



## State Health Policy, Payment Reform and Health Equity

Building a Consensus on how to Promote Health Equity in Connecticut:  
What's the Next Step?  
Connecticut Hospital Association

October 29, 2018  
Eliot Fishman, Ph.D.  
Senior Director of Health Policy



*Our vision is a nation where the best health and health care are equally accessible and affordable to all*

### Families USA's Mission and Focus Areas

Families USA, a leading national voice for health care consumers, is dedicated to the achievement of high-quality, affordable health care and improved health for all. We advance our mission through public policy analysis, advocacy, and collaboration with partners to promote a patient-and community centered health system.

Working at the national, state and community level for over 35 years



COVERAGE



HEALTH CARE VALUE



HEALTH EQUITY



CONSUMER ENGAGEMENT



### What's at Stake

#### Cost of Health Inequities

- Moral Cost = 3.5 million lost life years.
- Health Care System Cost = \$93 billion.
- Economic Costs = \$135 billion.
- By 2050 fixing health inequities will add \$230 billion yearly to the US Economy.

#### Demographic Imperative

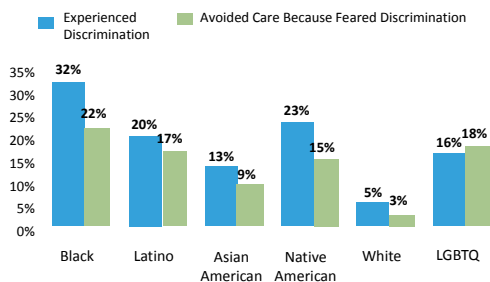
- 2011: Majority of births of color
- TODAY: Majority of kids under ten are of color
- 2020: 18 and under
- 2045: Entire nation

Sources: Compiled from the following sources: Ani Turner, The Business Case for Racial Equity: A Strategy for Growth (Battle Creek, MI: W.K. Kellogg Foundation, 2018) available online at <http://www.businesscaseforracialequity.org/>; More than 200 black people die daily because of disparities. More than a 727 crashing every day. Source: David Williams, Why Discrimination is a Health Issue (Princeton, NJ: RWJF, 2017) available online at <https://www.rwjf.org/en/blog/2017/10/discrimination-is-a-health-issue.html>; "Minorities will be the source of all of the growth in the nation's youth and working age population, most of the growth in its voters, and much of the growth in its consumers and tax base as far into the future as we can see." [Source: William Frey, The US will become 'minority white' in 2045, Census projects: Youthful minorities are the engine of future growth (Washington, DC: Brookings, 2018)]



