Building an Equitable Health Care Delivery System: Federal and State Strategies

Thursday, April 2, 2015
3:30-4:30 p.m. EDT

For audio, please listen through your speakers or call: (855) 850-0622

Supported by The Commonwealth Fund
What is Health Equity?

For the purposes of this webinar:

“Health equity is assurance of the conditions for optimal health for all people. Achieving health equity requires valuing all individuals and populations equally, recognizing and rectifying historical injustices, and providing resources according to need. Health disparities will be eliminated when health equity is achieved.” (Camara Jones, CDC, 2011).
New Payment Designs

- Prevalent fee-for-service reimbursement model has well-known deficiencies
  - Incentivizes service volume
  -Disconnected from the value of services provided
  -Encourages fragmentation of care delivery

- Payers turning to payment models that reward value
  - E.g., shared savings, episode-based payment, and global payments linked to performance on quality indicators

New Delivery Models

- Re-organizing care delivery to promote efficiency, quality
  - Linking payment to value, performance instead of service volume gives providers latitude to redesign care processes

- Encouraging teamwork, linking disparate providers and resources in communities
  - New models can help bridge a range of physical, behavioral, and social supports to meet the needs of communities

States are in the Midst of Ongoing System Transformation
## Financing Strategies

1. **Link reimbursement to high-value service delivery,** where “value” includes recognition of equitable care delivery and outcomes
2. **Pay for referrals and other connections to community and social supports**
3. **Make new payment incentives (e.g., shared savings) contingent upon meeting health equity goals**
4. **Incorporate health equity targets/goals (e.g., around data collection, provider training, or health outcomes) into managed care contracting relationships**

## Delivery Models

1. **Promote training and recruitment efforts of community health workers and others who can support community-based delivery models**
2. **Leverage new data collection systems to target underserved populations**
3. **Incorporate representation, perspectives from diverse populations in community health planning processes**
4. **Implement new delivery models in safety net settings and for diverse communities**
## Webinar Agenda

<table>
<thead>
<tr>
<th>Time</th>
<th>Session Title</th>
<th>Presenter(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>3:30 pm ET</td>
<td>Welcome and Opening Remarks</td>
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<tr>
<td>3:35 pm ET</td>
<td>State Strategies for Building an Equitable Health Care Delivery System</td>
<td>Rebekah Gee, Medicaid Medical Director, Louisiana Department of Health and Hospitals, Chip Allen, Director of Health Equity, Ohio Department of Health</td>
</tr>
<tr>
<td>4:00 pm ET</td>
<td>The Federal Perspective</td>
<td>Cara James, Director of the Office of Minority Health, CMS</td>
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<tr>
<td>4:10 pm ET</td>
<td>Questions and Discussion</td>
<td></td>
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<tr>
<td>4:25 pm ET</td>
<td>Wrap up</td>
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Health Equity in Louisiana

Rebekah E Gee, MD, MPH, MSHPR, FACOG
Medicaid Medical Director, Louisiana
Sources: United Health, U.S. Census Bureau (Huffington), U.S. Department of Education
## Racial Inequities in Louisiana

<table>
<thead>
<tr>
<th></th>
<th>Whites</th>
<th>Blacks</th>
<th>Hispanics</th>
</tr>
</thead>
<tbody>
<tr>
<td>Poverty Rate</td>
<td>17%</td>
<td>45%</td>
<td>40%</td>
</tr>
<tr>
<td>Males/No High School Diploma</td>
<td>2.5%</td>
<td>17.7%</td>
<td>11.8%</td>
</tr>
<tr>
<td>Incarceration Rate/100,000</td>
<td>425</td>
<td>1658</td>
<td>745</td>
</tr>
<tr>
<td>Life Expectancy</td>
<td>76.5</td>
<td>72.1</td>
<td>78.6</td>
</tr>
<tr>
<td>Infant Mortality Rate/1,000</td>
<td>6.6</td>
<td>13.9</td>
<td>3.9</td>
</tr>
<tr>
<td>Adult Overweight/Obesity Rate</td>
<td>64.7%</td>
<td>74.3%</td>
<td>72.3%</td>
</tr>
</tbody>
</table>

