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Strategies to Promote Health Equity & Reduce Health Disparities in a Post-COVID World

United Hospital Fund: 2021 Medicaid Conference

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NYS Department of Health, Office of Health Insurance Programs

July 15, 2021

Agenda

1. **Introduction:** Background and Definitions
2. **Medicaid & Health Equity:** Historical Commitment of the Medicaid Program to Health Equity and Pandemic-Related Successes
3. **Ongoing Challenges:** Continuing Challenges to Addressing Health Equity and Reducing Health Disparities Post-Pandemic
4. **Call to Action and Next Steps:** Opportunities and Strategies for Future Success
5. **Questions & Discussion**

Definition of Health Equity


What Is Health Equity?

And What Difference Does a Definition Make?

"Health equity means that everyone has a fair and just opportunity to be as healthy as possible. This requires removing obstacles to health such as poverty, discrimination, and their consequences, including powerlessness and lack of access to good jobs with fair pay, quality education and housing, safe environments, and health care."

Definitional Elements

- **Health Services** – physical and mental; holistic care
- **Opportunity to Be Healthy / Social Determinants of Health** – focus on the social determinants of health
  - Housing insecurity
  - Food insecurity
  - Transportation insecurity
  - Toxic stress
  - Interpersonal violence
  - Exclusion or employment insecurity
- **Focus on Disparities** – current and historical
- **Process and Outcome Measures** – how do we measure results? Can we measure results?
- **Continuous Monitoring**

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Definition of Health Disparities

- There are multiple definitions of "health disparities."
- Perhaps most broadly, Healthy People 2020 defines a health disparity as follows:

  Although the term disparities is often interpreted to mean racial or ethnic disparities, many dimensions of disparity exist in the United States, particularly in health. If a health outcome is seen to a greater or lesser extent between populations, there is disparity. Race or ethnicity, sex, sexual identity, age, disability, socioeconomic status, and geographic location all contribute to an individual's ability to achieve good health. It is important to recognize the impact that social determinants have on health outcomes of specific populations. Healthy People strives to improve the health of all groups.

  Health People 2020, Foundation Health Measures, Disparities, available at

- Consistent with the RWJF definition, health equity has generally referred to achieving the highest level of health through the elimination of disparities in health and healthcare.

  Harris & Buggs, Disparities in Health and Health Care: Five Questions and Answers, Kaiser Family Foundation (May 11, 2011), available at

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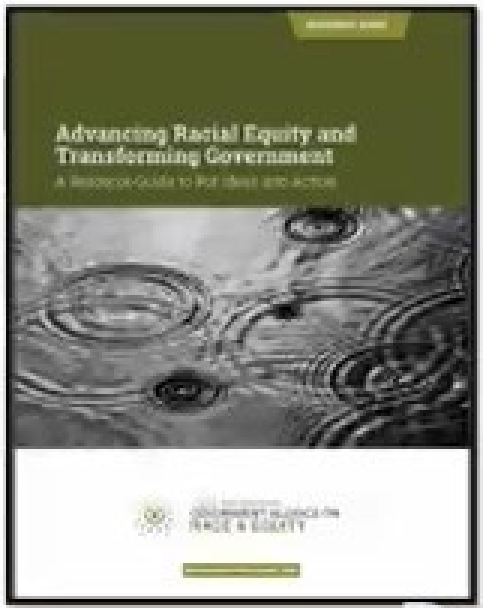
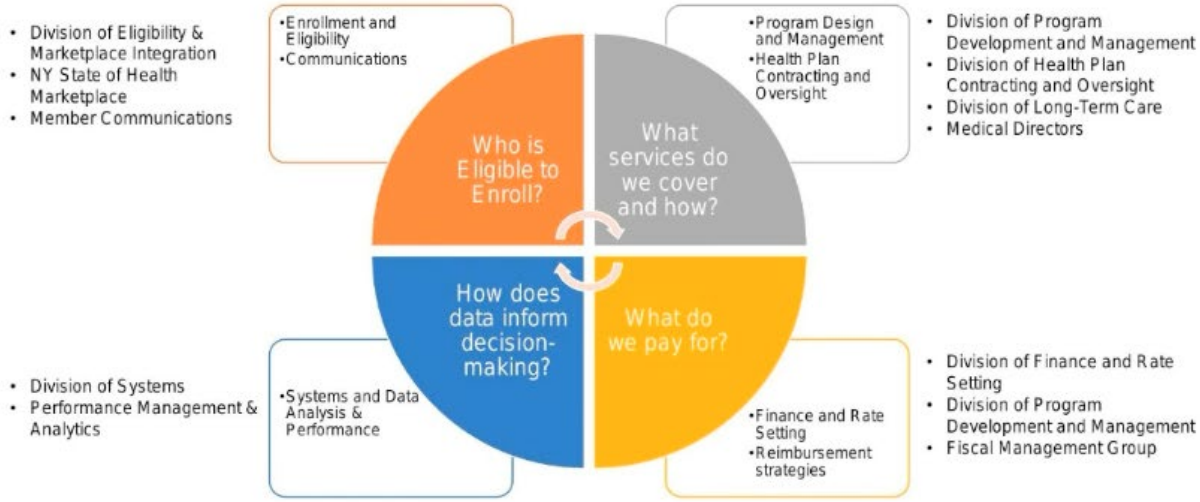
Government Alliance on Race & Equity (GARE): Role of Government

