Health Equity and Medicaid Managed Care: Using MCO Contract and Performance Requirements

September 24, 2019 | 2-3 pm EDT

A grantee of the Robert Wood Johnson Foundation
State Health and Value Strategies (SHVS) assists states in their efforts to transform health and health care by providing targeted technical assistance to state officials and agencies. The program is a grantee of the Robert Wood Johnson Foundation, led by staff at Princeton University’s Woodrow Wilson School of Public and International Affairs. The program connects states with experts and peers to undertake health care transformation initiatives. By engaging state officials, the program provides lessons learned, highlights successful strategies, and brings together states with experts in the field. Learn more at www.shvs.org.

Questions? Email Heather Howard at heatherh@Princeton.edu.

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Welcome from State Health and Value Strategies (SHVS)

Dan Meuse
Deputy Director
State Health and Value Strategies
dmeuse@princeton.edu
Today’s Facilitator and State Presenters

Mary Beth Dyer  
Senior Consultant  
Bailit Health

Leann Johnson  
Director of the Office of Equity and Inclusion  
Oregon Health Authority

Tom Curtis  
Manager, Quality Improvement and Program Development  
Michigan Department of Health & Human Services
Housekeeping Details

• All participant lines are muted. If at any time you would like to submit a question, please use the Q&A box at the bottom right of your screen.

• After the webinar, the slides and a recording will be available at www.shvs.org.
Agenda

1. Health equity webinar series
2. Overview of state efforts to hold MCOs more accountable for health equity
3. Examples of state MCO contract & performance requirements that aim to reduce health disparities -- and address health equity
4. Conversation with the presenters
5. Wrap-up
Webinar Series Overview

• This series of five webinars is designed to assist state Medicaid agencies in improving health equity through their contracted Medicaid managed care organizations.

• The webinars are open to all interested state Medicaid agencies and any interested state agency partners (e.g., departments of public health).

• Webinars are supplemented with virtual office hours: telephone calls for interested states with content experts on topics of state choosing.
The federal Medicaid managed care rule specifically requires states contracting with managed care entities to draft and implement a written strategy for:

- “assessing and improving the quality of health care and services furnished” by these managed care entities, and as part of its quality plan, “**identify, evaluate, and reduce, to the extent practicable, health disparities** based on age, race, ethnicity, sex, primary language, and disability status.”

Getting Started!

1. Start with an intentional plan to address health equity in Medicaid managed care contracts
2. Consider state partners, data sources, MCO staffing and available resources to support your efforts
3. Establish a clear objective(s), concrete timeline and process(es)
4. Collaborate with MCOs and other partners
5. Consider how best to evaluate your health equity efforts and evolve your approach over time
Tools to use with Managed Care

1. Establish clear contract requirements & accountability related to health equity
   - Staffing, network, reporting, language access, etc.
2. Offer technical assistance & shared learning
   - Trainings, collaborative improvement efforts
3. Stratify Medicaid performance on quality measures by race/ethnicity, consider regional differences
   - Produce annual reports of health disparities
4. Establish priority areas of focus
   - Identify health disparity reduction target(s)
5. Create managed care performance incentives
Performance Incentives

1. **Transparency** of MCO program and individual plan performance on disparity metrics

2. **Annual awards** presented by the state in different categories—e.g., top performer, “most improved”, most innovative

3. **Financial Incentives**
   - Consider upfront funds for infrastructure support and after-the-fact funds to reward performance
     - Link health equity efforts to MCO capitation withholds: process vs. outcome measures
     - Establish financial penalties for poor performance on health equity expectations/contractual requirements
State Health and Values Strategies
Health Equity in Oregon’s Medicaid Coordinated Care

Leann R Johnson, MS
Director, Equity and Inclusion
Background

• Oregon Health Authority
  – 2011
  – All health policy and services programs
  – Medicaid, Public Health, Oregon State Hospital, etc.

• Equity and Inclusion
  – Formerly Multicultural Health Services
  – Evolved from Public Health tradition of Minority Health Office/Officer (1993)
  – Agency and statewide scope
• Equity and Inclusion Division
  – 16 functions for Oregon Health Authority/State of Oregon
  – 8 functions are state or federally mandated
  – Examples include Traditional Health Workers, Language Access and Health Care Interpreters, Civil Rights, ACA Section 1557 compliance, Race, Ethnicity Language and Disability Data Collection Standards, etc.
Equity and Inclusion in Oregon: Priority Workplan

• Addressing structural and systemic barriers in health delivery systems to forward health systems transformation
  – Data quality/Health Equity measure
  – Engaging communities
  – Technical Assistance/Training
  – Compliance
  – Policy (Coordinated Care Organizations, State Health Improvement Plan, Legislation)
Coordinated Care Organizations (CCOs)

