JUSTICE IN AGING

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January 27, 2022

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California Department of Health Care Services
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Submitted via email to DHCSComprehensiveQualityStrategy@dhcs.ca.gov

Re: Comments on 2022 DHCS Comprehensive Quality Strategy

Thank you for the opportunity to submit comments on the Draft 2022 Department of Health Care Services Comprehensive Quality Strategy Report (CQS). Justice in Aging strongly supports a robust strategy to ensure quality throughout the Medi-Cal program and reduce health disparities. We appreciate the Department's increased focus on equity throughout the strategy report and the expansion of the strategy beyond Medi-Cal managed care. We submit the following comments.

We urge the Department to significantly improve the strategy's focus on older adults and individuals dually eligible for Medicare and Medi-Cal. The CQS outlines three bold goals including preventive care for children, maternal health, and behavioral health integration. While these clinical domains are essential and would have a positive impact on Medi-Cal beneficiaries across the lifespan, they do not serve to directly improve health outcomes for older adults and people with disabilities today.

The lack of focus on older adults and people with disabilities in the CQS is inconsistent with the state's commitment to improve the health care of this population outlined in the Master Plan for Aging. It also fails to recognize the disproportionate and significant impact COVID-19 has had on older adults and people with disabilities enrolled in Medi-Cal. Dual eligibles have the highest hospitalization and death rates.[1] This is because dual eligibles are more likely to have underlying health conditions that place them at higher risk for serious illness and death from COVID including chronic kidney disease requiring dialysis, cardiovascular disease, diabetes mellitus, and chronic lung disease. Dual eligibles of color have been at highest risk of infection and hospitalization and California's dual eligible population is diverse.[2] Communities of color represent two-thirds of California's dual eligible population.[3] Dual eligibles are also more likely

[1] CMS, "Preliminary Medicare COVID-19 Data Snapshot," (Sep. 17, 2021), available at https://www.cms.gov/files/document/medicare-covid-19-data-snapshot-fact-sheet.pdf
[2] Id.
[3] CHCF, "A Primer on Dual-Eligible Californians: How People Enrolled in Both Medicare and Medi-Cal Receive Their Care," (Sep. 2020), available at https://www.chcf.org/wp-content/uploads/2020/09/PrimerDualEligiblePeopleEnrolledMedicareMediCal.pdf

to receive care in nursing facilities that have posed particular risk for older adults and people with disabilities during the pandemic in California.[4]

While we recognize that Medi-Cal's role in providing care for dual eligibles largely does not encompass medical care, the role Medi-Cal plays in covering long-term services and supports, transportation, dental, hearing, vision, care coordination, and addressing social determinants of health is vital in improving health outcomes for this population. We therefore look forward to working with the Department to inform the development of the addendum specifically focused on long-term services and supports and home and community-based services. However, that addendum is not a replacement for the focus needed in this current draft.

We recommend the following to expand the strategy's focus specifically on older adults and dually enrolled individuals with an emphasis on improving health disparities.

- **Include Specific Strategies on Meeting Duals Needs in Managed Care**

Dual eligibles face significant barriers in accessing care that stems from having two separate insurance programs responsible for different benefits. Medi-Cal managed care plans, therefore, play a different role in providing care for individuals dually enrolled in Medicare and Medi-Cal than for other populations. This impacts all aspects of the delivery system from the need for tailored notices for dual eligibles enrolled in Medi-Cal to specific training for health plan staff on how the plan serves duals to the actual provision of care. For duals, Medi-Cal managed care plans are not responsible for medical care and instead are primarily responsible for long-term services and supports, transportation, hearing, vision, palliative care, and care coordination including coordination with Medi-Cal specialty mental health. The need for specific quality strategies to ensure managed care plans are adequately serving the dual eligible population and addressing health disparities is critical especially as more duals are required to enroll in Medi-Cal managed care and managed care plans become increasingly responsible for more benefits including enhanced case management, community supports, and the institutional long-term care benefit pursuant to CalAIM. The CQS must include specific disparity-reducing goals with respect to these types of services for all Medi-Cal members, including dual eligibles.

- **Better Address Medi-Cal Fee-for-Service, Including Dental**

While the CQS proports to "encompass all DHCS quality activities," it neglects to include specific measurements and strategies to address quality in Medi-Cal fee-for-service.