- GARE recognizes that governments need a special commitment to race and equity due to their power and influence, and ability to create meaningful partnerships
- GARE defines racial equity as when "race can no longer be used to predict life outcomes and outcomes for all groups are improved" (not just "closing the gaps")
- Recognizes there is a process for tackling racial equity in government:
  - Use an equity framework and common definitions
  - Build organizational capacity
  - Implement equity tools
  - Be data driven
  - Create partnerships
  - Communicate with urgency



Medicaid & Health Equity

All Components of the Medicaid Program Must Focus on Promoting Health Equity



- Division of Eligibility & Marketplace Integration
- NY State of Health Marketplace
- Member Communications
- Division of Program Development and Management
- Division of Health Plan Contracting and Oversight
- Division of Long-Term Care
- Medical Directors
- Division of Systems
- Performance Management & Analytics
- Division of Finance and Rate Setting
- Division of Program Development and Management
- Fiscal Management Group

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Eligibility: Statewide Medicaid Enrollment

- New York's historically comprehensive and expansive Medicaid program eligibility provided coverage to those impacted by the pandemic
- The NYS Medicaid Enrollment Databook has been recently updated to report monthly statewide enrollment trends: https://health.ny.gov/health_care/medicaid/enrollment/

Enrollment by Month

	NYC	Rest of State	Total Enroll...
May 2021	3,956,600	3,083,723	7,040,623
April 2021	3,929,992	3,075,002	7,004,994
March 2021	3,899,096	3,060,000	6,959,095
February 2021	3,867,492	3,038,160	6,905,652
January 2021	3,851,378	3,031,434	6,882,812
December 2020	3,809,395	3,012,815	6,822,210
November 2020	3,771,170	2,969,440	6,740,610
October 2020	3,726,446	2,939,033	6,665,479
September 2020	3,690,118	2,912,529	6,602,647
August 2020	3,648,618	2,892,055	6,540,673
July 2020	3,606,249	2,851,863	6,458,112
June 2020	3,557,258	2,816,287	6,373,545
May 2020	3,501,100	2,765,890	6,266,990
April 2020	3,440,771	2,751,048	6,191,819
March 2020	3,387,149	2,700,010	6,087,159
February 2020	3,383,953	2,691,999	6,075,952
January 2020	3,385,148	2,697,772	6,082,920
December 2019	3,387,460	2,687,934	6,075,394
November 2019	3,401,481	2,690,191	6,091,174
October 2019	3,417,612	2,700,635	6,118,247
September 2019	3,429,569	2,700,800	6,128,369
August 2019	3,430,428	2,707,684	6,138,112
July 2019	3,436,049	2,708,194	6,144,243
June 2019	3,438,451	2,705,155	6,143,606
May 2019	3,445,547	2,708,484	6,154,031