Preterm Births by Race/Ethnicity: 2010-2012

Percent of live births

Source: March of Dimes Peristats
US Cities with Highest Rates of New HIV Infections Per Capita, 2011

1. Miami
4. Jackson, Miss.
7. Memphis, Tenn. (includes Miss. and Ark. suburbs)
9. New York City (includes N.Y., N.J., and Pa. suburbs)

<table>
<thead>
<tr>
<th>Measure</th>
<th>Measure Description</th>
<th>Target Population</th>
<th>Baseline</th>
<th>Target for Improvement</th>
</tr>
</thead>
<tbody>
<tr>
<td>HIV Viral Load Suppression</td>
<td>% of patients, regardless of age, with a diagnosis of HIV and HIV viral load of &lt;200.</td>
<td>Chronic Disease</td>
<td>51.34</td>
<td>54.34</td>
</tr>
</tbody>
</table>
Health Equity Challenge - Progesterone

<table>
<thead>
<tr>
<th>Measure</th>
<th>Measure Description</th>
<th>Target Population</th>
<th>Condition</th>
<th>Baseline</th>
<th>Target for Improvement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Initiation of Injectable Progesterone Therapy</td>
<td>% of women 15-45 with evidence of previous pre-term birth event</td>
<td>Children’s and Maternal Health</td>
<td>Perinatal and Reproductive Health</td>
<td>~5.00</td>
<td>20.00</td>
</tr>
</tbody>
</table>
## AQM Disparities

<table>
<thead>
<tr>
<th>Quality Measure</th>
<th>White females</th>
<th>Black females</th>
<th>White males</th>
<th>Black males</th>
</tr>
</thead>
<tbody>
<tr>
<td>PQI 01: Diabetes Short-Term Complications Admissions Rate</td>
<td>150</td>
<td>207</td>
<td>245</td>
<td>362</td>
</tr>
<tr>
<td>PQI 08: CHF Admissions Rate</td>
<td>185</td>
<td>381</td>
<td>570</td>
<td>1243</td>
</tr>
<tr>
<td>Antidepressant Medication Management</td>
<td>19</td>
<td>10</td>
<td>19</td>
<td>11</td>
</tr>
<tr>
<td>Early elective deliveries</td>
<td><strong>23</strong></td>
<td>13</td>
<td>n/a</td>
<td>n/a</td>
</tr>
</tbody>
</table>
Major Initiatives

- **Office of Public Health/Medicaid partnerships**
- **Risk Bearing Medicaid Managed Care Delivery Model**
  - Contractual requirement to collect and report on race/ethnicity
  - Performance metrics tied to payment (HIV)
  - Performance improvement projects focused on disparities
  - Full integration of physical and behavioral health 12/1/15

- **Family Planning Eligibility Group SPA**
- **Birth Outcomes**
  - 39 weeks payment reform
  - Vital records registry allows for pay-for-performance metrics on C-sections and Progesterone administration
  - Unbundling of global OB codes, comprehensive coverage of long acting reversible contraceptives, initiatives to reduce sexually transmitted illnesses
  - Best Babies Zone
Applicable Federal Programs & Policies

• Section 2303 Family Planning Eligibility Group SPA
• 42 CFR Section 438—Medicaid Managed Care regulations
• CMS Adult Quality Measures Grant
• Center for Medicare and Medicaid Innovation
• Medicaid Innovation Accelerator Program (IAP)
  – Substance Use Disorder Treatment
  – ER Super Utilizers
  – Behavioral and Physical Health Integration
• CDC field placement of a physician within a Medicaid agency
Barriers and Overcoming Them

**Barriers:**
- Silos created by different funding streams (Public Heath and Medicaid)
- Required reporting by states to CMS does not include disparities; states may not have a full understanding of them
- CDC and federal funding mechanisms

**Proposed Solutions:**
- Technical assistance to reduce disparities in population health through collaboration between Public Health and Medicaid
- IAP
- Requiring states to submit a health disparities action plan; including expectations in new managed care regulations
“Of all the forms of inequality, injustice in health care is the most shocking and inhumane.”

