California Food Policy Advocates

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Richard Figueroa
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Sacramento, CA 95899-7413

RE: Recommendations to strengthen the CalAIM proposal

Dear Richard Figueroa,

Thank you for launching the CalAIM initiative and for the opportunity to provide feedback on the draft proposal. California Food Policy Advocates (CFPA) strongly supports the initiative's goal to identify and manage Medi-Cal member risk through social determinants of health. However, we are concerned that the proposal will not adequately address the critical needs of millions of Medi-Cal members whose health is suffering due to poor nutrition, nor will the plan support the development of the delivery system necessary for Medi-Cal providers to deliver appropriate care management to this population. As an organization with significant experience advocating policies to increase access to nutritious, affordable food, we write to offer our recommendations for how the plan can better support health systems in addressing food insecurity.

Food insecurity is worsening beneficiary's health and driving up health care costs for the state. Strategies to address food insecurity should be an essential component of CalAIM.

A substantial body of research has drawn an undeniable link between food insecurity and increased health care costs. Food insecurity is associated with an increased likelihood of chronic disease, hospitalizations, poorer disease management, developmental and mental health problems, as well as increased health care spending.[1,2,3] Researchers recently demonstrated that cost varies by locality and California has the highest associated annual model-based health care cost associated with food insecurity at over $7 billion.[4]

The association between food insecurity and increased health care costs is related to several factors. Individuals who are food insecure are more likely to skip meals and binge eat when food is available, often on low-cost foods that are calorically dense, but poor in nutritional quality.[5,6,7] Without the ability to afford or access sufficient healthy food options, individuals are left with unhealthy food choices that ultimately worsen their health. The competing financial demands of

declining health force individuals to make financial tradeoffs, including foregoing necessary medication or treatment.[8] Worsening health further drains household budgets as individuals face worsening health, increased hospitalizations, more frequent medical visits, and increased prescription costs. The stress and uncertainty that comes with food insecurity also increases the likelihood of depression and psychological distress.[9] Several studies now associate food insecurity with increased utilization of care and a growing body of research demonstrates that food insecurity drives up health care costs for both the individuals seeking care and for health insurers, even when accounting for other demographic and clinical characteristics.[10,11,12,13,14,15,16]

Food insecurity has significant economic consequences for health care payers, most importantly the state. In California, over 4 million adults and 2 million children are food insecure, meaning they live in households with limited, uncertain, or inconsistent access to the quality and quantity of food that is necessary to live a healthy life.[17] About 42% of these individuals are estimated to be enrolled in Medi-Cal.[18] Page 159 of the draft CalAIM proposal states "reimbursements to address food insecurities is not covered." This is at odds with CalAIM's goals and general reasoning given the evidence base and experience of food insecurity among the Medi-Cal population.

RECOMMENDATION 1: Add Nutrition Care Coordination and Nutrition Transition Assistance as an In Lieu of Service benefit.

Nutrition-related care coordination helps beneficiaries gain access to necessary food assistance and provides help navigating a complicated web of available services and supports. The below bullets outline different types of nutrition-related care coordination or transition assistance that should be included as an In Lieu of Services. Innovative Medi-Cal providers, whole person care pilots, hospitals, and health clinics, currently utilize the services listed below. Through inclusion of nutrition care coordination or transition services as an In Lieu of Services, the state could help build the infrastructure for more Medi-Cal providers to provide similar support to their clients. These services and supports would be beneficial to all individuals who screen positive for food insecurity using validated clinical screening tools, but would particularly benefit those who are homeless, at risk for institutionalization, transitioning from an institution, suffering from substance-use disorders, disabled, and the elderly.

- Conducting a food insecurity screening and assessment of participation in available forms of assistance, and an assessment of the participant's preferences and barriers related to food security. The assessment may include collecting information on the participant's unique needs and potential barriers to assistance.
- Developing an individualized nutrition support plan based upon the food insecurity screening and assessment that addresses identified barriers, includes short- and long-term measurable goals for each issue, establishes the participant's approach to meeting the goal, and identifies when other providers or services, both reimbursed and not reimbursed by Medi-Cal, may be required to meet the goal.
- Searching for nutrition support and presenting options.

