Center for Health Care Strategies
Better care where it's needed most

Texas MCO SDOH Learning Collaborative: Phase Three

Session 1: Introduction to Health Equity

February 11, 2022

Made possible through support from the Episcopal Health Foundation

Agenda

- Welcome and Introductions
- Health and Human Services Commission Updates
- Framing Remarks from Texas Association of Community-Based Health Plans
- National Focus on Health Equity
- Medicaid Managed Care Approaches to Advance Health Equity
- Facilitated Q&A
- Next Steps
- Wrap Up and Adjourn

Welcome & Introductions

Center for Health Care Strategies

Today's Presenters

Anna Spencer
Senior Program Officer
Center for Health Care Strategies

Shao-Chee Sim
Vice President for Research, Innovation and Evaluation
Episcopal Health Foundation

Andy Vasquez
Deputy Associate Commissioner for Quality and Program Improvement
Health and Human Services Commission

Kay Ghahremani
President and CEO
Texas Association of Community-Based Health Plans

Anne Smithey
Program Officer
Center for Health Care Strategies

Diana Crumley
Senior Program Officer
Center for Health Care Strategies

Nadia Glenn
Deputy Executive Director
Institute for Medicaid Innovation

Center for Health Care Strategies

Center for Health Care Strategies

Dedicated to strengthening the U.S. health care system to ensure better, more equitable outcomes, particularly for people served by Medicaid.

Together with our partners, our work advances:

- **Effective models for prevention and care delivery** that harness the field's best thinking and practices to meet critical needs
- **Efficient solutions for policies and programs** that extend the finite resources available to improve the delivery of vital services and ensure that payment is tied to value.
- **Equitable outcomes for people** that improve the overall wellbeing of populations facing the greatest needs and health disparities.

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Health Equity Learning Sessions & Workgroups

Three Learning Sessions

Similar in structure to past TX MCO SDOH LC meetings, with a focus on level setting and group learning

Two Workgroups

Deep dives on a particular issue to define actionable recommendations and strategies

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Potential Topics for Health Equity Workgroup Sessions

- *Race, ethnicity, language and disability (RELD) data*
  - → Collection of RELD data
  - → Efforts to stratify quality measures
- *Addressing maternal/child health disparities*
  - → Work building upon SB 750
- *Health care disparities and health care access in rural Texas*
  - → Community Health Access and Rural Transformation Model
- **Format**
  - → Two workgroups (three virtual or in-person sessions each)
  - → Development of health equity action recommendations

Texas Health and Human Services Commission

Andy Vasquez, Deputy Associate Commissioner for Quality and Program Improvement, HHSC

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Framing Remarks from TACHP

Kay Ghahremani, President and CEO, Texas Association of Community-Based Health Plans

National Focus on Health Equity

Anne Smithey, Program Officer, CHCS

Diana Crumley, Senior Program Officer, CHCS

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PRESS RELEASES

AMA releases plan dedicated to embedding racial justice and advancing he

Health Affairs Launches Health Equity

Racial And Ethnic Dispar
Experience Of Care Amo
Medicaid Managed Care

Kevin H. Nguyen, Ira B. Wilson, Anya R. Wallack, and Amal N. Triv

AFFILIATIONS

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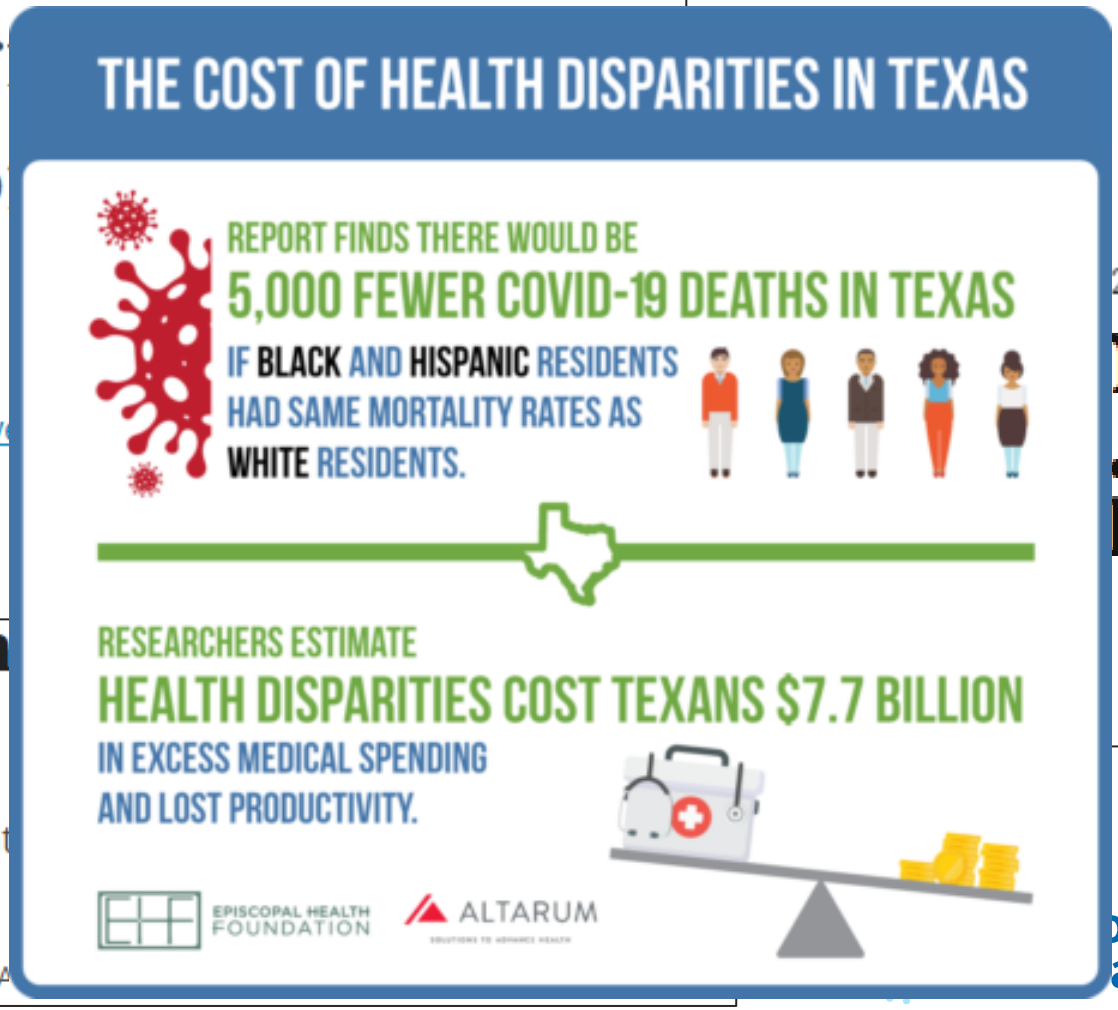
racial disparities persist amon residents

> White Texans are being vaccinated at nearly twice the rat times the rate of Black Texans, according to state data.

BY MARISSA MARTINEZ AND SAMI SPARBER MARCH 19, 2021 4 A



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What is Health Equity?