“Our waiting rooms look better when it is not our “Medicaid day.” We ultimately cancelled that day because we were tired of the patients showing up with children and their McDonald’s dipping sauces.”
• How do we make disparities a fundamental part of quality reporting so that disparities are central to the conversation and can therefore not be ignored?
Department of Health and Hospitals
Louisiana Birth Outcomes Initiative
DHH Bienville Building
628 N. 4th Street
Baton Rouge, Louisiana
(225) 342.9500
Website: www.dhh.la.gov

Ruth Kennedy, Medicaid Director
Kathy Kliebert, Secretary

Bureau of Health Services Financing (Medicaid)
Rebekah Gee, MD, MPH, FACOG
Medicaid Medical Director
Building New Partnerships and Community-Based Approaches to Equitable Delivery Systems

April 2, 2015

NASHP Health Equity Webinar

Johnnie (Chip) Allen, MPH
Director of Health Equity
Ohio Department of Health
• Fortify Medicaid managed care contracts language with health equity provisions.

• Develop partnerships outside of Medicaid and public health.

• Develop a set of health disparity and health equity metrics that can be routinely tracked as a standard operating procedure through dashboard indicators.

• Intensify pathways for community involvement.
Prerequisites for Effective Partnerships for Health Equity

- Used NASHP Learning Collaborative to enhance partnerships with other state agencies motivated to address health equity (i.e., Ohio Medicaid, Ohio Commission on Minority Health, Ohio Department of Health).

- Level of readiness to pursue policy initiatives to address health inequities.

- Plans to include community input in major decision-making activities.
Building New Partnerships to Support Equitable Delivery Systems

- Created health equity language for Medicaid Managed Care Contracts.

- Enhance Patient Centered Medical Home & Health Home initiatives to advance health equity.

- Advocated for the use of standards based on the HHS Data Standards for Race, Ethnicity, Sex, Primary Language & Disability Status in the new Medicaid Eligibility System.
Health Equity Strategy Development

Health Equity can fuse these elements together!

The Provider Agreement Structure:

- General Information in the Baseline Section
- Appendices such as:
  - Service Area Specifications
  - Managed Care Plan Responsibilities
  - Coverage and Services
  - Quality Care
  - Data Quality
Appendix K – Quality Assessment and Performance Improvement Program

The MCP must participate in, and support, OMA’s efforts to eliminate health disparities in Ohio. The U.S. Department of Health and Human Services -- Centers for Disease Control Prevention defines health disparities as “differences in health outcomes and their determinants as defined by social, demographic, geographic, and environmental attributes.”

The MCP will be required to participate in a Health Equity Workgroup (HEW) which will, at a minimum, be comprised of representatives from each MCP, OMA, Ohio Commission on Minority Health, and the Ohio Department of Health. The HEW will be charged with characterizing the extent of healthcare disparities among health plan members by establishing common health disparity measures and developing a strategy to address disparities revealed by the results of the measures. When establishing disparity measures, the workgroup will determine the data elements (e.g., self-identified race, ethnicity, and language) needed to calculate the health disparity measures. MCPs will collect the data elements and calculate the results of the measures to inform the development of the strategy.
Progress So Far

• First project--- Eliminating disparities in poor birth outcomes.

• Much of Ohio has extremely poor birth outcomes and high infant mortality rates, especially for African American Black Infants.

• The Medicaid Health Equity Language was an important catalyst for to improve birth outcomes and address infant mortality.

• Ohio Medicaid obtained special permission by CMS to work on a quality improvement project working on improving birth outcomes.

• Ohio Medicaid is working with MCOs to do quality improvement activities.

• Eventually extend findings to guide value-based purchasing.
The **Ohio Perinatal Quality Collaborative (OPQC)** is a statewide consortium of perinatal clinicians, hospitals, and policy makers and governmental entities that aims, through the use of improvement science, to reduce preterm births and improve birth outcomes across Ohio. OPQC involves subject matter experts, uses successful evidence-informed strategies, and employs data-driven quality improvement methods and well-accepted project management processes. Success comes from a collaborative approach that builds upon an established network of OPQC-member hospitals with a history of executing successful statewide quality improvement initiatives.
Where is health equity in this process?
Standard Identification of Progesterone candidate

OPQC clinicians submit standardized form

OPQC Progesterone Project
Measure: % PTB who received Progesterone
(after birth – w manual & Birth certificate info)