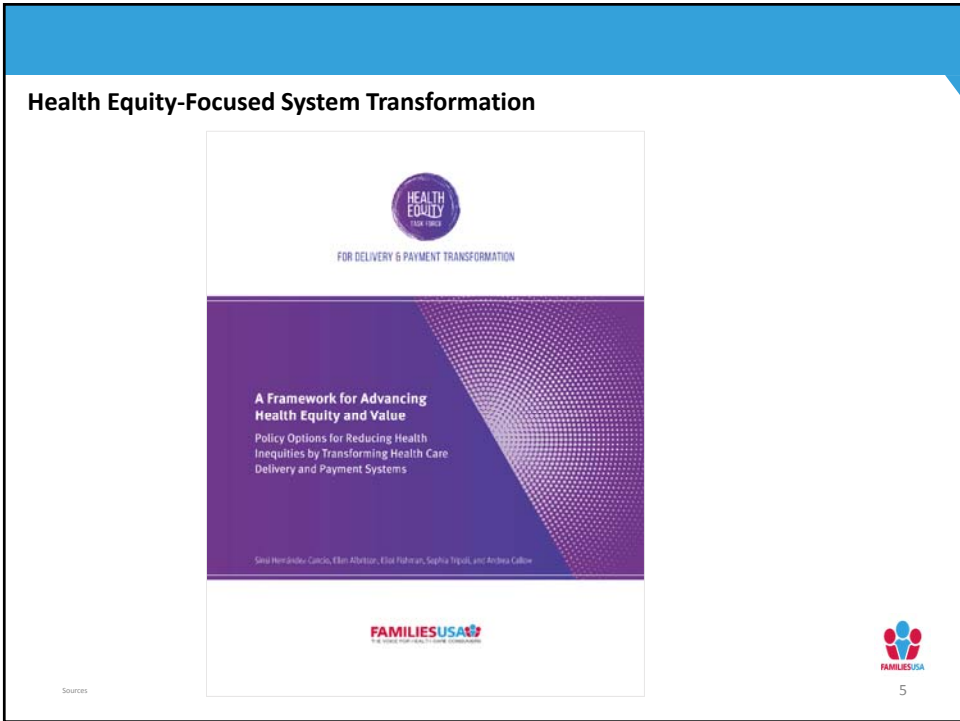
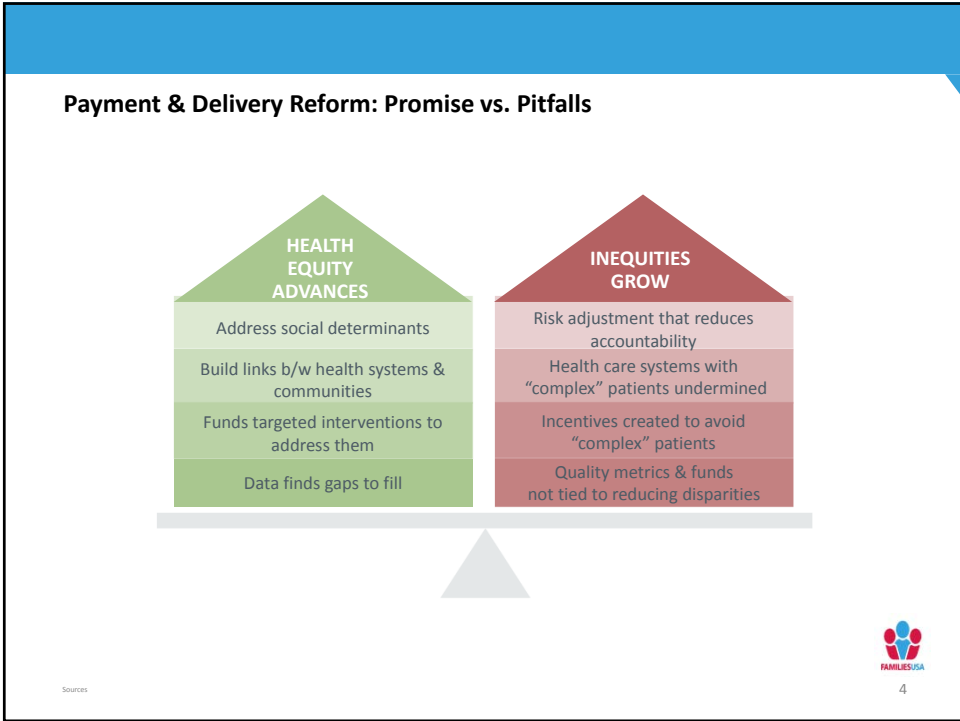
### Discrimination in Health Care

Percent Reporting Discrimination in Healthcare



Source: Discrimination in America, RWJF, NPR, Harvard






**Framework: Six Policy Option Domains**

Payment Systems that Sustain and Reward High-Quality, Equitable Health Care	Investing to Support Safety Net and Small Community Providers in Delivery System Reform	Building Robust and Well-Resourced Community Partnerships
Ensuring a Transparent and Representative Evidence Base	Equity-Focused Measurement that Accelerates Reductions in Health Inequities	Growing a Diverse Health Care Workforce that Drives Equity and Value


Sources



6

Payment reform ultimately is a key factor in changes to how medical care is delivered.

Sources



7

### Risks of Payment Reform for Health Equity

- Incentives to reduce utilization for communities that already lack sufficient access
- Insufficient adjustment for social risk
- Financially destabilizing for safety net and small community providers
- Communities of color not participating at the decision-making tables
- Focus on cost reduction; lack of focus on reducing inequities

Sources



8

### Current Status of Federal Efforts To Reform Healthcare Delivery

- When Obama administration took office in 2009, focused the Affordable Care Act on two primary goals:
  1. Affordable and available coverage
  2. Shifting payment from “fee-for-service” to payment methodologies in which providers are accountable for quality and cost.
- ACA created the new Center for Medicare and Medicaid Innovation with a \$10 billion budget to drive national change.
- From 2010-2016: Providers, payers, state governments, CMS, health advocates all focused on payment and delivery reform.
  - Taking seriously the possibility of new provider organizations, new staffing arrangements.
- 2017: Federal “Pause button”. Private initiatives continue—over 19 million commercial insurance enrollees in “Accountable Care Organizations”.
- 2018 and beyond: Restart—and with an opening for fresh perspective.

Sources: D. Muhlenstein, B. Saunders, and M. McClellan, “Growth of ACOs and Alternative Payment Models in 2017,” Health Affairs Blog, June 28, 2017.



9

## Medicaid is Changing

- Over the last thirty years most states started to use Medicaid HMOs
  - Helped manage cost and admin burden
  - Did not change the way providers were organized or deliver care (much).
- Connecticut turned away from Medicaid HMOs in 2010-11.
- Multiple models now implemented at scale involving a more direct financial responsibility for hospitals or physician groups for quality or total cost:
  - Accountable Care Organizations: Minnesota, Vermont, Massachusetts, Rhode Island
  - Global Budgets: Maryland
  - Regional Provider Organization is Medical Insurer: Oregon
- Numerous other states with pilots
- As of mid-2018, about 7% of Medicaid beneficiaries in ACOs (vs. 15% of Medicare beneficiaries).

