Cary Sanders, Director of Policy Analysis, if you have any further questions at (510) 832-1160.

Sincerely,



Sarah de Guia, JD

Executive Director/CPEHN

Cc: Peter Lee, Executive Director Covered California

1. Peter Lee, Executive Director’s Report, March 2015: <http://board.coveredca.com/meetings/2015/3-15/PPT%20-%20Executive%20Director's%20Report_March%205,%202015.pdf> [↑](#footnote-ref-1)
2. “Californians with the Top Chronic Conditions: 11 Million and Counting,” California Health Care Almanac 2015. California Health Care Foundation, April 2015. [↑](#footnote-ref-2)
3. “Burden of Diabetes in California,” California Department of Public Health Chronic Disease Control Branch, September 2014 [↑](#footnote-ref-3)
4. Ibid [↑](#footnote-ref-4)
5. Ibid [↑](#footnote-ref-5)
6. “Understanding Medi-Cal’s High-Cost Populations,” Department of Health Care Services, Research and Analytic Studies Division (RASD), June 2015. [↑](#footnote-ref-6)
7. “Californians with the Top Chronic Conditions: 11 Million and Counting,” California Health Care Almanac 2015. California Health Care Foundation, April 2015. [↑](#footnote-ref-7)
8. California Health Interview Survey data. 2011. UCLA Center for Health Policy Research. http://ask.chis.ucla.edu/main/default.asp. Accessed August 11, 2015. [↑](#footnote-ref-8)
9. Asthma in California: A Surveillance Report, May 2013. California Department of Public Health: <https://www.cdph.ca.gov/programs/ohsep/Documents/Asthma_in_California2013.pdf> [↑](#footnote-ref-9)
10. Milet M, Lutzker L, Flattery J. Asthma in California: A Surveillance Report. Richmond, CA: California Department of Public Health, Environmental Health Investigations Branch, May 2013. [↑](#footnote-ref-10)
11. “Quality Measurement Approaches of State Medicaid Accountable Care Organization Programs,” Center for Health Care Strategies, Inc. Technical Assistance Tool, September 2014. [↑](#footnote-ref-11)
12. California Health Interview Survey, 2007 [↑](#footnote-ref-12)
13. “Californians with the Top Chronic Conditions: 11 Million and Counting,” California Health Care Almanac 2015. California Health Care Foundation, April 2015. [↑](#footnote-ref-13)