Panel and Discussion Notes: Building a Consensus to Promote Health Equity in Connecticut

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Opening

Karen Siegel re: why now:

- Election
- Fiscal stress
- Opportunities

Tekisha Everette

- Promoting strategies for best health
- Build consensus around health equity and reform
- Landscape is rapidly changing
    - Aetna/ CVS/ Amazon - all looking for new ways to pay for care
    - If not done right, lead to worse health outcomes especially for those who are vulnerable
- Must come together to ask the right questions to hold system accountable
- We are concerned by grave disparities deemed minorities in CT - education, social class and other reasons you care about health policy
    - When you control for everything else / social factors - r/e ppl fare worse
- What unites us?
- Framework to assess delivery and payment reforms - help us ask the right questions
    - Something to take with us
    - Who is not here? Let us know

Panel

Eliot Fishman

- Urgent public health crisis, effecting a larger proportion of our population
    - As you begin at any work - cost, access, coverage - health equity bubbles up
    - Discrimination is an access issue but increasingly clear it is a medical issue in and of itself - burden of discrimination
- Payment and Delivery Reform
    - One hand, we cannot keep doing what we do and expect outcomes to change
        - We've had a system in which there is a lack of delivery of community based services and lack of integration between health and human services and not equipped to deal with health equity challenges
    - Other hand, if we change it in the wrong way, we will make it worse
        - Focus on cost (expensive health care system) - changes to payment and delivery - those who are under-delivered to will suffer most
            - Must be intentional so we don't make things worse
    - Initial effort to group together things that will mitigate inequities
        - SDOH - add capacity to manage and support
        - Better links between community orgs and communities more broadly and system
        - Fund targeted interventions - don't dump on more work without resources
        - Measure what we are doing as directly as possible on HE

- Detailing the options
  - Boils down to "risk" - in 2 senses
    - Paying care providers based on outcomes, how are we adjusting for patients and communities in our state to pay for quality of care delivery and not the underlying mix of patient pops - we want pay accurately for actual quality of service delivered - and if we get that wrong, pulling resources away from providers who need them and toward providers who don't need them
    - Variations of that theme
      - Not giving safety net providers (underserved) a pass but accurately capturing the challenges they face
      - Just getting started nationally - and I want to talk about it
      - SLIDE - frame a conversation (see FUSA paper)
    - 6 different domains to improve health equity
      - Payment to providers
      - SN integration - community Providers and community services
      - Clinical research - inequities around clinical evidence base
      - Measurement-driving quality and monitoring
      - Workforce
      - Community Partnership
- Core predictive factor - if they are paid on the basis of narrowing disparities, they will pay attention
- Risks
  - Reduction in utilization
  - Insufficient adjustment for social risk
  - Financial destabilizing for safety net
  - Communities of color not at the table
  - Becomes a cost convo only rather than cost AND equity
- Current state of Federal Efforts
  - Affordable and available coverage
  - Shift from FFS to payment methodologies
  - ACA CMMI efforts
  - Focus on payment and delivery system reform (2010-2016)
  - 2017 PAUSE button - private initiatives continue through ACOs
  - 2018 RESTART and beyond fresh perspective (new CMS Director - resumption of activity with an increasing opening for considering things in a new way)
- State level
  - How to organize payment and delivery pulling together community based services into regional structure and pay though regional structure - global thinking
  - MCO thought to be form of fundamental change to care delivery - did not work out that way
  - States are still trying to think about how to change payment to drive health equity
  - Efforts to pay providers more financially responsible for more of the total which ranges from total responsibility
    - Oregon and others tying to accountable care communities
    - Maryland - global budgets
    - ACOs
    - About 7 percent of beneficiaries
  - Measuring equity - national quality forum

- Potential payment reform for health equity
    - Massachusetts ACO
        - Key building blocks - direct measurement of health equity as how they are looking at over time
        - Aggressively pursuing a payment model (insufficient for HE)
    - Washington
        - Metrics
        - Slower on payment
    - Minnesota
        - Started w a payment structure
        - Starting to think about health equity