- Assisting in securing nutrition support, including the completion of applications for medically-tailored meals, emergency food assistance, food prescription programs, and processing of referrals to local food assistance providers.
- Securing required identification and documentation for accessing available nutrition support (e.g., proof of medical expenses, proof of housing costs, proof of disability or program exemption, proof of identify).
- Communicating and advocating on behalf of the client with benefit providers.
- Establishing procedures and contacts to remain connected to supportive programs and services, including developing a nutrition support crisis plan that includes prevention and early intervention services.
- Targeted outreach to the member if identified as at risk for food insecurity.
- Referring clients to additional income supports that could reduce the likelihood of food insecurity (e.g., education on the Earned Income Tax Credit and referral to free tax preparation services; evaluation for child care subsidies and referral to supports, etc.)
- If included in the nutrition support plan, identifying and securing resources to cover expenses for necessary equipment for healthy, safe, preparation of food (e.g., refrigerator, stove, or other kitchen supplies for the homeless or individuals living in single-room occupancy units).
- If included in the nutrition support plan, identifying, coordinating, environmental modifications to install necessary accommodations for food preparation accessibility (e.g., lowering a kitchen counter so a disabled beneficiary can prepare food on their own while sitting in their wheelchair).
- Provision of emergency food at discharge from an institution (e.g., hospital, skilled nursing facility).
- If included in the nutrition support plan, identifying, coordinating, securing, or funding non-emergency, non-medical transportation to assist member's access to nutrition support.
- Establishing HIPAA-compliant pathways to communicate bi-directionally with other providers or services.

RECOMMENDATION 2: In addition to pursuing pre-release Medi-Cal, coordinate with the California Department of Social Services to incorporate a mandatory inmate pre-release CalFresh application process for interested individuals.

Research has shown that participation in SNAP (known as CalFresh in California) reduces a person's likelihood of admission into a hospital by an average of 14 percent, into a nursing home by an average of 23 percent, and has the potential to save $2,100 in annual healthcare expenses per person enrolled.[19] Unfortunately, those returning from prison and jail face challenges with enrolling into the program. Some are unable to secure access to the necessary documents required to enroll and in many cases it can take up to a month after applying before benefits are actually received. Establishing a pre-release CalFresh application process has the potential to reduce recidivism by providing formerly incarcerated individuals with better access to the basic resources necessary for successful reentry, and it has the potential to lower health care costs for the state.

Although incarcerated individuals are ineligible to receive SNAP benefits while they are residents of an institution, the California Department of Social Services can request a waiver from USDA which would allow counties to accept applications and conduct eligibility interviews from incarcerated applicants and other applicants from institutions such as from skilled nursing facilities prior to their release. USDA historically approves such waivers. In the last year, USDA approved 10 states' applications for prerelease application processes from institutions, including Colorado, Illinois, Maine, Missouri, Montana, New Jersey, New York, Oregon, South Dakota, and Tennessee.[20] Most Medi-Cal recipients are also eligible to receive CalFresh and the application process for Medi-Cal is regularly handled by the same county workers who process CalFresh applications. If the state will be pursuing a mandatory inmate pre-release process for Medi-Cal, it only makes sense to also take the necessary steps to provide inmates and individuals who will soon be released from skilled nursing facilities or other institutions with the ability to choose to enroll in food assistance. Similarly, DHCS should consider requiring warm handoffs to case workers who can assist with food access upon release from county jail and other institutions.

In addition, it is not clear why this proposed aspect of the plan is limited to only county jails as opposed to state corrections facilities. We encourage the state to not limit pre-release Medi-Cal or CalFresh to only county inmates as individuals in state corrections facilities and other facilities would also benefit.

RECOMMENDATION 3: Include food insecurity as a required component of the initial risk assessment member-contact screening. Ensure the screening responses can be shared with and later reported on by DHCS.

A significant number of health care experts recognize the potential of food insecurity screening to mitigate the harmful effects of the cycle of food insecurity and chronic disease. In 2013, the California Medical Association adopted a resolution promoting the use of food insecurity screening among medical providers to identify children and adults who are food insecure.[10] The American Academy of Pediatrics released a policy statement in 2015 encouraging the integration of food insecurity screening as part of regularly scheduled health maintenance visits for children.[11] In 2016, the American Diabetes Association also encouraged food insecurity screening in their annual Standards of Medical Care in Diabetes.[12] These screening tools, shortened for clinical use, have provided a means to integrate food insecurity screening into medical practice.