- **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.
- Health equity can be a **process** and an **outcome**.
- Health equity and the social determinants of health are **related**, but are **not the same**
  - → SDOH can contribute to health inequities, but other experiences also contribute (e.g., different experiences when seeking care for Black vs. white patients)
  - → SDOH/health-related social needs interventions that do not focus on equity may perpetuate disparities

Health Equity Area of Interest – RELD Data

Collection of standardized data on race, ethnicity, language, and disability (RELD) is critical for:

- Identifying problems
- Implementing targeted solutions
- Evaluating impact

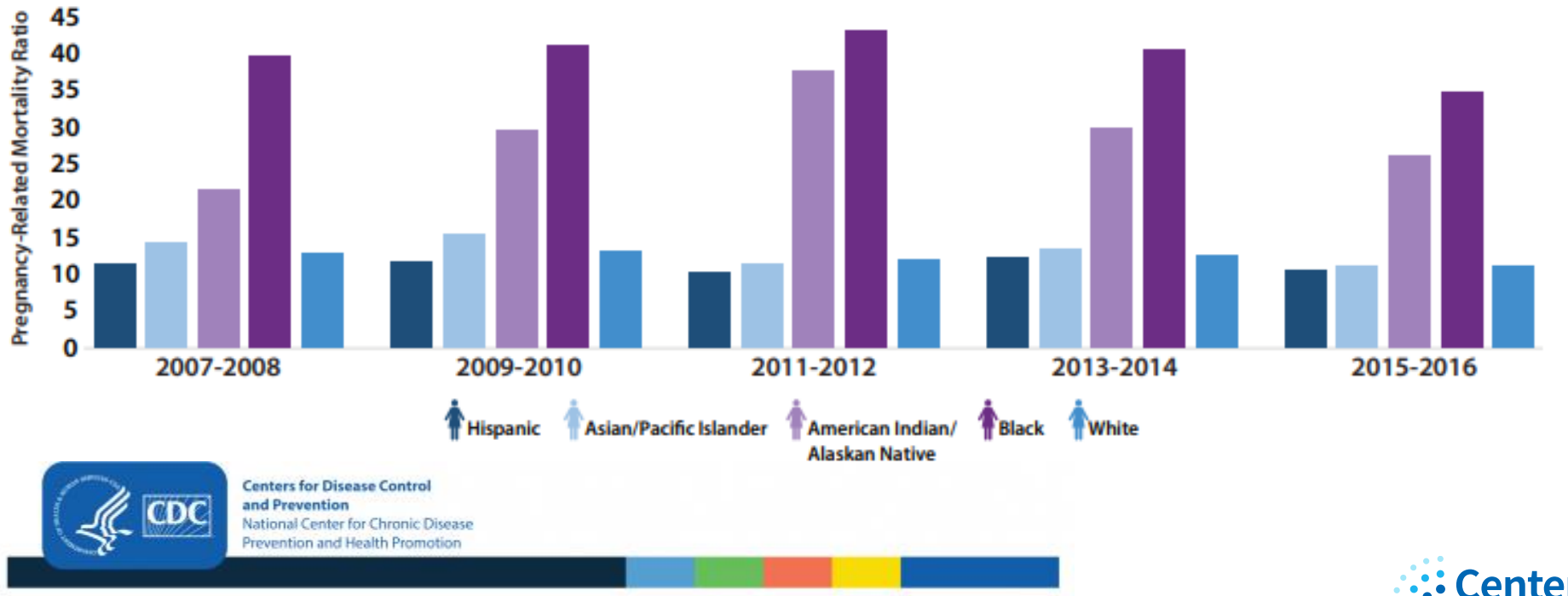
Common challenges in RELD data collection include:

- Lack of reporting standards
- Evolution in self-identification
- Voluntary reporting and lack of trust
- Lack of understanding on why data are important

In 2019, CMS identified that race/ethnicity data from 22 states was of “high concern” or “unusable”

Health Equity Areas of Interest – Maternal and Child Health

Data confirms significantly higher pregnancy-related mortality ratios among Black and American Indian/Alaskan Native women. These gaps did not change over time.



Source: CDC Infographic: Racial/Ethnic Disparities in Pregnancy-Related Deaths — United States, 2007–2016

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Health Equity Areas of Interest – Rural Health Disparities

Rural residents face significant barriers to accessing health care:

- Further distance between home and services
- Health care workforce shortages in rural areas
- Higher uninsured rates compared to non-rural areas
- Lack of broadband access decreasing usability of telehealth

Rural residents are at greater risk of death from five leading causes of death compared to urban residents:

- Heath disease
- Cancer
- Unintentional injury
- Chronic lower respiratory disease
- Stroke

CMS and CMMI Strategic Vision

Equity efforts include:

Strengthen data collection including demographic factors of race, ethnicity, language, geography, and disability – in order to identify and intervene in disparities

Develop and disseminate promising practices and models to promote health equity

Develop workforce's ability to meet the needs of populations experiencing inequities

Engage with providers and beneficiaries in underserved communities, including by increasing the number of beneficiaries in underserved communities served through VBP models and addressing social needs

Improve access to care and accessibility of care and resources

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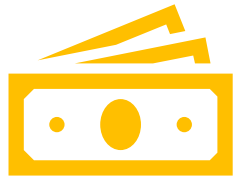
CMS/CMMI Strategic Vision in Action

- Identifying “birthing friendly” hospitals through Medicaid
  - → Hospital Inpatient Quality Reporting Program to assess if hospitals are part of maternal health/safety collaborative and implementing best practices

- ESRD Changes through Medicare
  - → Updates to the ESRD Quality Incentive Program and Treatment Choices Model to decrease disparities in rates of home dialysis and kidney transplants among patients with lower socioeconomic status

- State Transformation Collaboratives through CMMI
  - → HCP LAN, in partnership with CMMI, developing multi-stakeholder payment models in four states designed to promote person-centered care and health equity



Other National Players

- Health equity as a critical piece of quality and patient safety
  - → NCQA Health Equity Accreditation
  - → Institute for Healthcare Improvement: “there can be no progress on quality without equity”
  - → CMS considering adding Health Equity Index into Star Rating for Medicare Advantage plans
- Health equity in value-based payment
  - → HCP LAN *Advancing Health Equity through APMs*
  - → PTAC report on addressing SDOH and health equity in APMs
- Education about health equity
  - → AMA guidance on health equity and language
  - → Health Affairs health equity project

Medicaid's Role in Addressing Health Equity

Who is covered?