Paul Dworkin

CT specific conversation

- Try to do three things - set the stage and reinforce the background of NOW; second what I believe to be the key concepts to inform advocacy; emphasize why I am optimistic - real progress
    - Health Equity lens - long appreciated the expectation on behalf of CTHF be framed in this context
        - Respectfully suggest 2 caveats - even in referencing health equity
            - Universal approach that particularly targets those who are at increased risk due to social and environment factors - we cannot exclusively target those who are disproportionately disenfranchised - the benefits of a universal approach is a key concept
            - Too narrow a frame for this discussion - health is a vehicle to the outcomes that we seek. If we are promoting health w/o being mindful of achieve wellness and wellbeing - we are not winning. We no longer talk about promoting optimal health; we talk about optimal wellbeing (80 percent outcomes we seek are a function of SDOH)
- Transformation of child health services - has been relatively ignored as part of health care reform
    - Past should not be a prelude to the future - if we are going to focus on society - we must go beyond the reasons that children and families are not the focus on HC reform - kids don't vote and are cheap (same with communities / he)
    - 24 percent of US pop and 12 percent or less of costs -and on the whole, they are quite healthy
    - Disproportionate cost of adults with chronic conditions
- Hard to capture ROI - long term investments - Heckman (early childhood investments have the greatest pay back)
- Book keeping problem - we cannot attribute savings to our investments (home visiting, child care) - $ savings come in corrections in BH and other sectors - wrong pocket problem
- Outcomes for prevention and promotion are elusive - less explicit than chronic disease management
- Have to invoke proximate measures as intervention success - hope and happiness as measures!! 3rd grade level reading; child health is family health - few tested examples of value based payment models in child health
    - Compelling reasons to focus on children and leveraging Medicaid
    - Many of these same reasons exist for your constituencies
- Strategies for successfully leveraging Medicaid and advancing HC transformation lie in embracing critical concepts (come out of our work)

        - Promote a universal approach with a particular focus on vulnerable children and families at risk (adversity) - disproportionately at risk
        - Support community based efforts to promote safety across a variety of settings (child care, education, child welfare, BH)
        - Support CB efforts to identify and address children and family needs as early as possible
        - Integrate services and supports linking child health, support services, housing safety, food, nutrition
        - Encourage design and dissemination (parent mentors, home visitors, etc.)
        - Elevate and expand care coordination in accessing services within and across sectors (care coordination model - brought to scale)
        - ID ways to achieve costs efficiencies through blending and braiding funding streams (BH integration, Child Health Info Line, HMG)
        - Develop methodology for long and short term cost savings (linages to CB services) - de-medicalization - models at work, bring to scale
        - Encourage financial scoring of interventions over multiple years (state and federal)
        - Employ a variety of effective strategies - process called mid-level dev assessment, facilitate connection to CB programs - real time cost savings to impress Medicaid and private payors
- Paul comments on his work to promote federal opportunity to pursue BH integration
    - Model innovation center plan for InCKids - cross-sector collaboration
    - We just heard that in this year - announcement focus on treatment, integration, case management and state alternative models and consider all we have in place that favorably position CT
    - SIM - primary care model - opportunities for us to learn from states like NY (1,000 days) and OR and VT to embrace best practices
- One recommendation
    - Encourage you to think beyond Value Based Payment - to primarily think boldly about delivery system reform - key to our success to the extent that we engage in system building - we need to build systems characterized by all systems "in" and x-sectors - we have the capacity to do this

Sarah de Guia

- How we are transforming care to be health equity focused - stronger together is our model
- CPHEN was brought to do a major unified voice - engagement, policy and advocacy, research and comms
- Data overlay - show that your environment and social status impact your health
- CT slide and CA slide - on Medicaid
    - Both have been able to cut our insurance gap by half
    - Majority of folks on Medicaid are working adults
    - 2/5 children are on Medicaid and 1/4 in Medicare and Medicaid
- Data on race/ethnicity breakdown
- Centering Equity in transformation
    - Medicaid contract requirements
        - REL data - analysis and working toward poverty and sexual orientation data
        - Break down by HEDIS measures - link the two together by using our contracts, leverage our contract requirements through out health plans and with providers
        - CA is a majority managed care setting - but we have some on FFS and some on Public hospital systems and MCOs

        - Require collection of REL and require HEDIS break down (failed legislatively but Medicaid did take rec) - disparities report breaks down the HEDIS metrics - in commercial and Medicaid - require translation no matter what - materials translation required to a percentage
    - FFS requirement around dental - restored dental benefits in Medicaid
        - CRA and disease management - all of them are FFS - experiment with bundling service together
            - Risk assessment, follow up with bundled services (across sectors) - then certain high risk communities,
                - All through our 1115 waiver
    - Goal of Care Coordination
        - How can we manage and coordinate all this care in a more comprehensive way?
        - Sitting at the table, push the state to consider equity perspectives
    - PRIME Initiative in CA
        - Public hospital systems - have pay for performance in public hospitals
            - Seeing patients 2 x a year - how can we better coordinate
            - Look at specific disparity rates and focus - came up w disparity plans
                - Focus on comprehensive diabetes care
                - Engage ppl into their own health transformation? Engage the ppl themselves? Story project
    - Health benefit exchange
        - Covered CA - 1 million lives
        - Lots of churn w Medicaid - pretty solid 1 million ppl - covered CA is about improving quality and costs but about reducing disparities
            - Contracts with QHPs - specific requirements to show year over year reductions in disparities reductions (diabetes, hypertension, Asthma and depression)
            - Data continues to be a barrier
- Coalition of orgs - many are local - consistent partnership investments; TA, capacity building -
    - Testify - bring to Sacramento
    - Space for feedback
    - Sustainable partnerships
    - Relationship building
- Quality improvement
    - What metrics do we want are tied to payment
    - Reinvestment in the system to allow for different pops (CHWs, peer navs)
    - Certain communities or pops that we really want to think about - some principles
        - Incorporate reducing health disparities
        - Not replacing clinical visits
        - Not penalizing providers trying to do the right thing