Now, many health clinics, hospitals, and medical providers across California are using validated one- or two-item screening tools to identify patients who would benefit from a food resource referral: Contra Costa County Health System conducts food insecurity screenings universally on all patients.[21] In January 2019, the 2-item screener was integrated into Los Angeles County's electronic health record, ORCHID and the county has been training county staff on how to use the screener and track referrals.[22] There

are many other examples of health clinics and health systems using food insecurity screening across California. When effectively implemented in health care, screening for food insecurity can flag food-insecure individuals who can then be assessed for appropriate interventions based on their preferences and barriers to food security.

We support the plan DHCS has laid out to require a member-contact screening as part of the initial health assessment, however we would like to see the recommendation around screening for "access to basic needs" strengthened to specify food insecurity, given the evidence base supporting screening in health care settings. Previously, as the California Department of Health Care Services convened the Staying Healthy Assessment workgroup to provide recommendations to update the Staying Healthy Assessment, the majority of advisors strongly recommended the inclusion of a screening tool around food insecurity. There may be conflicting opinions about what validated screening tool to use, and we recommend providing flexibility to plans, but directing them to use evidence-based screening tools or screening questions that are approved by DHCS. We also support the requirement to make these questions reported electronically. Plans should be required to report this data to DHCS and the aggregate data should be shared publicly for appropriate planning within our Medi-Cal system.

RECOMMENDATION 4: Provide greater specificity to "use of community-based services and supports," requiring specific questions related to evidence-based supports that have a significant impact on health and economic security, including SNAP, EITC, Supplemental Security Income, General Assistance, federal housing subsidies, CalWORKs, and WIC. Seek stakeholder input on the opportunity to access enrollment data for these programs in a secure manner that protects patient privacy while limiting obstacles for patient-centric integrated care.

Food insecurity and housing insecurity are often the result of poverty. It makes sense to screen patients for social safety net programs that keep Californians out of poverty, especially those that often go unused because individuals may not know that they qualify or face challenges with accessing available supports. The largest social safety net programs - SNAP, EITC, Supplemental Security Income, General Assistance, federal housing subsidies, CalWORKs, and WIC - kept an estimated 7.1% of Californians out of poverty in 2017.[23] With more targeted outreach from health care providers to a population of individuals who may not know they qualify, these safety-net programs may be able to reach an even greater number of Medi-Cal beneficiaries. We therefore recommend providing greater specificity to "use of community-based services and supports," requiring specific questions related to evidence-based supports that have a significant impact on health and economic security or alternatively seeking input on opportunities for Medi-Cal Managed Care Plans to access enrollment data for these

programs in a secure manner that protects patient privacy while limiting obstacles for patient-centric integrated care.

RECOMMENDATION 5: Require Medi-Cal Managed Care Plans to describe in the population health management program how they will coordinate with and refer members to WIC and require Medi-Cal Managed Care Plans to support data sharing and more seamless enrollment of eligible Medi-Cal patients into WIC.

Federal law requires state Medicaid agencies to coordinate with WIC agencies, to notify all eligible Medicaid recipients about WIC's services, to refer eligible individuals to local WIC agencies, and to combine WIC program intake procedures with intake procedures for other health programs or services administered by state and local agencies, whenever possible. However, evidence suggests that the processes the state has put in place to connect individuals who are enrolled in Medi-Cal to WIC have significant room for improvement. A recent data match conducted by the California Department of Public Health in coordination with the California Department of Health Care Services found that 500,000 Medi-Cal recipients are eligible, but not participating in the WIC program. Through CalAIM, there is a window of opportunity to encourage greater integration between Medi-Cal and WIC. This could occur through greater coordination between Medi-Cal Managed Care health plans and local WIC agencies.

As part of their existing contracts with the state, Medi-Cal Managed Care Plans are already required to have a Memorandum of Understanding with local WIC agencies and to have procedures to identify and refer eligible members to WIC.[24] However, a recent study by the California WIC Association found that only three local agencies are actually exchanging information about WIC with their health plan. In most other cases, WIC referrals are happening by medical providers via paper-based referrals. For those few WIC agencies that are exchanging client information with health plans, a list of enrolled Medi-Cal members who are also eligible to participate in WIC are provided to the WIC agency who can then conduct targeted outreach. Similar coordination should be occurring across all Medi-Cal Managed Care Plans. Health plans should be required to establish data exchange processes with local WIC agencies to provide streamlined access and enrollment for Medi-Cal members to WIC. The state should seek the input of local WIC agencies on other opportunities to strengthen seamless enrollment of Medi-Cal patients into WIC while also considering how to support more seamless enrollment of WIC clients into Medi-Cal.