- 80 million Americans
- 54% are age 20 or under
- 20% are Black and 29.3% are Hispanic
- Covers 24% of non-elderly rural people
- Covers 42% of births in America

Access to high-quality care

- 95% of children and 80% of adults had a well visit in the last year
- In 2022, 20 states set requirements for VBP uptake in Medicaid managed care
- In 2020, 35 states reporting requiring at least on managed care strategy to address health-related social needs

State Approaches

- Define the state's goals relating to health equity, within Medicaid and across state government
- Partner with communities to design more equitable models of care
- Monitor and enhance access to primary care
- Promote the collection of race, ethnicity, and language data
- Target social needs associated with health inequities
- Address disparities in behavioral health treatment
- Design VBP models to promote comprehensive, equitable care
- Hold MCOs accountable for progress toward goals

State Example: Louisiana

- Setting **goals**
  - → Creation of Louisiana Department of Health Office of Community Partnership & Health Equity and Health Equity Strategic Plan
  - → Development of Health Equity Action Teams across the agency to set and implement goals
  - → Additional equity-focused programs through LDH, such as the Perinatal Quality Collaborative and the Adverse Childhood Experiences Program
- **Community engagement** as a goal embedded within the new office and its strategic plan
- Requirements relating to **VBP** and health equity plans
- Crafting **MCO accountability**
  - → MCO procurement focused on health disparities and health equity
  - → Plans to stratify quality measures by MCO and link withhold to performance related to health disparities

Advancing Health Equity in Texas

- 2021 state law expanding postpartum coverage in Medicaid to 6 months
- Texas was selected to participate in CMMI's Community Health Access and Rural Transformation (CHART) Model, which focuses on rural access to care and health equity
- Texas Medicaid's new health equity measures (detailed on next slide)

Texas Context: New Health Equity Measures

Attachment W: Texas Medicaid Health Equity Measures [Proposed]

Domain	Measure	Measure Steward	Primary Uses	Proposed Stratifications
Effective Preventive Care (Children)	Well Child Visits: 1. In first 30 months of life 2. Child and Adolescent Well-Care Visits^	NCQA	• CMS Scorecard • 2021 Core Measures (Child) • MCO Report Cards • Texas Medicaid P4Q	1. Race/Ethnicity 2. Metro/Non-Metro
Effective Preventive Care (Women)	Prenatal and Postpartum Care: Postpartum Care**,^	NCQA	• CMS Scorecard • MCO Report Cards • Texas Medicaid P4Q	1. Race/Ethnicity 2. Metro/Non-Metro
Effective Management Chronic Conditions	Hemoglobin A1c Control (<8.0%) for Patients with Diabetes*,^	NCQA	• Texas Medicaid P4Q	1. Race/Ethnicity 2. Metro/Non-Metro 3. Gender
Effective Management of Chronic Conditions	Controlling High Blood Pressure (CBP)*,^	NCQA	• CMS Scorecard • 2021 Core Measures (Adult)	1. Race/Ethnicity 2. Metro/Non-Metro 3. Gender
Effective Management (Mental Health)	Antidepressant Medication Management	NCQA	• 2021 Core Measures (Adult) • MCO Report Cards	1. Race/Ethnicity 2. Metro/Non-Metro 3. Gender
Making Care Safer	Potentially Preventable Complications	3M	• Hospital Quality-based Payment Program • Texas Medicaid P4Q	1. Race/Ethnicity 2. Metro/Non-Metro 3. Gender

*Hybrid measure: combines administrative data with data from a medical records review.
**Hybrid, but an administrative data only specification is available.
^Identified as a priority measure for race/ethnic stratification by NCQA.

- Proposes to stratify P4Q and Hospital Quality-based Payment Program measures by:
  - → Race/ethnicity (6/6)
  - → Metro/non-metro (6/6)
  - → Gender (4/6)
- Demonstrates focus on preventive care, and effective management of chronic conditions

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Medicaid Managed Care Approaches to Advance Health Equity

Nadia Glenn, Deputy Executive Director, Institute for Medicaid Innovation

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INSTITUTE FOR
MEDICAID INNOVATION