Most notably, the strategy fails to include goals or activities to improve access to oral health care outside of dental managed care. Dental managed care operates in just two counties, Sacramento and Los Angeles and is voluntary in Los Angeles. The overwhelming majority of Medi-Cal enrollees receive their dental care through fee-for-service. Accordingly, the Department must include strategies to address quality in access to oral health care. This is

[4] CHCF, "COVID-19 in California's Nursing Homes: Factors Associated with Cases and Deaths," (Dec. 2020) available at https://www.chcf.org/wp-content/uploads/2020/11/COVID19CAsNursingHomesFactorsCasesDeaths.pdf.

critical for older adults and people with disabilities who have poor oral health outcomes that impact their overall health. These strategies should specifically focus on addressing disparities based on age, disability, race, sexual orientation, gender identity, and where one lives. Older adults and people with disabilities living in institutional settings like nursing facilities in particular have very poor oral health and continue to face significant barriers in accessing dental services in Medi-Cal.[5]

The CQS should set targets in improving access to oral health in these settings as well as targets for increasing access to dental services such as annual cleanings and periodontal treatment that include specific targets to address disparities. The CQS should also include as a strategy fully implementing AB 2207 enacted into law nearly six years ago that requires Medi-Cal plans to conduct dental screenings for all enrolled members, refer members to dental providers, and identify plan liaisons to better coordinate with dental managed care and dental fee-for-service contractors to facilitate referrals and coordination of dental care with other medical care.[6]

Medi-Cal fee-for-service also continues to play a critical role for dual eligibles. Twenty-nine percent or approximately 405,000 dual eligibles continue to receive care in fee-for-service and will do so until they transition to Medi-Cal managed care plans in January 2023. For this population, access to Medi-Cal transportation through fee-for-service in particular continues to be fraught and acts as a barrier to accessing care. Regardless of future plans to transition duals and the eventual size of the remaining populations in fee-for-service, the CQS should account for Medi-Cal's continued role in serving the fee-for-service population.

- **Include Transportation**

The current draft CQS does not include transportation, either through managed care or fee-for-service. Medi-Cal transportation is a critical benefit for all Medi-Cal enrollees and can literally be a lifeline for older adults and people with disabilities who are less likely to be able to drive and rely on transportation for lifesaving care like dialysis.[7] There are well-documented and long-standing problems with the availability, reliability, and quality of transportation in Medi-Cal and with the transportation vendors that Medi-Cal plans contract with to deliver the benefit. Given who in the Medi-Cal program relies on transportation, e.g. individuals with End-Stage Renal Disease requiring dialysis, and the inequities they face, the CQS must include specific activities and targets to improve and ensure quality of the transportation benefit and that it is equitably available and utilized.

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[5] See, *Brown v. Azar*, Amicus Curia Brief of Justice in Aging, et al., Aug. 17, 2021, available at, https://justiceinaging.org/wp-content/uploads/2021/08/amicusBrownVAzar.pdf and Center for Oral Health, "A Healthy Smile Never Gets Old: A California Report on the Oral Health of Older Adults," (Mar. 2018), available at https://www.centerfororalhealth.org/wp-content/uploads/2018/11/Oral-Health-of-Older-Adults.pdf.

[6] AB 2207, Medi-Cal: Dental Program, Sep. 25, 2016.

[7] Justice in Aging and Center for Consumer Engagement in Health Innovation, "Medicaid Non-Emergency Medical Transportation: An Overlooked Lifeline for Older Adults," (Oct. 2016), available at http://justiceinaging.org/wp-content/uploads/2016/11/NEMT-Medicaid-Transportation.pdf.

- **Include Palliative Care**

In January 2018, the Department issued guidance to Medi-Cal managed care plans to implement SB 1004, legislation aimed at increasing the availability of palliative care services to Medi-Cal recipients. As a relatively new benefit, the CQS should be tracking the quality of the benefit and ensuring that it is equitably available. For duals, palliative care is particularly critical. Medicare does not provide coverage for the bulk of services provided under Medi-Cal palliative care benefit and duals are more likely to suffer from multiple chronic conditions and therefore, more likely to use the emergency room or require hospitalization, particularly near the end of life. It is during this period of time that the highest Medicare-Medi-Cal spending occurs and when dual eligibles would most benefit from palliative care.[8] Palliative care has proven to both improve quality of life and health outcomes and reduce health care expenditures through decreased emergency department use, hospital stays, and associated costs.[9] However, the use of palliative care is lower among communities of color and often not delivered in a way that takes into consideration cultural differences and customs. It is therefore imperative that the CQS include palliative care.[10]

- **Improve Data Requirements to Advance Equity for Older Adults and People with Disabilities in Medi-Cal**

The COVID-19 pandemic has exposed the inadequacies in our healthcare data systems. Early on, it was difficult to get accurate data around infections for individuals in nursing facilities and other congregate settings by race and age. Even today, COVID-19 vaccination data in California at the intersection race and age is not publicly available. In order to combat health disparities in 2022 and beyond, DHCS must invest in a public-facing data infrastructure that measures disparities in access and utilization using a framework of intersectional discrimination.