Sweet spot of accelerated improvement due to aligned working together

Medicaid MCP PIP Progesterone Project
Measure: Number of Women who received Progesterone
( 6 week lag of pharmacy/claim data)

**Courtesy of Ohio Medicaid & Dr. Mary Applegate**
The Power of Collaboration

Integration of Data

Social Determinants of Health
Consumer Behaviors
Clinical Care
Policy
Historical Factors

Information to Achieve Health Equity
Integration of Different Data Sources for Health Equity

Infant Mortality Metrics

Women of Childbearing Age In Hot Spots

Clinical

Infant Mortality

ODH Vital Statistics & Market Research

Birth Outcomes
Understanding the Population Beyond Clinical Personas

10,818 Households

- Sixty-Six (66) Segments or Groups in the U.S.
- Five (5) Predominant Segments or Groups in the Hotspots

| Urban Achievers (21%) | Multi-Culti Mosaic (17%) | Low-Rise Living (11%) | City Roots (12%) | Urban Elders (9.5%) |

- 1206 Households.
- Less likely to visit a General/Family Doctor in the last year.
- 48% more likely to visit a OBGYN.
Each partner recognized we lack critical data and information.

We had to make consciousness decisions to share data and respect insights.

Sharing information provided insights that we could have never realized working separately.

This is only the beginning! More good collaboration is planned for the future!
Highlights from CMS Efforts to Reduce Health Disparities

Cara V. James, PhD
CMS Office of Minority Health
April 2015

“Working to Achieve Health Equity”
HHS Action Plan to Reduce Racial and Ethnic Health Disparities

• **Goal 1:** Transform Health Care

• **Goal 2:** Strengthen HHS Workforce and Infrastructure

• **Goal 3:** Advance the Health, Safety, and Well-Being of the American People

• **Goal 4:** Advance Scientific Knowledge and Innovation

• **Goal 5:** Increase Efficiency, Transparency, and Accountability of HHS Programs
Sec. 10334 of the ACA and the HHS Offices of Minority Health
New Data Collection Standards

- Required by Section 4302 of the Affordable Care Act for the following:
  - Race
  - Sex
  - Ethnicity
  - Disability
  - Primary Language

- Secretary has the authority to add other categories (e.g. socioeconomic status and sexual orientation)
Receipt of All Annually Recommended Services for Adults with Diabetes by Race/Ethnicity, 2008

<table>
<thead>
<tr>
<th>Race/Ethnicity</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>White, Non-Hispanic</td>
<td>23%</td>
</tr>
<tr>
<td>Hispanic</td>
<td>19%</td>
</tr>
<tr>
<td>Black, Non-Hispanic</td>
<td>17%</td>
</tr>
<tr>
<td>Asian</td>
<td>?</td>
</tr>
<tr>
<td>Native Hawaiian and Other Pacific Islander</td>
<td>?</td>
</tr>
</tbody>
</table>

NOTE: Recommended services include a dilated eye exam, a foot exam, hemoglobin A1C check and receipt of the flu shot.  
Changes in Quality of Care Disparities Over Time: Summary by Race and Ethnicity, 2013

<table>
<thead>
<tr>
<th>Comparison</th>
<th>Improving</th>
<th>Same</th>
<th>Worsening</th>
</tr>
</thead>
<tbody>
<tr>
<td>Black vs. White</td>
<td>74%</td>
<td>7%</td>
<td>7%</td>
</tr>
<tr>
<td>Asian and PI vs. White</td>
<td>72%</td>
<td>11%</td>
<td>11%</td>
</tr>
<tr>
<td>American Indian/Alaska Native vs. White</td>
<td>73%</td>
<td>17%</td>
<td>10%</td>
</tr>
<tr>
<td>Hispanic vs. Non-Hispanic White</td>
<td>70%</td>
<td>12%</td>
<td>18%</td>
</tr>
</tbody>
</table>

NOTES: “Improving” means disparity is becoming smaller over time; “worsening” means disparity becoming larger over time. Data on all measures are not available for all groups. Totals may not add to 100% due to rounding. Time period differs by measure and includes oldest and newest years of available data.