The Institute for Medicaid Innovation

Nadia Glenn, PhD, MSW

INSTITUTE FOR MEDICAID INNOVATION

MISSION

Improve the lives of Medicaid enrollees

Develop, implement, and diffuse innovative and evidence-based models of care

Promote quality, value, and equity

Engage patients, families, and communities

VISION

Provide independent, unbiased, nonpartisan information

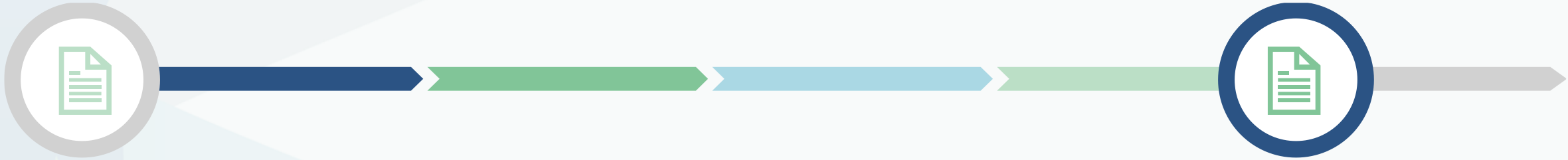
Inform Medicaid policy

Improve the health of the nation

INSTITUTE FOR MEDICAID INNOVATION

2021 Annual Health Plan Survey

Identifying Trends Over Time



2017

First year of report release

2018

2019

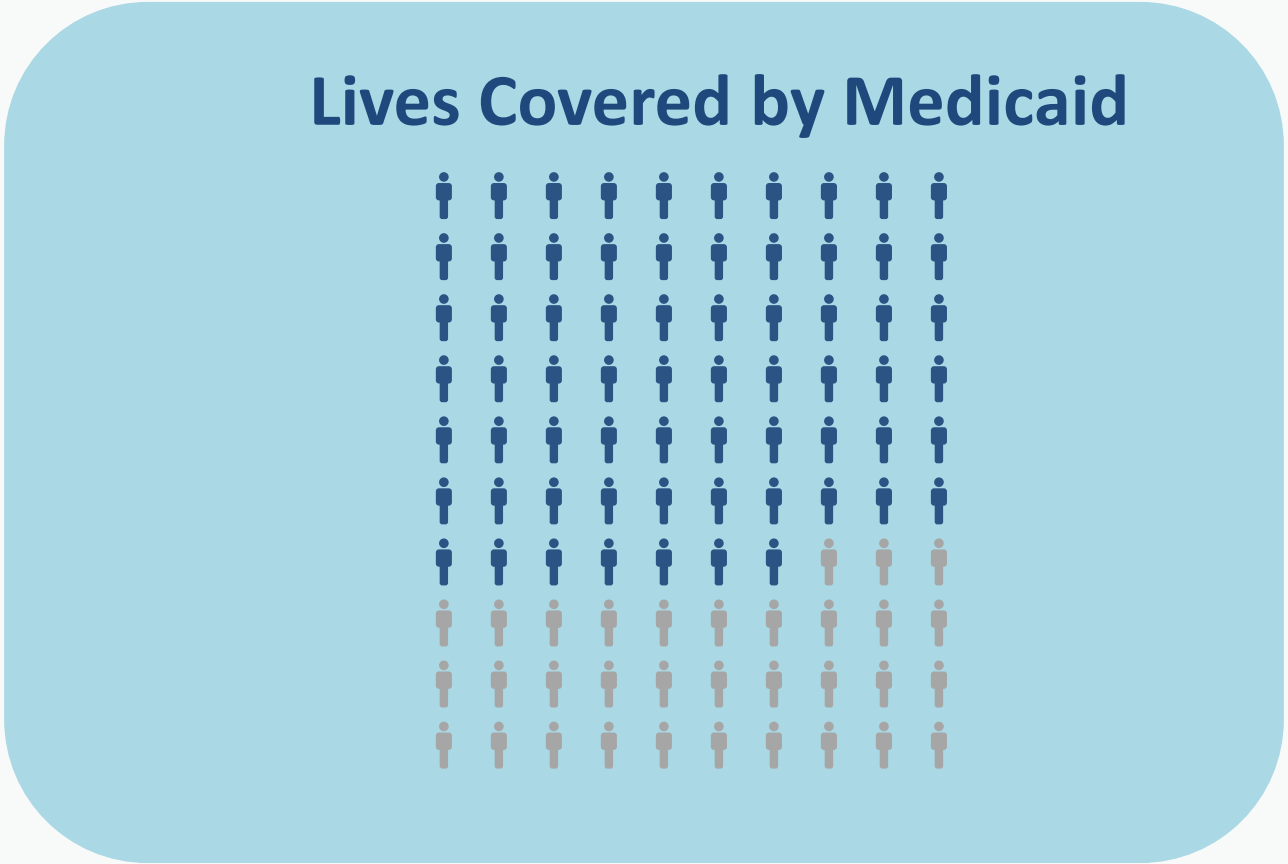
2020

2021

Current report year

A Comprehensive Snapshot

- **67%** of individuals covered by Medicaid
- **37** states



A Roadmap for Innovation

10 Health Domains

1. High-risk care coordination
2. Value-based purchasing
3. Pharmacy
4. Behavioral health
5. Women's health
6. Child and adolescent health
7. Managed long-term services and supports
8. Social determinants of health
9. COVID-19 pandemic
10. Health equity and structural racism

Health Equity Framing

Health equity means that everyone has a fair opportunity to attain and maintain their optimal health regardless of race, ethnicity, disability, gender identity, sexual orientation, socioeconomic status, geography or any other social barriers/ factors.

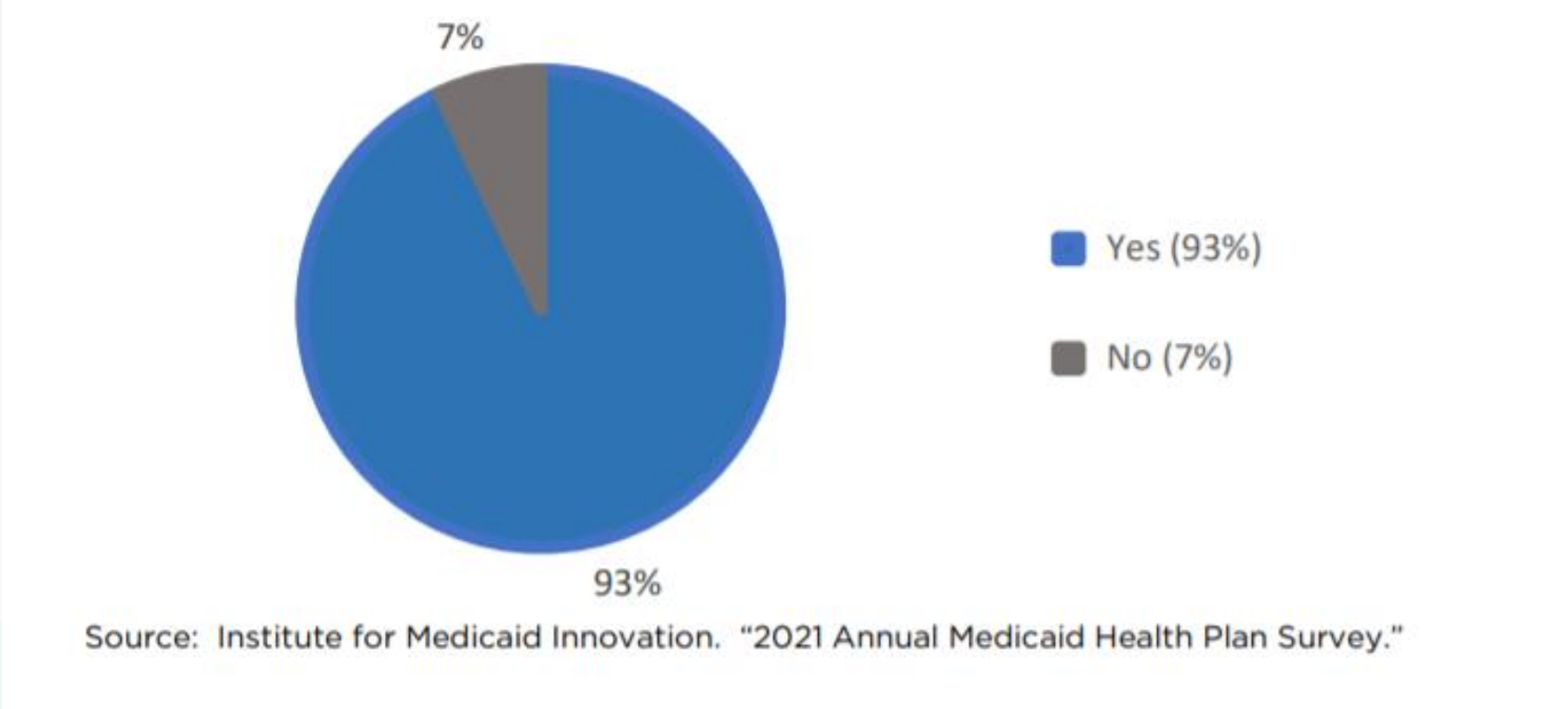
Our goal in **advancing health equity** is to maintain a focused commitment on eliminating health and healthcare disparities and identifying practical steps to help everyone have a fair and just opportunity to be as healthy as possible.

Health Equity Framing

Medicaid Managed Care Approaches to Advance Health Equity

Strategy and Leadership

Medicaid Health Plans with a Health Equity Plan



Source: Institute for Medicaid Innovation. "2021 Annual Medicaid Health Plan Survey."

Prioritizing Equity

- Medicaid serves populations at-risk for health disparities
- Health plans have taken concrete action:
  - **70%** had a health equity plan
  - **100%** of those implemented supporting programs
  - **53%** had a chief equity officer or similar position
  - **33%** worked with Small Disadvantaged Businesses and Small and Diverse Businesses

Focus of Medicaid Health Plans with Dedicated Person or Team


Structural racism


Health equity


Racial equity


Health disparities

- Incorporated education and awareness of health disparities, social injustice, and systemic oppression and how they impact members in all programs, operations, and levels of care
- Established consistent and regular trainings, individual and group supervision, and steering committees and councils dedicated to furthering diversity, equity, and inclusion in health care
- Facilitated internal and external trainings and webinars
- Established long-term commitments to health equity
- Enacted partnerships with community and civic organizations
- Engaged members to learn about their lived experiences and relationships with the health care system and infrastructure
- Committed to learning and unpacking the role of the health system on an individual and larger scale in upholding systemic oppression

Medicaid Managed Care Approaches to Advance Health Equity

Community Engagement

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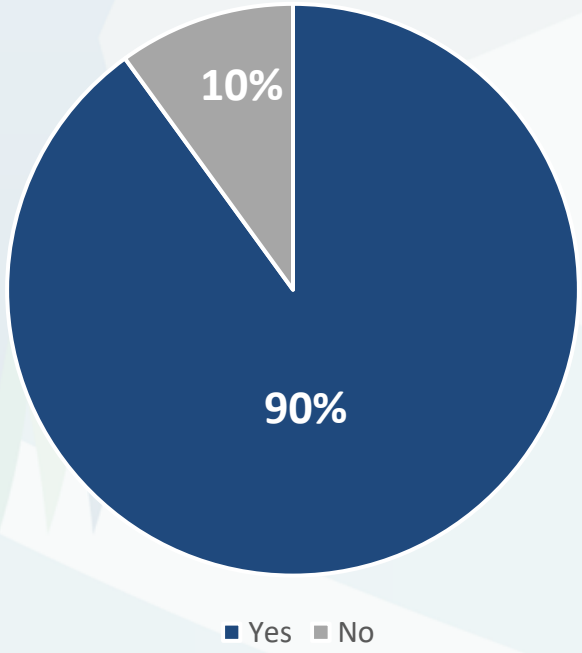
Where people live, matters.