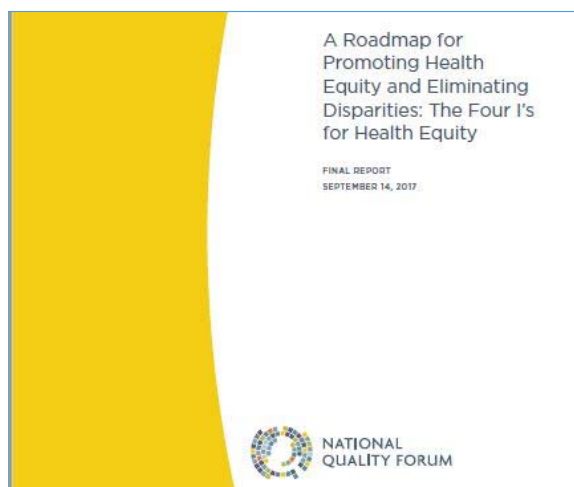
Sources



10

## Potential of Payment Reform for Health Equity

- Paying for Performance → Tying Payment to Improvement.
- Makes Possible Measurement of Equity as a P4P Measure.



Sources



11

## Potential of Payment Reform for Health Equity

- More flexible, global payment can enable payment for nontraditional community-based services:
  - Community Health Workers
  - Peer Supports

The Community Health Worker Sustainability Collaborative

*Working to Reduce Disparities in Health and Health Care*




Sources

12

## Potential of Payment Reform for Health Equity

- Building new regional provider organizations that incorporate some or all of:
  - Hospital
  - LTSS
  - CHC
  - Community-Based Organizations
  - Community Physician
  - Housing
  - Mental Health
  - Human Services
  - Substance Use

Sources

13

## State Examples of Regional Cross-Sector Approach

### Massachusetts Medicaid ACO Program

2. Improves integration among physical health, behavioral health (BH), long-term services and supports (LTSS) and health-related social services.
  - a. ACOs and community-based organizations who become BH and LTSS Community Partners will be eligible to receive \$1.8 billion over five years of Delivery System Reform Incentive Program (DSRIP) funding available to improve integration of care, outcomes for members with serious mental illness and co-morbid conditions or long term services and supports.
  - b. Establishes DSRIP funding and expectations for ACOs and a range of community partners to address social determinants of health, including for certain approved community services, such as housing stabilization and supports and other health -related social services.

Sources: Massachusetts EOHHS



14

## State Examples of Regional Cross-Sector Approach

### Washington State Accountable Communities of Health

#### What is an ACH?

Accountable Communities of Health (ACHs) bring together leaders from multiple health sectors around the state with a common interest in improving health and health equity. As ACHs better align resources and activities, they support wellness and a system that delivers care for the whole person. [See our video](#).

There are nine ACHs. Their boundaries align with Washington's Medicaid regional service areas. View the [ACH regions map](#).

#### What are the goals of the ACHs?

- Promote health equity throughout the state.
- Create, support and collaborate on local health improvement plans.
- Support local and statewide initiatives such as the [Medicaid Transformation](#), practice transformation and value-based purchasing.
- Align resources and activities that improve whole-person health and wellness.

Sources



15



## State Examples of Regional Cross-Sector Approach

### Minnesota Integrated Health Networks

#### Impact of Quality on Payment in the 2018 IHP Model

Population-Based Payment	Total Costs of Care Risk Model
IHP will be evaluated on quality, health equity, and utilization measures to determine eligibility to continue participation after the conclusion of each three-year cycle.	Quality results affect the IHP portion of the shared savings amount but do not influence losses.


#### Quality and Population-Based Payment

- Population-based payment is tied to an IHP's ability to evaluate, intervene, and improve the health of Medicaid beneficiaries.
- Clinical quality, health equity, and utilization measures showing improvement in health outcomes.
  - Determined through mutual agreement between IHP and DHS
- Population-based quality score - eligibility to continue participation in the program after the conclusion of each three-year cycle.
  - Will not impact the per member per month (PMPM) payment amount during the initial three-year cycle.

Sources

## Additional State Examples of Regional Cross-Sector Approach

- Rhode Island Accountable Entities (similar to ACOs)**
- New York Performing Provider Systems (Project-Focused, Payment Reform TBD)**
- Vermont Green Mountain Health (Statewide ACO)**



17

Sources

*Our vision is a nation where the best health and health care  
are equally accessible and affordable to all*

