Medicaid in New York: Fostering Equity During a Time of Crisis

United Hospital Fund Annual Medicaid Conference
GoToWebinar Live Webcast
July 15, 2020

@UnitedHospFund - #UHFMedicaid20

Presented with Support From The Commonwealth Fund

United Hospital Fund

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Fostering Equity During a Time of Crisis

United Hospital Fund (UHF) Conference

July 15, 2020

Donna Frescatore, NYS Medicaid Director

Coverage in New York

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Statewide Medicaid Enrollment

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 Enrollment
May 2018	3,466,751	2,703,470	6,170,221
June 2018	3,465,948	2,698,928	6,164,876
July 2018	3,466,431	2,700,902	6,167,333
August 2018	3,463,559	2,704,958	6,168,517
September 2018	3,461,105	2,699,831	6,160,936
October 2018	3,462,971	2,705,211	6,168,182
November 2018	3,459,618	2,702,765	6,162,383
December 2018	3,456,356	2,704,341	6,160,697
January 2019	3,455,878	2,713,851	6,169,729
February 2019	3,451,952	2,701,487	6,153,439
March 2019	3,449,615	2,701,557	6,151,172
April 2019	3,446,980	2,698,525	6,145,505
May 2019	3,446,207	2,700,127	6,146,334
June 2019	3,440,738	2,696,415	6,137,153
July 2019	3,439,000	2,698,886	6,137,886
August 2019	3,435,776	2,697,774	6,133,550
September 2019	3,432,137	2,692,245	6,124,382
October 2019	3,424,668	2,689,127	6,113,795
November 2019	3,401,429	2,675,899	6,077,328
December 2019	3,386,204	2,671,802	6,058,006
January 2020	3,383,467	2,679,613	6,063,080
February 2020	3,385,825	2,674,749	6,060,574
March 2020	3,395,534	2,682,878	6,078,412
April 2020	3,456,366	2,734,716	6,191,081
May 2020	3,541,227	2,780,020	6,321,246

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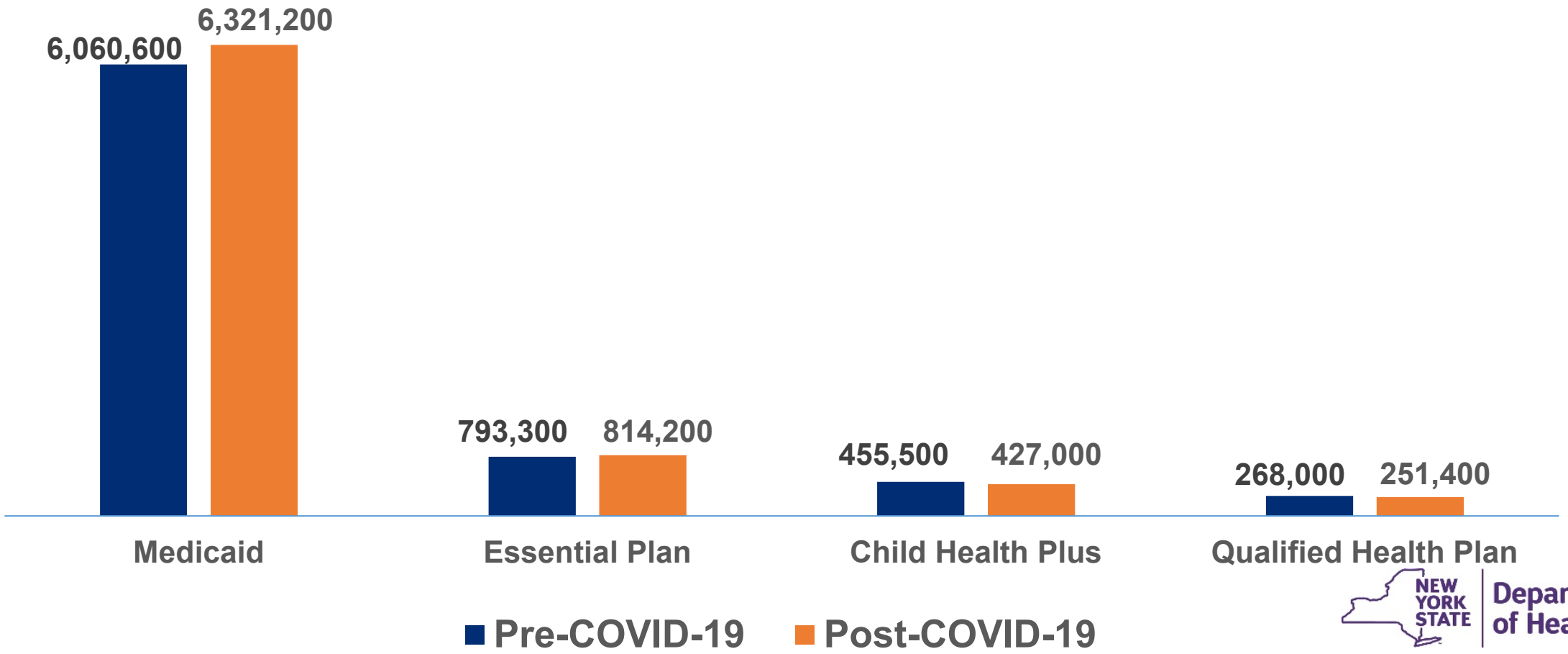
2020 New York State Program Enrollment

Enrollment in New York State programs increased by 236,000 between February and May 2020