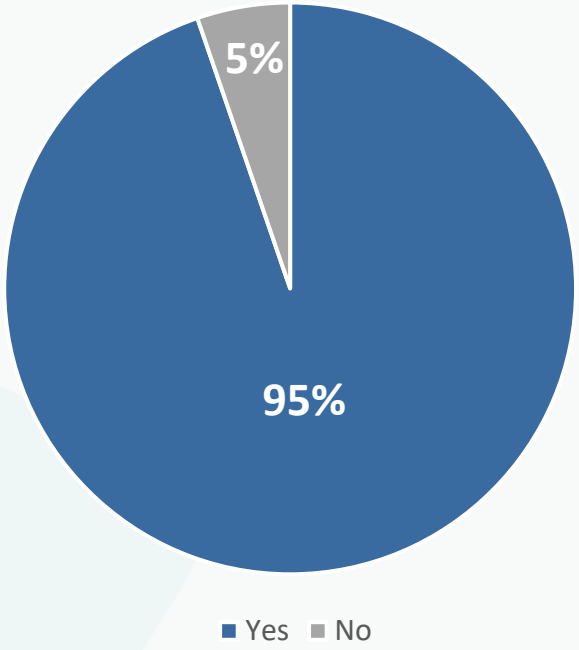
Initiatives to help community members maintain and improve their health must happen in the community.

Engaging Communities

% Contract with Community Health Centers

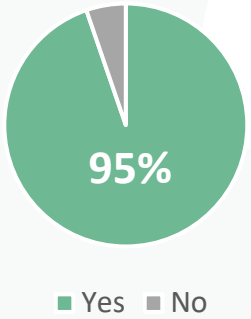


% Work with Community-Based Organizations to Address Social Needs

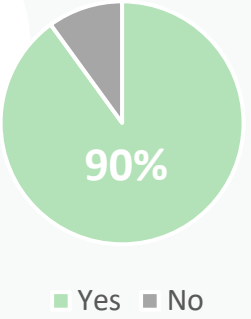


These needs are addressed by…

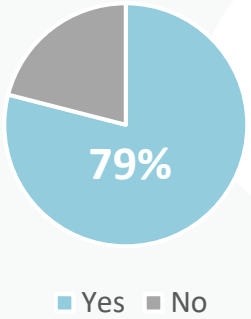
Maintaining resource databases



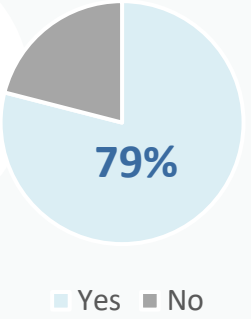
Facilitating Referrals to Community Services



Working with Community Health Workers



Making Direct Investments in Community Capacity Building

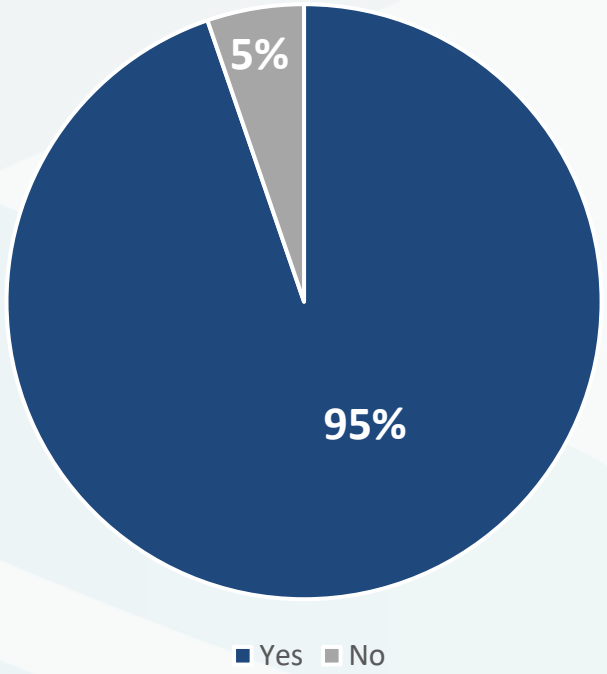


Managed Care Service Areas

- Community-based organizations provide insight into “the experience” of community members and can address disparities with unique solutions
  - Health plans partner with CBOs for connection to care, chronic disease management, community and peer staff, and discharge planning
- Front and center data- aggregate versus detailed data
- Allows managed care entities to be present and have front line visual cues
- Understand how public and population health data is used
- Promotes a partnership versus a collaboration- effectively creates a plan with clarifying responsibilities, identified gaps that need to be filled, and measurable outcomes
- Creates trusting, dependent, sustainable relationships and combats health inequity

Addressing Social Needs

% Offering Programs to Address Social Determinants of Health



- Housing *(100%)*
- Nutrition/ Food Security *(100%)*
- Social Isolation *(95%)*
- Non-Emergency Medical Transportation *(95%)*
- Employment *(90%)*
- Application Assistance *(90%)*

Medicaid Managed Care Approaches to Advance Health Equity

Population Health Management

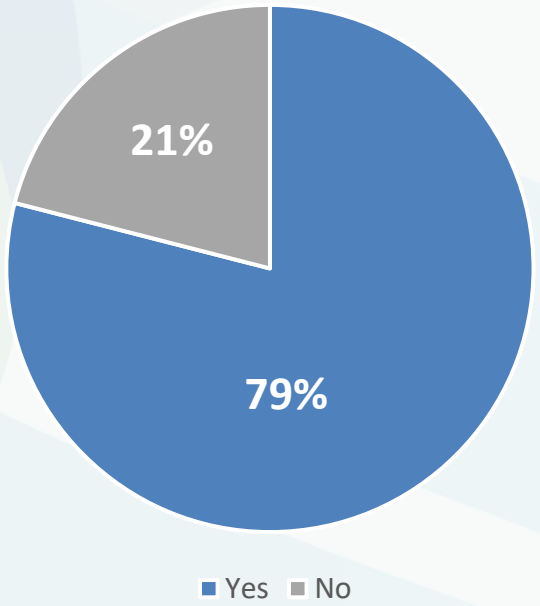
Population Health Management

One solution: Integrating health equity into population health and care management programs takes focusing on identifying "clean" race, ethnicity, and language data to complete a data readiness assessment, from this data identifying health disparities, and through programs addressing conditions that create health inequities.