Data last updated on: 6/7/2021

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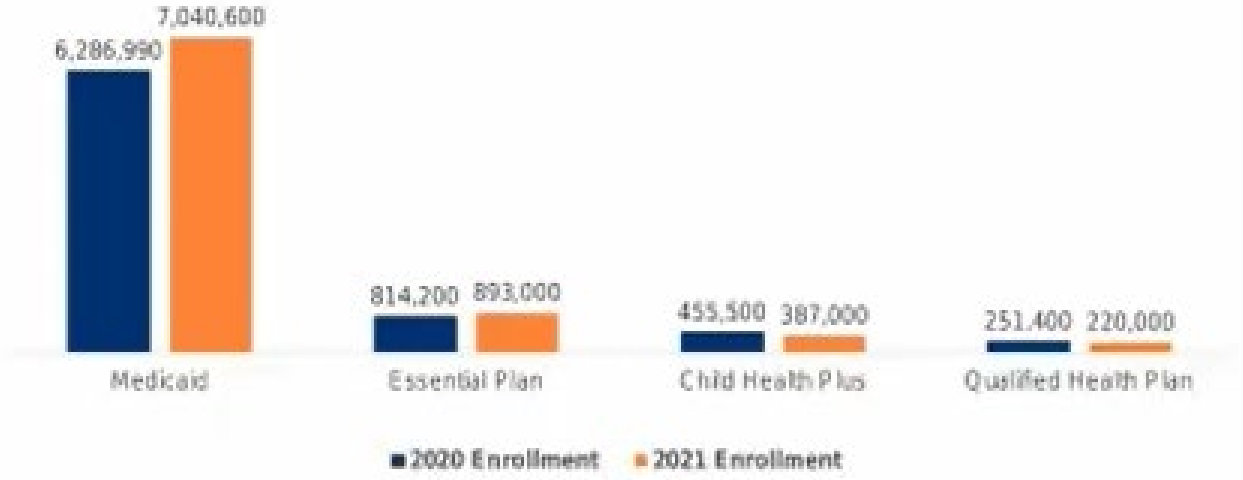
Eligibility:
2021 New York State Program Enrollment



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Program Design:
Bureau of Social Determinants of Health (BSDH)

History

Evolved from the Bureau of Supportive Housing in December 2017 to help implement the Value Based Payment (VBP) Roadmap requirement regarding Social Determinants of Health and Community Based Organizations (CBOs)

Purpose

Transform the New York State Healthcare delivery system by integrating health and human services. Addressing the Social Determinants of Health to improve the quality of care and health outcomes for NYS most vulnerable populations.

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Program Design: Supportive Housing Initiative

- Started in 2012, following the Medicaid Redesign Team (MRT)
- Goal of increasing availability of affordable supportive housing
- Focus on high-utilizers Medicaid members who are:
  - ✓Homeless (street or shelter)
  - ✓Living in institutional settings

Dept. of Health/ AIDS Institute

Home and Community Renewal

Office of Mental Health

Office for People With Developmental Disabilities

Office of Addiction Services and Supports

Office of Temporary and Disability Assistance

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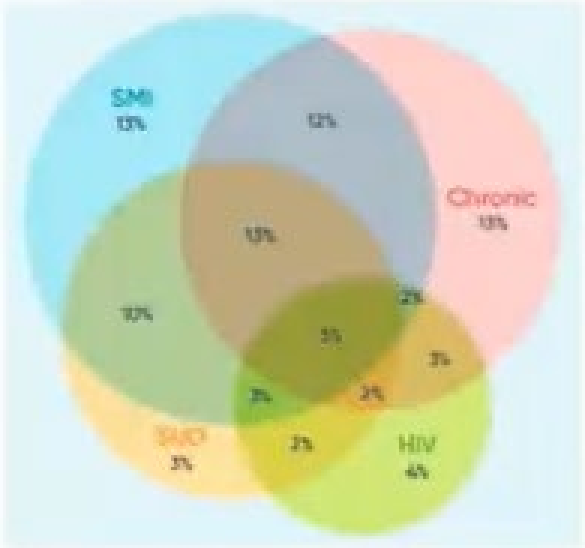
Program Design: Supportive Housing Initiative



Seriously ill population, high rate of comorbidities:

- 62% have at least one serious mental illness;
- 41% have substance use disorder;
- 33.5% have "other chronic condition";
- 5% are HIV+; and
- 24% have diagnoses in 3 or more of above categories

Source: McGinnis et al. "Medicaid Redesign Team Supportive Housing Evaluation Utilization Report 1," prepared by the SUNY Research Foundation for NYS DOH (June 2015).