Current CMS OMH Efforts

- Reducing Disparities in Healthcare Quality
  - The development of a strategic plan that identifies multilevel solutions to reduce disparities.

- Strengthening CMS Data & Systems
  - Improving CMS data on race and ethnicity and other demographics
  - Reporting stratified quality measures
  - Developing measures to identify beneficiaries who are sexual and gender minorities

- Culturally and Linguistically Appropriate Services (CLAS) Measurement

- Building the Business Case for Health Equity
  - Creating an evidence base that demonstrates the economic/financial return on investing in health equity
What is *From Coverage to Care*?

- C2C is an effort to help educate consumers about their new coverage and to connect them with primary care and preventive services that are right for them so they can live long, healthy lives.

- Resources online and in print include the Roadmap, Discussion Guide, videos, and more.

- C2C builds on existing networks of community partners to educate and empower newly covered individuals.
From Coverage to Care Resources


- Roadmap
  - Poster Roadmap
  - Consumer Tools
    - Insurance card
    - Primary Care vs. Emergency Care
    - Explanation of Benefits
  - Pull-out steps

- Discussion Guide
- Video vignettes

Print copies available from the CMS Clearinghouse
Coverage to Care Roadmap

Your ROADMAP to health

1. Start here
   - Put your health first
     - Staying healthy is important for you and your family.
     - Maintain a healthy lifestyle at home, at work, and in the community.
     - Get your recommended health screenings and manage chronic conditions.
     - Keep all of your health information in one place.

2. Understand your health coverage
   - Check with your insurance plan or state Medicaid or CHIP program to see what services are covered.
   - Be familiar with your costs (premiums, copayments, deductibles, co-insurance).
   - Know the difference between in-network and out-of-network.

3. Know where to go for care
   - Use the emergency department for life-threatening situations.
   - Primary care is preferred when it’s not an emergency.
   - Know the difference between primary care and emergency care.

4. Find a provider
   - Ask people you trust under what circumstances.
   - Check your plan’s list of providers.
   - If you’re assigned a provider, contact your plan if you want to change.
   - If you’re enrolled in Medicaid or CHIP, contact your state Medicaid or CHIP program for help.

5. Make an appointment
   - Mention if you’re a new patient or have been there before.
   - Give the name of your insurance plan and ask if they take your insurance.
   - Tell them the name of the provider you want to see and why you want an appointment.
   - Ask for days or times that work for you.

6. Be prepared for your visit
   - Have your insurance card with you.
   - Know your family health history and make a list of any medicines you take.
   - Bring a list of questions and things to discuss, and take notes during your visit.
   - Bring someone with you to help if you need it.

7. Decide if the provider is right for you
   - Did you feel comfortable with the provider you saw?
   - Were you able to communicate with and understand your provider?
   - Did you feel like you and your provider could make good decisions together?
   - Remember, it is okay to change to a different provider.

8. Next steps after your appointment
   - Follow your provider’s instructions.
   - Fill any prescriptions you were given, and take them as directed.
   - Schedule a follow-up visit if you need one.
   - Review your explanation of benefits and pay your medical bills.
   - Contact your provider, health plan, or the state Medicaid or CHIP agency with any questions.

Online at marketplace.cms.gov/c2c for more information.
Next Steps: From Coverage to Care Translations

• Which languages should you choose?
• How many should you do?
• How do you ensure a high quality product?
Next Steps: *From Coverage to Care 2.0*

- Expanding our partnerships
- Supporting understanding of and access to behavioral health services
- Understanding access to care and utilization of health care services by the newly insured
- Evaluating C2C
Conclusion

“A journey of a thousand miles begins with a single step.” (Lao-tzu, 604 BC - 531 BC)

Together we can ensure that all Americans have access to quality affordable health coverage, and that health disparities are eliminated.
PLEASE TYPE YOUR QUESTIONS INTO THE CHAT BOX
Additional Resources

- **NASHP Report:** Building an Equitable Health Care Delivery System: Considerations for State and Federal Policymakers

- **NASHP Report:** Promoting Physical and Behavioral Health Integration: Considerations for Aligning Federal and State Policy
Your opinion is important to us. After the webinar ends, you will be redirected to a web page containing a short survey. Your answers to the survey will help us as we plan future NASHP webinars.