The CQS must include age as a required characteristic for which data is reported and publicly available, which is currently not included in the draft CQS. This is necessary for both the reporting strategies identified in the CQS with the Centralized QPHM as well as the data-driven improvement strategies. It also applies to the CQS's vision with respect to data collection and stratification under the health equity roadmap. Aging introduces unique issues faced by older adults and exacerbates existing disparities for individuals experiencing multiple forms of discrimination over the course of their lives. The inclusion of age must be in addition to and intersectional with other demographic characteristics DHCS intends to collect, stratify and report on. This is needed because looking at any characteristic in a vacuum potentially masks unique trends and disparities that may exist at those intersections.

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[8] Bynum, J. P., Austin, A., Carmichael, D., & Meara, E. (2017). High - cost dual eligibles' service use demonstrates the need for supportive and palliative models of care. Health Affairs, 36(7), 1309-1317.
[9] Brumley, R., Enguidanos, S., Jamison, P., Seitz, R., Morgenstern, N., Saito, & Gonzalez, J. (2007). Increased satisfaction with care and lower costs: results of a randomized trial of in-home palliative care. Journal of the American Geriatrics Society, 55(7), 993-1000.
[10] Ornstein, K., et al., "Evaluation of Racial Disparities in Hospice Use and End-of Life Treatment Intensity in the REGARDS Cohort," (Aug. 2020), available at https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2769692.

Because many medical services for older adults and people with disabilities are covered under the Medicare program, the CQS must identify opportunities to incorporate Medicare data in order to mitigate disparities faced by dual eligibles. This includes the information gathering element of the Population Health Management Program Framework, as well as other opportunities. We note that DHCS working with Medicare data is not without precedent; Medicare claims data was utilized in the enrollment process for dual eligibles under the Coordinated Care Initiative. It may be an opportunity for work under the new DHCS Office of Medicare Innovation and Integration (OMII). Obtaining and leveraging Medicare data to eliminate disparities for older adults and people with disabilities is absolutely critical.

Finally, to the extent that the CQS relies on algorithms for stratification or enrollment purposes, we encourage the Department to seriously evaluate whether the use of those algorithms may result in racially disparate outcomes. A growing body of literature suggests that algorithmic bias in healthcare settings may automate the ignoring of Black pain.[11] The CQS presents an opportunity for DHCS to review its algorithms across programs and functions to ensure that they do not harm the very communities they are intended to support.

- **Undocumented older adults**

The expansion of full-scope Medi-Cal benefits to undocumented older adults age 50 and over in May 2022 is a momentous change. This population group has long been barred from accessing comprehensive health coverage through both public insurance and the private exchange, including access to primary and specialty care, behavioral health, In-Home Supportive Services, among other benefits Medi-Cal offers. This means this group will have health needs, including medical, behavioral, and dental, that likely went untreated for years.

The inclusion of older adults into the CQS and the specific strategies listed in this letter to target dental, transportation benefits, palliative care, and data requirements would also benefit this population group. Because this group will be new to managed care, setting specific goals to track the completion of Health Risk Assessments, or a scheduled primary care appointment within a set amount of time from date of enrollment will track this group's access to care. While access to health coverage is a critical first step, tracking access and quality of care is needed to reduce health disparities and improve health outcomes for all population groups.

- **LTSS Addendum**

We look forward to working with the Department in developing the CQS addendum for long-term services and supports over the next year. The complexity of oversight and delivery of these services across state departments requires unique and targeted strategies that we applaud the Department for recognizing. Justice in Aging has been very engaged in the state's efforts to strengthen and expand access to Medi-Cal home and community-based services

[11] Ghassemi, M., Nsoesie, E., "In medicine, how do we machine learn anything real?", (Jan. 2022), available at https://www.sciencedirect.com/science/article/pii/S2666389921002592?via%3Dihub

especially with regard to ensuring these benefits are equitable available based on age, disability, race, ethnicity, sexual orientation, gender identity, and where one lives in the state.[12] We welcome the opportunity to provide feedback throughout the development of the addendum.

Please feel free to reach out to us to discuss our comments in more detail. You can reach me at thuyenhcho@justiceinaging.org.

Sincerely,

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[12] CHCF, "Using Data for Good: Toward More Equitable Home and Community-Based Services in Medi-Cal," (Dec. 2021), available at https://www.chcf.org/wp-content/uploads/2021/11/UsingDataGoodHCBSMediCal.pdf.