"Other chronic condition" = 12 other most common chronic conditions: hypertension, asthma, diabetes, osteoarthritis, coronary heart disease, chronic kidney disease, chronic obstructive pulmonary disease, cerebrovascular disease, congestive heart failure, cancer, angina, acute myocardial infarction.

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Program Design: Supportive Housing Initiative

On average, Medicaid claim costs declined by about $6,800 per person. However high-utilizers had an average savings of $45,600.

Clients showed lower overall mortality (8%) than the comparison group clients (15%).

Supportive Housing decreased utilization of emergency department, nursing home, inpatient, and primary care utilization.

12-month retention in MRT-SH resulted in a 19% savings, 29% reduction in ER visits, and 48% reduction in inpatient days

Program Design: Bronx Equity Integrated Care for Kids (InCK)

- Pilot program funded through a Cooperative Agreement with CMS/CMMI
- Montefiore Health System is the lead organization.
- InCK is a child-centered local service delivery and state payment model
- Aim is to reduce costs and improve quality of care for Medicaid members under 21 years of age through prevention, early identification, and treatment of behavioral and physical health needs.
- The Bronx InCK pilot strives to improve access to care coordination and integration of primary and specialty care, while reducing avoidable inpatient stays and out of home placements, through a two-generational approach to care while applying a health equity lens.
- A goal of the cooperative agreement is to create an alternative payment model (APM) for a segment of the attributed population.

BE-InCKNY

Program Design: Healthy Homes VBP Pilot

- The Healthy Homes intervention engages Medicaid members between ages 0 to 17 who have persistent asthma that is not well controlled.
- Participating Medicaid members will be enrolled in a healthy homes intervention that integrates residential energy efficiency measures, asthma trigger reduction and home-injury prevention measures, with home-based asthma services.
- The Pilot aims to address the social determinants of health key areas related to health and healthcare, neighborhood and environment, and economic stability. This is a joint effort between the New York State Department of Health (NYSDOH) and the New York State Energy Research and Development Authority (NYSERDA).

VBP Arrangement Information (example):

- **MCO & Provider:** Empire HealthPlus and Chinese American IPA (CAIPA)
- **Arrangement Type**: Total Cost of Care for the General Population
- **Risk Level:** 2

Program Design: Healthy Homes VBP Pilot (Cont'd.)

Implementing 500 healthy homes interventions in Medicaid member homes, intended to:

- Improve asthma-related health outcomes
- Reduce energy use, reduce utility bill costs, improve home comfort and safety
- Reduce Medicaid utilization associated with avoidable hospitalization and emergency department use

Eligibility

- Eligible residents will be Medicaid members residing in a high asthma burden region of New York State, as determined by DOH and as prescribed by participating managed care organizations
- Participating households will include at least one resident aged 0-17 with poorly controlled asthma

Program Design: Maternal Health - Standards of Care

- Updating pre-natal care standards to articulate prenatal **and** postpartum care expectations for all Medicaid providers; including but not limited to:
  - Prenatal and Postpartum care processes aligned with national clinical guidelines and evidence-base clinical recommendations
  - Screening and Health Education
  - Cultural Competency of Providers
  - Access to Prenatal Childbirth Classes
  - Access to Postpartum Home Visits
  - Referrals and Connections to Services (Nutrition Services/WIC, Behavioral Health Care Services, etc.)

Program Design: Maternal Health - Doula Services Pilot

- Evaluating the impact of Medicaid reimbursement for doula services in Erie County
- Evaluation will assess reach, effectiveness, and doula and member satisfaction through SFY23.
- As of June 2021:
  - 599 pregnant Medicaid members enrolled
  - 10 Medicaid Managed Care plans participating
  - 25 doulas enrolled
  - 541 estimated deliveries before July 2021

Program Design: Maternal Health – New Pilot Initiatives

- **Early Literacy Pilot:** Funding being provided to Reach Out and Read, a national non-profit organization, to expand their program in selected Pediatric Primary Care settings across NY State. Evaluation will assess the impact of the expansion on the target population.
- **Maternal Infant Care Initiative:** Incorporates Peer Family Navigators into pediatric and OB/GYN clinics to provide "light touch" home visits and refer parents or patients to community-based services in response to identified needs.
- **Centering Pregnancy Pilot:** Provides enhanced reimbursement for group prenatal visits following the Centering Health Institute's Centering Pregnancy model.