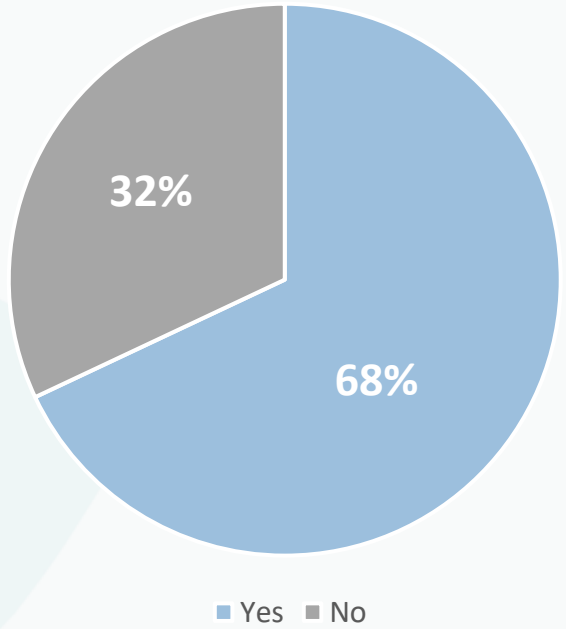
Serving Populations At-Risk

- Enrollees primarily women and children
- Targeted services for:

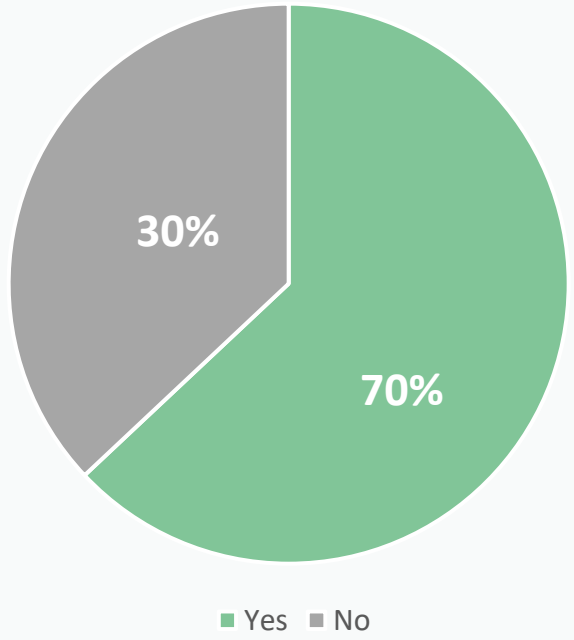
Homeless and Housing Secure Individuals



Pregnant Individuals



Adults with Serious Mental Illness



High-Risk Care Coordination

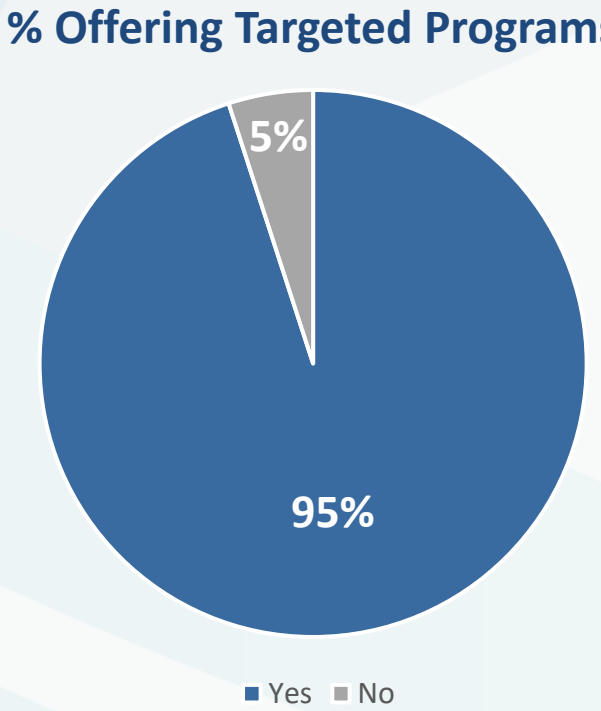
- Provided by **100%** of health plans
- Barriers:

Inaccurate Member Information
(100%)

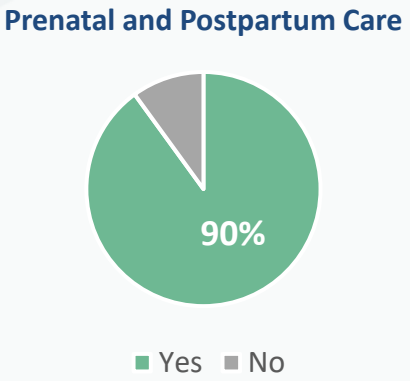
Difficulty Contacting Members
(100%)

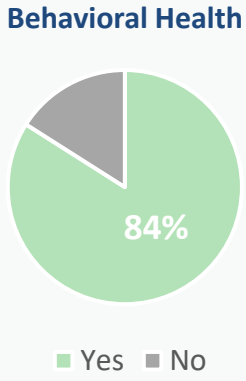
Lack of Member Willingness to Engage
(100%)

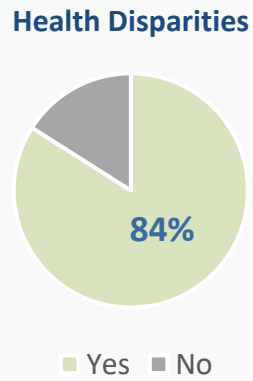
Women's Health

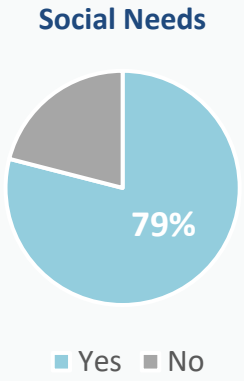


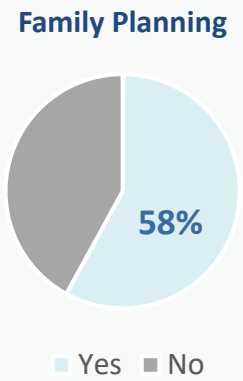
Priorities:







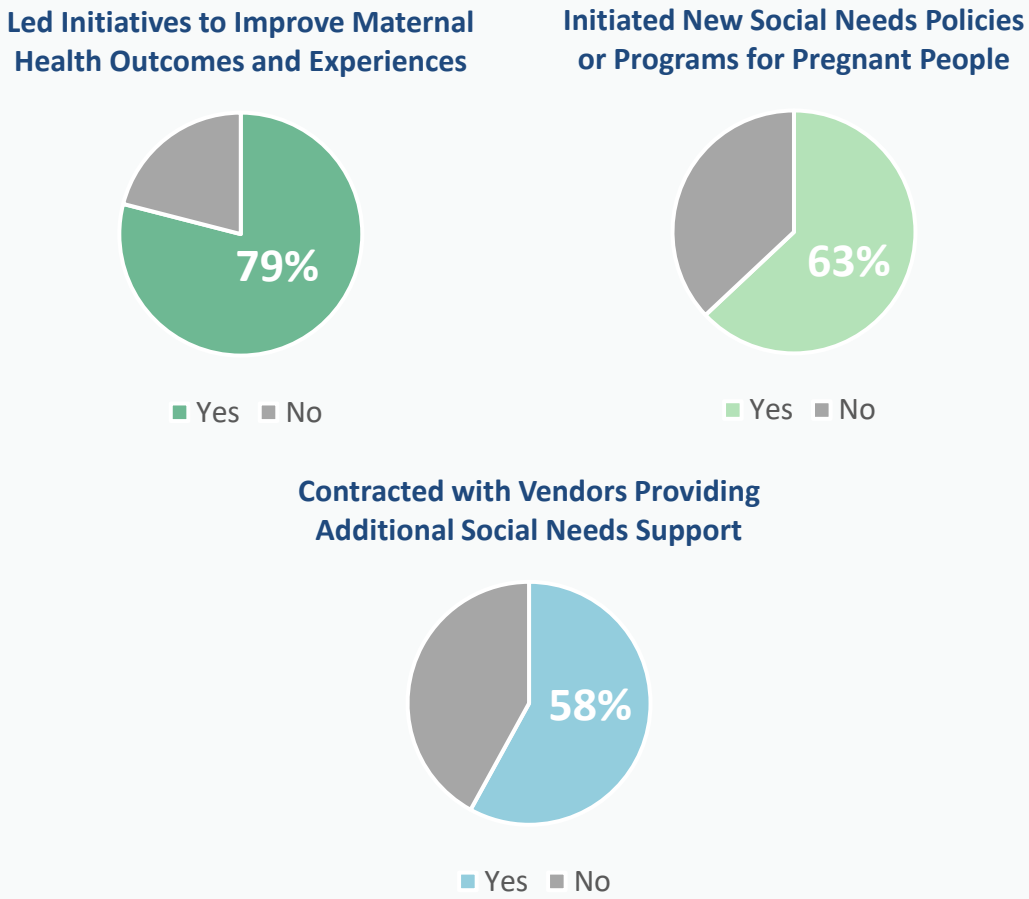




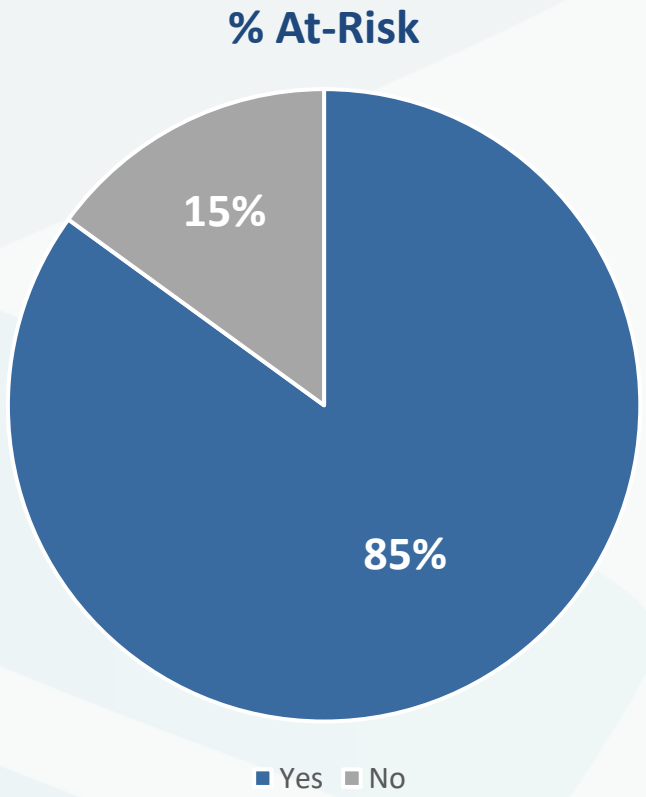
Maternal Mortality

- U.S. maternal mortality rate: 17.2 deaths per 100,000 live births
  - Black women are 3 – 4x more likely to die during pregnancy or childbirth than their white counterparts

How are Medicaid Health Plans Responding?

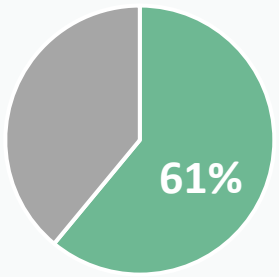


Behavioral Health



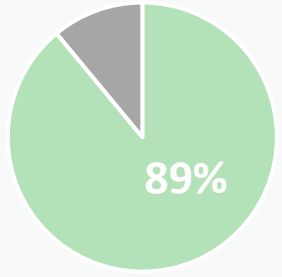
Common Barriers:

Operational



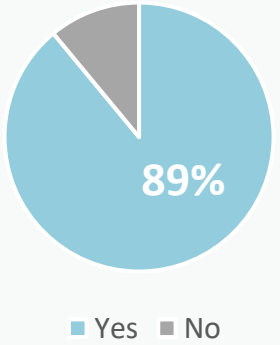
Access to data between care management and behavioral health

Network



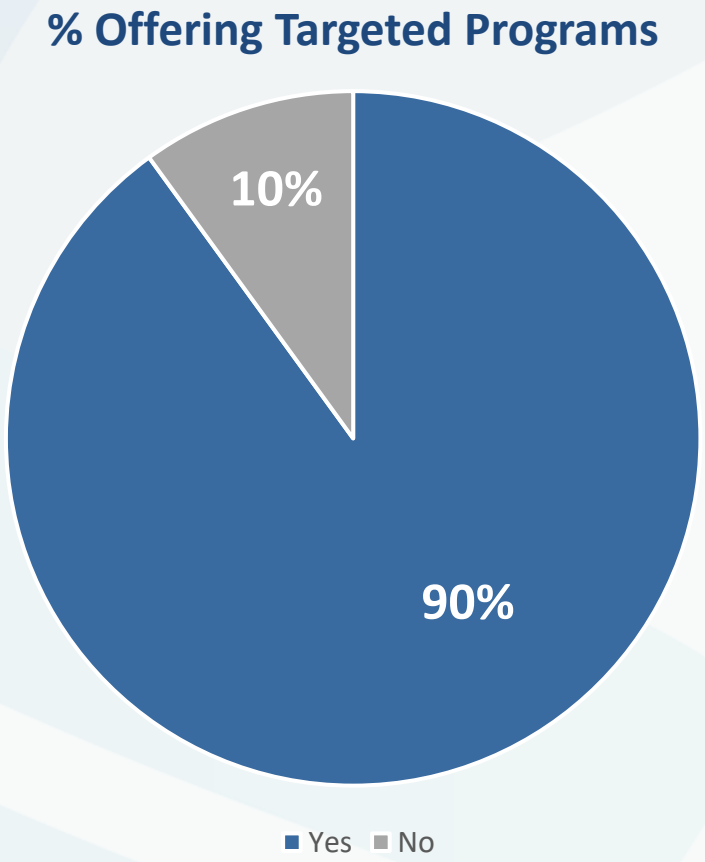
Provider ability to deliver integrated physical and behavioral health