• New five-year contract (CCO 2.0)
  – Integration of health equity policy options
  – Extensive community engagement process

• Areas Identified/CCO requirements
  – Health Equity Plan
  – Traditional Health Workers
  – Health Equity Administrator
  – Training and Development
  – Health Care Interpreters
Health Equity Plan

- Grievance and appeal system
- Use of disaggregated demographic data
- Culturally and linguistically appropriate services
- Governance system to promote health equity
- Recruitment and retention strategies
- Training and education plan
- High-quality language access services
- Compliant member communication
Traditional Health Workers (THWs)

- Plan to work with and integrate THWs
- Integrate best practice for THW services in consultation with THW Commission
- Designate a CCO liaison for THW services
- Identify and include THWs affiliated with organizations listed in ORS 414.629
- Incorporate alternative payment methods to establish sustainable payment for THWs
Health Equity Administrator

- Single point of accountability for CCO
- Develops and monitors organizational oversight structure of health equity work
- High-level director position (may have other responsibilities in CCO)
- Authority to communicate with CCO executives and governing board
- Responsible for budgetary, personnel and other resource allocation
Training and Development

• Fundamental training areas
  – Social/cultural diversity
  – Language access/Health Care Interpreters
  – Adverse Childhood Experiences
  – Trauma-Informed Care (culturally responsive)
  – Civil Rights and Non-Discrimination
  – ADA, accessibility and universal access
  – Working with Traditional Health Workers
Training and Development

• Fundamental training areas (con’d)
  – Systemic oppression, cultural barriers and social determinants of equity
  – Social determinants of health
  – Meaningful community engagement
  – Use of data to advance health equity
  – Culturally and Linguistically Appropriate Services (CLAS) standards
  – ACA Section 1557
Health Care Interpreters & Language Access

• Component 1
  – Language Access Plan
  – Report annually

• Component 2
  – Submit individual level data on member visits with interpreter needs where services were provided
  – Spoken and sign language
  – Report quarterly
Michigan Medicaid Managed Care:

Health Equity

Tom Curtis, Manager
Quality Improvement and Program Development
• Performance rates by race/ethnicity
• Rates stratified by Health Plan
• Trended over time (2012-2017)
• Two calculations:
  ✓ Pairwise comparison (White reference population)
  ✓ Index of Disparity (Each subpopulation rate compared to overall Health Plan rate)
• Year over year, African American subpopulations experience disproportionately lower quality of care than all other comparisons, including the White reference population

Website: https://www.michigan.gov/mdhhs/0,5885,7-339-71547_4860-489167--,00.html
Post-Partum Care

- African American rate increased from 46% in 2012 to 54% in 2017
- White reference population fluctuated between 2012 and 2017, beginning and ending at 63%

Chlamydia Screening

- African American rate increased from 74% to 76%
- White reference population increased from 56% to 58%
- We view this as a reverse racial disparity
Health Equity Approach Over Time

1. Created Health Equity performance improvement projects
2. Identified measures that demonstrate significant geographic and/or racial disparity in access to and quality of care
3. Using capitation withhold and quality-based auto-assignment programs to reward MHP performance in reducing racial disparities and improving regionally-defined performance
4. Moving toward population health defined measurement targets requiring regional health plan collaboration and partnership with communities to address geographic performance
Overview of MHP Withhold/Bonus

• Use of points – portion attributed to HE
• Changes in HE measures over time
• Use of qualitative and quantitative measures of performance
• State templates for reporting progress on process/qualitative measures
• Collaborative approach with MHPs – preliminary and final submissions
Managed Care Performance Incentives

• **1% Medicaid Health Plan (MHP) capitation withhold program:**
  1. SDoH and ED Utilization
  2. Housing and Community Collaboration
  3. Racial Disparities in Low Birth Weight Rates by Region
  4. Racial Disparities in HEDIS Rates
  5. Community Health Workers

• Quality performance as component of Medicaid Health Plan (MHP) Compliance
• Quality-based auto assignment algorithm
• Collaborative performance improvement projects
## Incentives to Reduce Racial Disparities

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<th>Measure 1</th>
<th>Health Equity</th>
<th>Measure 2</th>
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**Health Equity and Regional Low Birth Weight Rates Project**

**2017 data**

AP: Asian/Pacific Islander

SW: Statewide

### LBW Rate (%) by Race

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<th>R1</th>
<th>R2</th>
<th>R3</th>
<th>R4</th>
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<th>R6</th>
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<td>6.6</td>
<td>6.9</td>
<td>6.9</td>
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<td>5.8</td>
<td>5.6</td>
<td>6.8</td>
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<td>0.0</td>
<td>13.2</td>
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<td>13.8</td>
<td>14.1</td>
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<td>12.2</td>
<td>12.3</td>
<td>12.3</td>
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<tr>
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<td>6.8</td>
<td>9.5</td>
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Future Plans Related to Health Equity

1. Standardize reporting of SDoH data to the State by MHPs.
2. Expand the use of measurement stratification by region and race/ethnicity in performance monitoring and improvement incentives
3. Support MHP care management by providing additional member information such as incarceration or homelessness; and facilitate promising partnerships between Health Plans and other agencies
4. Continue to improve the CHW ratio, and develop incentives and policies to encourage contracting with community-based and clinical-based CHWs
Discussion

The slides and a recording of the webinar will be available at www.shvs.org after the webinar
Discussion

• Mary Beth Dyer will pose several questions to panelists.