Reimbursement: Value-Based Payment Arrangements

DOH has a total of **143** SDH interventions and CBO contracts:

- Mainstream Managed Care – 108 contracts
- Managed Long-Term Care – 26 contracts
- Programs of All-Inclusive Care for the Elderly – 9 contracts

A list of approved interventions are posted on the SDH CBO website: www.health.ny.gov/mrt/sdh

Current approved interventions:

- Food security – 47
- Housing – 24
- Transportation – 4
- Children – 5
- Social isolation – 10
- Primary care engagement – 14
- Self-management of chronic conditions – 32
- Health literacy and education – 25

Note: some interventions address multiple factors and are counted more than once in the above.

*MMC/PACE Roadmap requirement started 1/1/18 and MLTC started 4/1/19

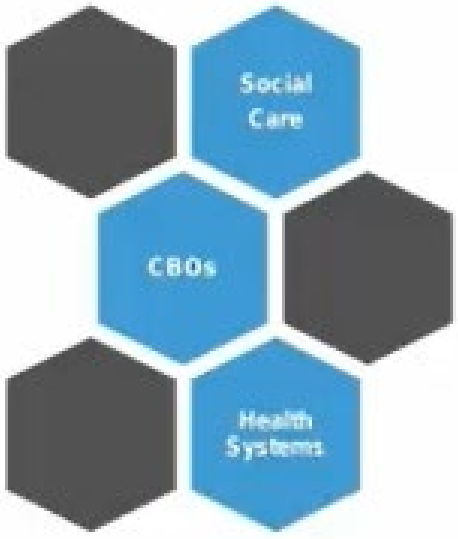
Reimbursement: High Value Social Determinants of Health Pilots

Medicaid Redesign Team (MRT) II recommended the creation and direct reimbursement of three SDH pilots to improve health outcomes:

1. **Medical Respite** – low intensity care that includes **temporary room and board** that allows individuals the opportunity to recuperate in a safe environment while accessing **medical care and other supportive services.**
2. **Medically Tailored Meals** – tailored meals delivered to individuals living with severe illness through a referral from a medical professional or healthcare plan. **Meal plans are tailored** to the medical needs of the recipient by a Registered Dietitian Nutritionist, and are designed to **improve health outcomes**, lower cost of care, and increase patient satisfaction.
3. **Street Medicine** – enables providers to deliver minimally invasive treatments and medical assessments at locations **outside of medical centers**, including drop-in centers, shelters, transitional housing sites, and on the streets.

Reimbursement: MRT II Pilot Goals

- Remove barriers to allow for social care interventions;
- Encourage partnerships between community-based organizations, hospitals and Managed Care Organizations;
- Target Medicaid members that are frequent utilizers of inpatient and the emergency department; and
- Evaluate health outcomes and savings.



Reimbursement: Medical Respite

- Special licensure of Medical Respite programs was enacted in April 2021
- DOH is creating a certification for Medical Respite Programs

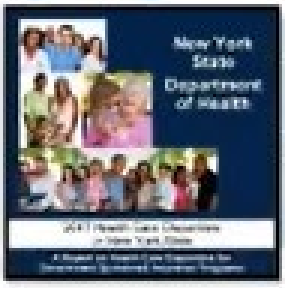
Road Forward:

- Engaging with key stakeholders
- Create a managed care offering
- Conduct pilot program selection and implementation
- Issue regulatory language and guidance
- Evaluate pilots for outcomes and savings

Reimbursement: Medically Tailored Meals (MTMs)

- **Definition:** MTMs are delivered to individuals living with severe illness through a referral from a medical professional or healthcare plan. Meal plans are tailored to the medical needs of the recipient by a Registered Dietitian Nutritionist (RDN), and are designed to improve health outcomes, lower cost of care, and increase patient satisfaction
- **Eligibility:**
  - High-volume service utilizer with at least one of the following diagnoses: cancer, diabetes, heart failure, and/or HIV/AIDS
  - Limited in ability to perform ADLs
  - One or more hospitalizations in the last 12 months
  - Recommended for MTM by a healthcare provider or MCO
  - Must have a secure place to store and heat meals
  - Must be able to benefit from the MTM intervention to improve overall health
- **Implementation:**
  - MTM prevents inpatient and emergency department use
  - DOH will create a managed care offering

Data in Decision-making: Ongoing Measurement and Reporting Efforts



- Evaluates whether health disparities disproportionately affect vulnerable groups by examining disparities in health care quality among NYS Medicaid members enrolled in Medicaid Managed Care programs.
- This report has been published on the NYS Managed Care Report website since 2013.
- Data from the report has been leveraged for purposes such as Medicaid Redesign workgroups and the NYS Quality Strategy and could serve as a resource for health disparity research. Additionally, NYS tracks efforts towards improving health equity.