Policy



Limitations on sharing substance use disorder treatment information

Child and Adolescent Health



- Common services:
  - Asthma *(84%)*
  - Behavioral health *(68%)*
  - ADHD/ADD *(68%)*
  - Depression/anxiety *(63%)*
  - Children with special healthcare needs *(74%)*
- Barriers:
  - Coordinating with schools *(74%)*
  - Uncoordinated communication among providers and families *(72%)*
  - Policies not designed for multi-children families *(63%)*

Medicaid Managed Care Approaches to Advance Health Equity

VBP/APM

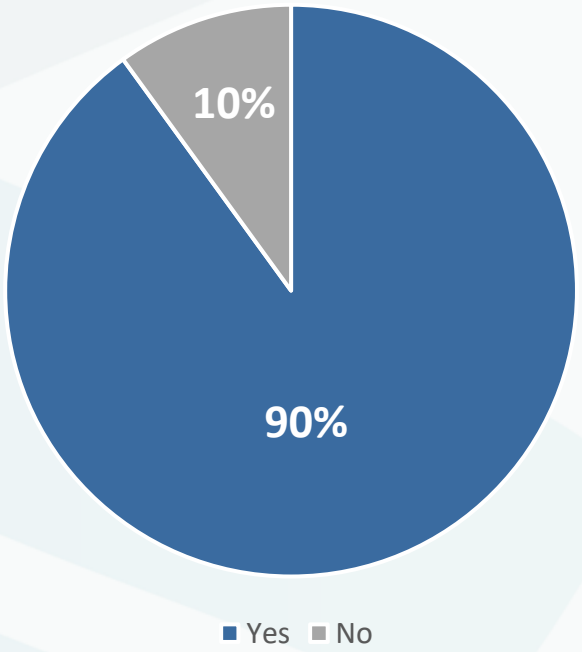
VBP/APM

Value-based payment (VBP) models are widely used across Medicaid managed care organizations. Given Medicaid's role in delivering care to individuals with low-income, the program is uniquely situated to address health-related disparities.

Value-based payment (VBP) can be an effective tool in designing equity-focused payment and contracting models. The development of equity-focused VBP approaches to support care delivery transformation is an important lever that can help payers advance health equity and eliminate disparities in health care with their provider organizations and members.

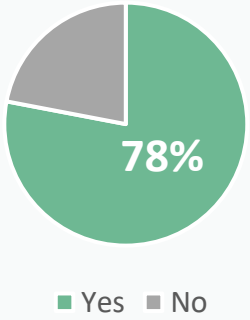
Value-Based Purchasing

% Utilized an Alternative Payment Model or Value-Based Purchasing Arrangement

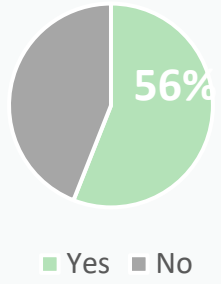


Frequently used payment strategies:

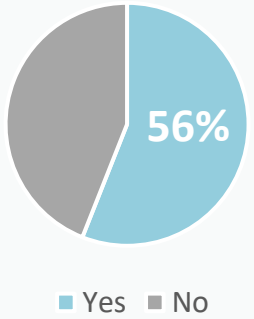
Incentives Related to Access to Care



Incentives Related to Availability of Same-Day or After-Hours Appointments



Enhanced Payment Rates for Hard-to-Recruit Provider Types



Six Strategies leading to VBP

In developing equity-focused VBP approaches to mitigate health disparities. Strategies should include:

(1) articulating an equity goal;

(2) assessing the payment and care delivery environment;

(3) selecting performance measures;

(4) setting performance targets;

(5) designing the payment approach; and

(6) addressing operational challenges.

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Questions?

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Next Steps

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Health Equity Learning Sessions & Workgroups

Three Learning Sessions

Similar in structure to past TX MCO SDOH LC meetings, with a focus on level setting and group learning

Two Workgroups

Deep dives on a particular issue to define actionable recommendations and strategies

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Potential Topics for Health Equity Workgroup Sessions

- *Race, ethnicity, language and disability (RELD) data*
  - → Collection of RELD data
  - → Efforts to stratify quality measures
- *Addressing maternal/child health disparities*
  - → Work building upon SB 750
- *Health care disparities and health care access in rural Texas*
  - → Community Health Access and Rural Transformation Model
- **Format**
  - → Two workgroups (three virtual or in-person sessions each)
  - → Development of health equity action recommendations

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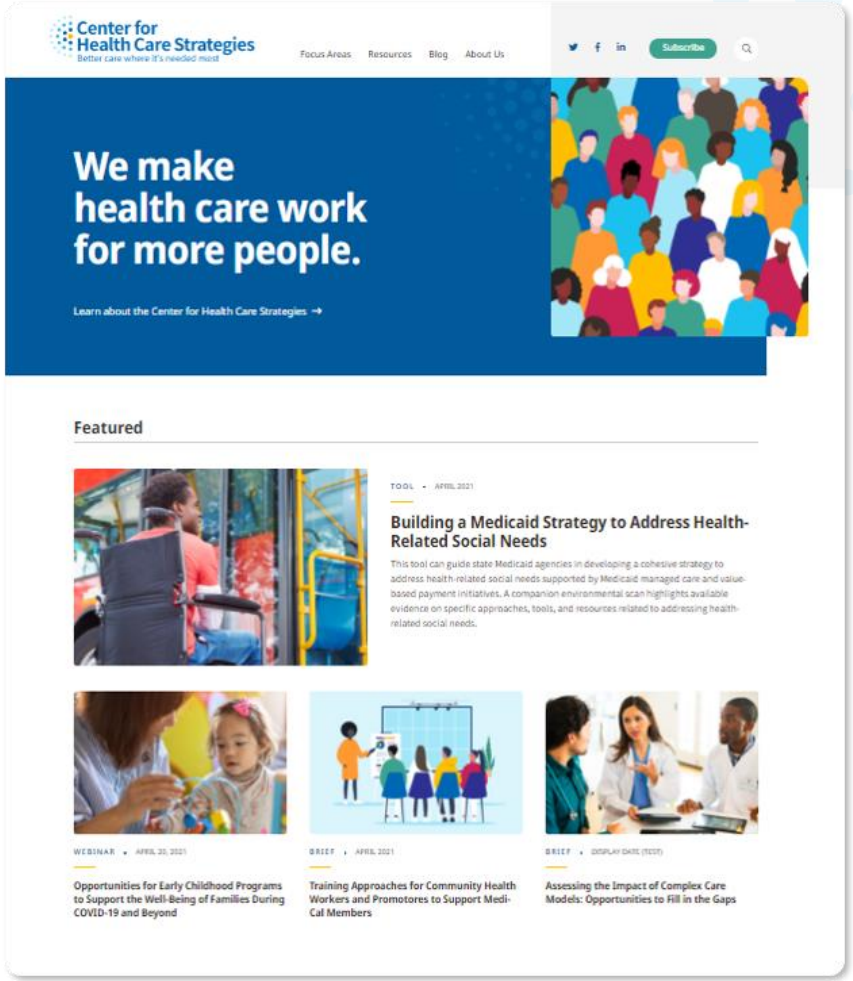

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