RECOMMENDATION 6: Expand Targeted Enhanced Care Management services to include individuals experiencing food insecurity as a target population and expand the programmatic elements to specify that Enhanced Care Management can be used to "help beneficiaries obtain and maintain food security, as appropriate."

Although many of the target populations listed on page 42 of the CalAIM proposal likely experience food insecurity, DHCS should specifically mention individuals with food-insecurity as a target population for targeted/enhanced care management. Food-insecure individuals drive up

health care costs to the state. Although they also increase costs for Medi-Cal Managed Care plans, any financial return related to social service investments may take many years to realize, which can decrease the financial feasibility of addressing food insecurity by care plans. Therefore, Medi-Cal Managed Care plans are unlikely to fund care management for food-insecure beneficiaries unless there are dedicated resources to do so. A recent John Snow Institute and Commonwealth Fund issue brief have suggested the need for flexible funding for case management related to addressing social needs coordination.[25] To help connect food-insecure individuals to the supports they need to achieve food security, DHCS should include food-insecure individuals as a target population for Targeted Enhanced Care Management. In addition, DHCS should update the programmatic elements, as has been done for housing stability, to specify that funds can be used to help beneficiaries obtain and maintain food security, as appropriate.

RECOMMENDATION 7: Expand on Skilled Nursing Facility Coordination to require Medi-Cal Managed Care plans to coordinate with skilled nursing facilities to ensure that at discharge the member is connected to adequate nutrition support.

A large number of individuals who are discharged from Skilled Nursing Facilities end up back in the hospital relatively soon after discharge. Studies have indicated that malnourished patients are more likely than well-nourished patients to be readmitted. In addition, studies have indicated that when individuals are connected to post-discharge meals or to SNAP at discharge their likelihood of readmission is decreased. As part of the discharge process, DHCS should ensure that in addition to medically necessary services being available, that connection to adequate nutrition support is available. This might direct the plan to, for example, provide a referral to SNAP, emergency food assistance, medically tailored meals, an IHSS worker who can help with food preparation, a referral to Older Americans Act nutrition programs, a referral to an adult day health facility that serves meals, etc. We suggest the following items be included as part of the allowable expenses for Nursing Facility Transition/Diversion services outlined on pages 148-153 of the draft proposal:

- Assessing the participant's food security needs and presenting options.
- Establishing procedures and contacts to retain nutrition support.
- Assisting in searching for and securing food support.

RECOMMENDATION 8: Ensure that home modifications related to food preparation are included as part of the Environmental Accessibility Adaptations (Home Modifications) In Lieu of Services.

Just as bathrooms or showers must be made wheelchair accessible to ensure that a person can remain in their home, individuals may require kitchen modifications to enable them to continue to cook and prepare food from a wheelchair. Most kitchens were not made for individuals who require wheelchairs or who can not stand for long periods of time due to their medical condition. Kitchen counters may be too high. Cupboards may be out of reach. Creating accessible work areas and storage in the kitchen can make it easier to access food from a sitting position. By

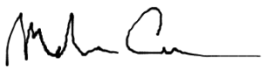
making kitchen areas more accessible, individuals who would otherwise have to rely on an IHSS worker or another means to access food, such as home-delivered meals that might not meet their cultural needs, would be able to reside in their home longer and have greater dignity in terms of their food choices. DHCS should add “making a kitchen wheelchair accessible (e.g., lowering a kitchen counter, or creating a wheelchair accessible work station) as an example of allowable home modifications.

RECOMMENDATION 9: Add greater specificity to the requirement for Medi-Cal Managed Care Plans to develop data exchange protocols. Require Medi-Cal Managed Care Plans to include within their data exchange protocols member information sharing protocols for sharing data with social service providers.

Health information technology is not only necessary to support the provision of care with health care providers, but also with providers of social services and community supports. DHCS has proposed to require Medi-Cal Managed Care Plans to establish protocols that support integrated behavioral health-physical health coordination. In order to better support CalAIM’s goal for addressing social determinants of health, the CalAIM proposal should be expanded to include protocols that support social determinants of health coordination, at a minimum for addressing food and housing security. This supports other efforts underway by the California Health and Human Services Agency, the California Office of Health Information Integrity plans to update the existing State Health Information Guidance to include data sharing guidance related to nutrition care coordination.

Thank you for your consideration of our recommendations. We look forward to participating in the development of CalAIM over the next year. If you have any questions, we can be reached at the contact information provided below.

Sincerely,



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