- Biennial report that highlights the health status of racial and ethnic populations.
- The goal of the report is to increase awareness about the health of racial and ethnic populations in NYS.
- Examines 46 health indicators by race and ethnicity and looks at measures inclusive of socio-demographic status, birth outcomes, prenatal care usage, and rates of hospitalizations and mortality for an assortment of chronic diseases and injury-related conditions.

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Data in Decision-Making: Collection and Reporting Efforts

- Upcoming 2020 Essential Plan Quality Incentive

Bonus Points

To reduce disparities across patient groups, health plans must first understand where disparities exist, the magnitude of the disparities, and why those disparities are occurring within their member population. As a first step towards stratification of quality data by patient race, ethnicity, language spoken, and other demographic variables health plans will need to increase reporting of data by race and ethnicity.

The enrollment transactions that NY State of Health provides to health plans include self-reported race and ethnicity information that consumers provide as part of the NY State of Health application. Most, but not all, plans provide this data as part of the patient record with their QARR submissions. All plans must report this data with their QARR submissions.

For Measurement Year 2020 (State Fiscal Year 2021-22) plans will have the opportunity to earn 5 bonus points for implementing strategies that do one or more of the following:

- Report race and ethnicity data beyond what is reported to plans through NY State of Health enrollment transactions. The plan should demonstrate the steps taken to gather member demographic information.
- Submit a credible "Health Disparities Plan" (HDP). The HDP should demonstrate the action steps the plan will take with this data to improve care, such as but not limited to evaluating the differences in care being received by plan members; designing culturally appropriate educational and other member communications; and implementing clinical and service quality improvement activities.

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Ongoing Challenges

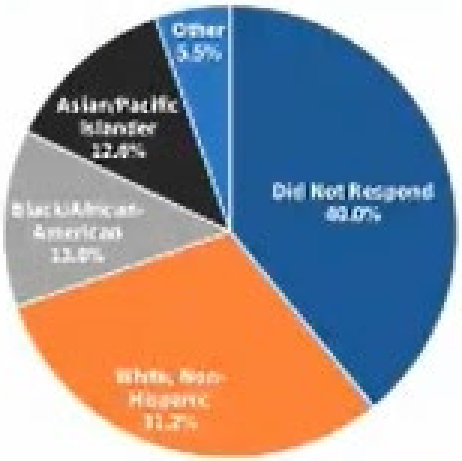
COVID-19 Further Revealed Persistent Challenges in Health Disparities

Data Collection Challenges

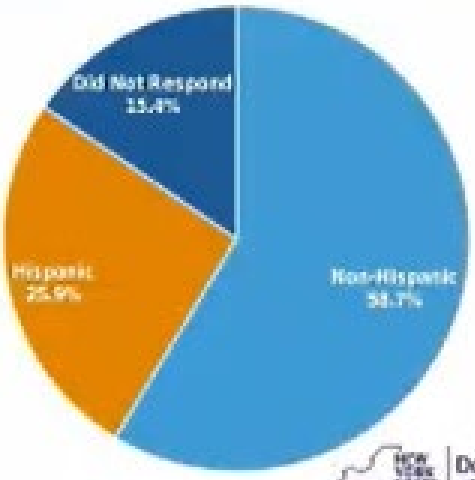
- Data collection is integral to being able to target and ameliorate health disparities.
- Existing challenges include:
  - Many race categorical variables are used in data submitted to the State, but there is a lack of standardization around ethnicity within the data; and
  - Many datasets have incomplete race and ethnicity data, with growing levels of incompleteness from data sources over time (e.g., both race and language spoken from the marketplace enrollment dataset have decreased in recent years).
- Initiatives to identify and mitigate health disparities will be challenged if the data has high levels of inaccuracy, and accurately stratifying data measures based on race and ethnicity would not be possible.