• We will then open up the discussion for your questions entered in the webinar Q&A box.

• The slides and a recording of the webinar will be available at www.shvs.org after the webinar.
Health Equity Series

- As a reminder, our next and final webinar, “The Medicaid MCO Experience in Addressing Health Equity,” is scheduled for **October 22 (2:00pm EDT)**.

- **REL Data Virtual Office Hour**
  - Wednesday, November 20 from 1:00 to 2:00 p.m. ET

- Registration details to follow
Wrap-Up

• Should you wish to identify health equity-related topics that you would like addressed during virtual office hour calls with other states or other content experts, please email Margaret (mtrinity@bailit-health.com).
Thank You

Mary Beth Dyer
Senior Consultant
Bailit Health
mbdyer@bailit-health.com

Dan Meuse
Deputy Director
State Health and Value Strategies
dmeuse@princeton.edu
609-258-7389
www.shvs.org
Appendix
Excerpts:

“Health Equity - When all people have the opportunity to attain their full health potential and no one is disadvantaged from achieving this potential because of their social position or other socially determined circumstance.”

“Contractor recognizes that Population Health management interventions are designed to address the Social Determinants of Health, reduce disparities in health outcomes experienced by different subpopulations of Enrollees, and ultimately achieve Health Equity.”
Targeted Interventions for Subpopulations Experiencing Health Disparities:

1. MCO must offer evidence-based interventions that have a demonstrated ability to address SDOH and reduce Health Disparities to all individuals who qualify for those services.

2. MCO must collaborate with its high volume primary care practices to develop, promote and implement targeted evidence-based interventions.

3. MCO must collaborate with Community Health Innovation Regions (CHIRs) to develop, promote, and implement these targeted evidence-based interventions.

4. MCO must fully and completely participate in the Medicaid Health Equity Project and report all required information to MDHHS within the specified timeframe.
Targeted Interventions for Subpopulations Experiencing Health Disparities: (continued)

5. MCO must measure and report annually to MDHHS on the effectiveness of its evidence-based interventions to reduce Health Disparities by considering such measures as:
   – Number of Enrollees experiencing a disparate level of social needs such as transportation, housing, food access, unemployment, or education level,
   – Number Enrollees participating in additional in-person support services such as Community Health Worker, patient navigator, MIHP, or health promotion and prevention program delivered by a community-based organization, and
   – Changes in Enrollee biometrics and self-reported health status.
Oregon CCO 2.0 Contract


- **Health Equity Plans**: Contractor must develop and implement a Health Equity Plan designed to address the cultural, socioeconomic, racial, and regional disparities in health care that exist among contractor’s Members and the Communities within Contractor’s Service Area.

- **Traditional Health Workers**: Requirements include that contractor must implement THW Integration & Utilization Plan; establish THW Payment Grid, based on OHA guidelines; and implement the THW Commission’s best practices to enhance organizational capacity.

- **Health Equity Administrator**: Contractor shall hire or designate an existing employee to serve as an Health Equity Administrator.

- **Health Care Interpreters**: Contractor shall make OHA certified or qualified health care interpreter services available free of charge to each potential member and member.
Appendix K Quality Care

- MCO shall submit a clearly delineated, outcomes-driven strategy for improvement (e.g., work plan) as part of its annual QAPI submission. The strategy shall measure, analyze, and track performance indicators that reflect the ODM Quality Strategy population health focus, including: population streams (e.g., women of reproductive age, chronic conditions, and behavioral health), value-based purchasing strategies (e.g., comprehensive primary care, episode-based payments), and health equity focus.
• The MCO shall participate in, and support, ODM’s efforts to eliminate health disparities in Ohio.

• According to the U.S. Department of HHS’ Office of Minority Health, a health disparity is: “a particular type of health difference closely linked with social or economic disadvantage.”

• Health disparities adversely affect groups of people who have systematically experienced greater social and/or economic obstacles to health based on characteristics historically linked to discrimination or exclusion (e.g., race or ethnic group; religion; socioeconomic status; gender; age; mental health; cognitive, sensory or physical disability; sexual orientation; or geographic location).