Q & A

- Sheldon: We moved from capitated care (2012) - we made other changes and Medicaid in CT a success story because Medicaid has done so well - and as we improve Medicaid - the question I have, both advocates and the state agree that we've improved - one argument we hear is that FFS does not provide us flexibility - other options to provide flexibility?
    - SPA - there is a view that CHWs can address

    - There is an assumption that the payment reform we want is to push risk onto primary providers
        - If you don't have a mechanism to measure or change the behavior to drive health equity outcomes, it is not so much you need providers to be in charge of Medicaid
            - Element of measuring how we are doing and having it drive some entity to drive outcomes - that will be important
            - Build on and don't follow the national trajectory
            - "system" ness - if you are paying for each service individually
- More creative ways to build on Medicaid?
- Tom - don't suck money out of the Medicaid program
    - Codifying what they have to report - how are they dealing with hc disparities
    - Other pathways to capture resources like community benefit
    - Hospital monopolies
    - I want us to figure out goals and prioritize that we don't put ppl enrolled in Medicaid at risk
- Key theme here is that this not a way of delivering care
    - Convo that is being had - respond to
    - Not being had - Tom - lots of delivery and systems changes that we could advocate for
- Tekisha: Appreciate these first 2 comments
    - What are the questions that we are asking to force the conversation - are we prepared to say what the principles are?
- Sarah
    - We would not characterize that the costs are associate with Medicaid - the majority of folks are in the program and their quality is less and we are tired of it
        - Huge amount of ppl that we can utilize and hold plans accountable
        - Not acceptable that these continue
        - Holding disparities - accountable
- Ellen: CT should not just pursue the new toy
    - MC does not solve everything, Medicaid is working better
    - CT is not comparable to CA
    - Payment reform - where we start - then they do the payment reform (mechanism to measure)
        - Public health committees
    - Data is inconsistent - HC Cabinet Mtg - facility fees
    - We just recently found out how many ppl are in the Medicaid program - reckless disregard to talk about payment before other things in place
    - How did you get to a place where you can get so much solid data?

Sarah:

Evolving process - part of it was building requirements to collect data

- Commercial side - ticking away at it - work with the right ppl bc much is in contract language and get other agencies on board
    - Multiple orgs pushing
    - If we are going to set goals and targets and right leadership
- In the interim, we continue to have other strategies
    - Medicaid data collection
    - Pushing at another level pushing for auto-assignment
- Organize around data
    - Initiative on the ballot - Prop 209 - resonated with ppl, our health is tied to data collection

- What is the momentum post-SIM?
    - First 5 - tobacco taxes/ counties need to think about alternative funding mechanisms
    - Variety of federal initiatives to support related innovations - we know in states where Fed gov't have used home visiting, CDC dollars, SAMHSA dollars, InK dollars - that extends the period of time
    - Capturing savings to make the case at leg/exec to justify programs
    - Frame initiative to meet local priorities
        - Workforce - VT
        - MS and FL - "defense strategy"
        - Convince legislators
        - More funders want their funding leveraged with other partnerships

- Eliot: Develop a locus of accountability - build on what you have and have a less segregated delivery system AND build on gains shifting into FFS but still have a lever/entity that is accountable to measure - is the needle to thread
    - Measure what? - the looking under lamp post
        - Not minimizing
        - Health development and wellbeing - Oregon and New York - using proximate measures what it takes (third grade reading, K readiness)
        - How to come some common understanding related to measurement - convening of 30 ppl by RWJF - what are the outcome measures (health and wellbeing) - remarkable; summary of the convo that would be worthwhile
    - Methodology of measuring long term cost savings
        - Solve the accounting problem
        - CHCS - capture long term investment - forthcoming
- Danielle: Outcomes - Key Themes
    - Where is CT at right now? what are the convos that are and are not happening?
        - Data
    - Measurement and data
        - Quality metrics
    - Balancing payment and delivery reform
        - Concerns about managing risk
        - Medicaid works now - how do we build on this?
        - Over-reliance on cost
    - Integration, Addressing SDOH and Community Based Linkages and Community Engagement

A summary of the discussion from after lunch is included in the survey. We attempted to summarize the key goals and principles and look forward to refining this list with you all.