Data Collection Challenges: NY State of Health Enrollment by Race and Ethnicity

Marketplace Enrollees, by Race



Marketplace Enrollees, by Hispanic Ethnicity



Post DSRIP: Leverage Opportunities to Enhance Health Equity-Focused Initiatives

Social Care and CBO Inclusion — **How do you support and sustain CBO-related social care interventions into the Medicaid program?**

- Provide direct and sustainable support to broad provider networks, including CBOs that address the social determinants of health, across the continuum of health and social care to advance VBP approaches that align with efforts to address health disparities

Special Populations — **How do you use VBP effectiveness to promote whole person care for specific, high-needs populations?**

- Incorporate VBP interventions that focus on episodic and sub-population arrangements or that focus on whole-person or episodic needs, which would require consideration of episodic or sub-population attribution in VBP arrangements.

Regional Variation — **How do you align objectives within and across regions?**

- Encourage regional coordination and planning, as local health care providers and community-based organizations that deliver social and human services are most familiar with the needs of their local populations.

MCO Inclusion — **How do you appropriately involve MCOs without duplicating efforts?**

Involve MCOs early in the planning process for population health management to develop strong and sustainable partnerships and increase opportunities for successful outcomes.

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Call to Action: Opportunities and Strategies

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"Top Five" Strategies for Promoting Health Equity in the Medicaid Program

1. Better Data Collection and Performance Measurement
2. Focus on Workforce Development – Recruitment, Retention, and Advancement
3. Continue to Build CBO Capacity
4. Thoughtful VBP Redesign that Integrates Health Care and Social Care
5. Expand Supportive Housing and Alternatives to Institutionalization

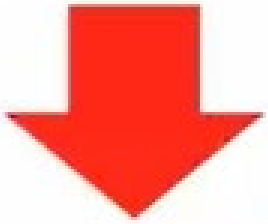
BONUS: Statewide Telehealth and Digital Infrastructure

1. Better Data Collection and Performance Measurement

- The National Quality Forum (NQF) recognizes that quality measurement is an important tool in the advancing of health equity.
- In 2017, NQF published: *A Roadmap for Promoting Health Equity and Eliminating Disparities: The Four I's for Health Equity*
  - Identify and prioritize reducing health disparities
  - Implement evidence-based interventions to reduce disparities
  - Invest in the development and use of health equity performance measures
  - Incentivize the reduction of health disparities and achievement of health equity
- DOH is exploring with its Clinical Advisory Groups (CAG) the introduction of race and ethnicity stratifications to quality measurement in Medicaid VBP Contracts.

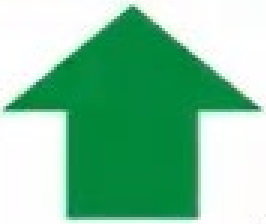
1. Better Data Collection and Performance Measurement (Cont'd.)

CAG Comments: Stratification of Quality Measures



Underreporting
Data Inaccuracies
Member Discomfort
Insufficient Data Collection Guidance
Provider and Staff Barriers
Billing Issues for Families

Important Issue
First Step in Identifying Disparities
Coordinated Care Management
Focus on Sub-Population and Advanced VBP Arrangements



1. Better Data Collection and Performance Measurement (Cont'd.) – Data Sources

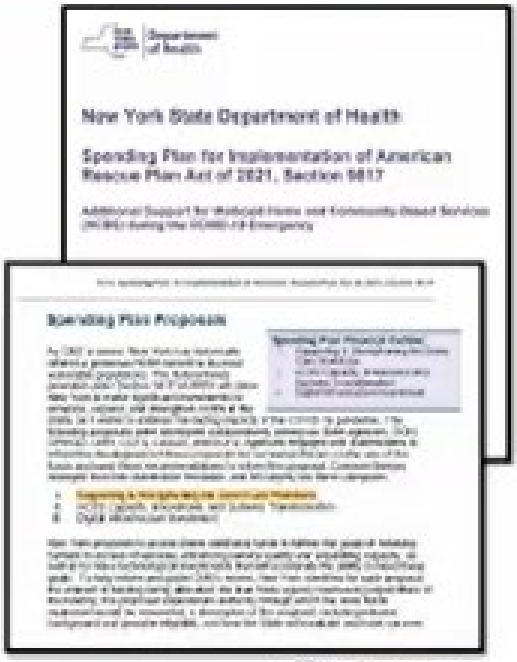
- Effective measurement to identify healthcare disparities requires complete and accurate collection of data

Primary Sources	Secondary Sources
○ Health plan enrollment data ○ Disease management programs ○ Health Risk assessments ○ Medical encounters ○ Member web portal ○ Direct outreach to members ○ Member survey	○ Surname or geocoding of address ○ Census Data

- There are many ways that incorporating the stratification of quality measures into a value-based arrangement can help to further the State's goal of more equitable care, but this is going to take effort and/or new approaches.

2. Workforce Development

- It is necessary to expand capacity and have a strong and well-trained workforce that is **representative** of the populations being served (i.e., ethnically concordant), **culturally attuned,** and **free of implicit bias**.
  - Expand and enrich the workforce to address shortages across the healthcare continuum, recruit greater participation by people of color in medical professions, and improve quality of care and to provide workers with a greater range of opportunities for advancement, and support the move to more advanced models of VBP.
  - Invest American Rescue Plan Act Home and Community Based Services (HCBS) funding in recruitment, retention, and training investments aimed at developing a highly skilled workforce, encouraging longevity, and attracting workers to the HCBS system.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Spending Plan for Implementation of American Rescue Plan Act of 2021, Section 9817

Spending Plan Proposals

Department of Health

3. Continue to Build CBO Capacity

- Encourage CBOs and social service providers to develop the programming and workflows necessary for them to coordinate and work with health care delivery systems and create regional referral networks with multiple CBOs and health systems.
- Take a comprehensive and outcomes-focused approach to addressing the full spectrum of social care needs offered by CBOs in a region, create a supportive IT and business processes infrastructure, and adopt interoperable standards for a social care data exchange.
- Create a single point of contracting for SDH arrangements and enable CBOs to coordinate and work with providers in MCO networks to more holistically serve Medicaid patients, particularly those from marginalized communities, effectively wrapping a social services provider network with existing MCO clinical provider networks.

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4. Thoughtful VBP Redesign

- Redesign the VBP Roadmap to address health equity and regional SDH needs through a comprehensive range of VBP arrangements, including more advanced VBP models to support the transformation and integration of the entire NYS health care and social care delivery system by funding the services needed to address SDH at scale.
- Focus on the needs of sub-populations that would benefit most from CBO interventions.
- Encourage the evolution of the MCO-network entity agreements into more sophisticated VBP contracting arrangements that incorporate health equity design, fund the integration with social care, are risk adjusted to reflect both the health care and social care needs of their members, and reward providers' improvements in health outcome and health equity measures.

5. Expand Supportive Housing and Alternatives to Institutions

- Build upon existing supportive housing programs through additional housing subsidies and support services, both long-term and transitional, to address the ongoing challenges that prevent stabilization in community settings for high needs and high-cost populations.
- Consolidate the array of supportive housing and medical respite programs and promote interagency coordination, including the development of a comprehensive and unified supportive housing and respite services menu.
- Take a regional approach to assessing and planning for supportive housing needs.
- Expand available services to include services that support reintegration into the community, including services to get and keep individuals housed, including housing navigation and landlord tenancy support services.

BONUS: Create Statewide Digital Health and Telehealth Infrastructure

- Increase and expand telehealth investments to fully leverage the value of telehealth in new ways.
- Ensure equitable access to telehealth services by building digital and telehealth infrastructure and care models to significantly expand access to care, both in underserved areas, such as rural and other communities without convenient access to primary or specialty care, and for underserved needs, such as behavioral health and the management of chronic diseases.
- Expand telehealth capabilities for safety net providers needs, beyond siloed solutions thrown into service during an emergency, into thoughtfully designed platforms integrated with EHRs, care management programs, social care services, and the statewide health information exchange, with professionals and non-professionals trained to maximize the use of such technology.

Questions & Discussion

SC

Sharon Chesna

From Binghamton NY • July 15, 2:13 PM

Where can we find more information about the post part coverage learning collaborative?

Like Reply

EA

Emily

From UHFNYC • July 15, 2:11 PM

: Some key resources are here: https://bit.ly/3z0xoeN