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Medicaid Response to COVID-19

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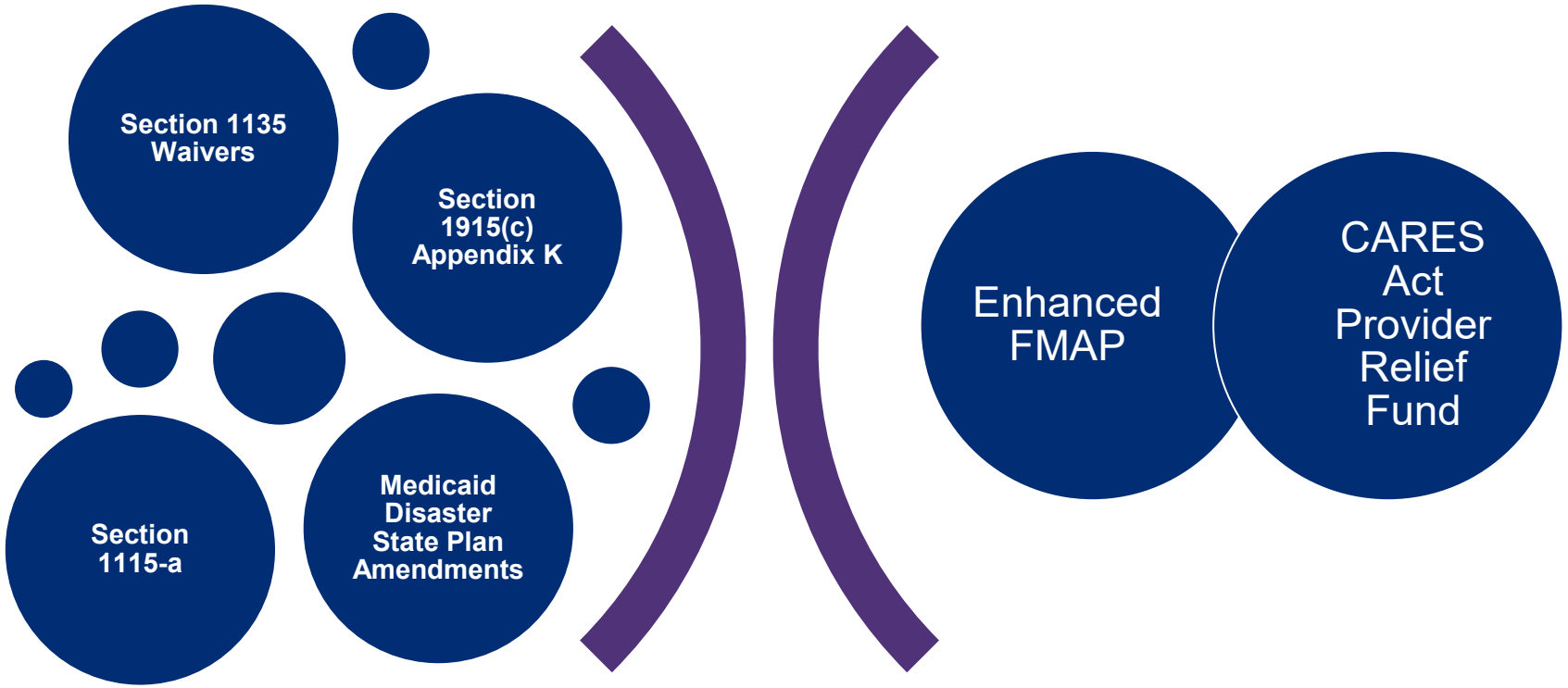
Regulatory and Program Flexibility During the COVID Pandemic



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Modify Service Delivery to Protect Patients and Providers (Examples)

- Suspend Face to Face Requirements for:
  - Initial patient assessment and reassessment for home and community-based services
  - Suspend requirement to sign care plans for community-based long-term services and supports
  - Health Home Care services
  - Permit hospice and home health agencies to perform certifications, initial assessments and determine patients' homebound status remotely via telephone or through telehealth modalities.
- Allow facilities to bill for services provided in an alternative setting such as a temporary facility.

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Ensure Services are Available (Examples)

- Allow billing for telephonic visits for new and established patients
- Expand the types of clinicians, facilities, and services eligible for billing under telehealth rules
- Create an online provider enrollment application to allow practitioners to enroll on a temporary basis, allow out-of-state providers to enroll temporarily and allow applications to be signed electronically rather than through hard copy signature
- Established reimbursement policies for specimen collection by pharmacies

Waive Administrative Requirements to Better Serve Consumers (Examples)

- Automatically extend cases at renewal for 12 months
- Allow attestation at application to reduce administrative burden on consumers
- Suspend certain Utilization Review Requirements for managed care plans
- Suspension of health care surveillance activities or realign to desk review

Section 1115 Waiver

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Section 1115 Waiver – What's Next

- Seeking a one-year extension to the current 1115 waiver, due to expire on March 31, 2021 in order to provide enough time to determine the impact of COVID-19 on the next iteration of system redesign

- Other waiver amendments needed to implement MRT II recommendations will be submitted

Medicaid Redesign Team II

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Reconvening the Medicaid Redesign Team

- Convened on February 11 with final recommendations made on March 19th
- Over 2,200 suggestions received through the public portal and through (7) public forums
- Long-Term Care Advisory Group advanced 30 proposals (across 12 topic areas) to the full MRT for consideration

Governor's Directive that MRT II Recommendations Address:

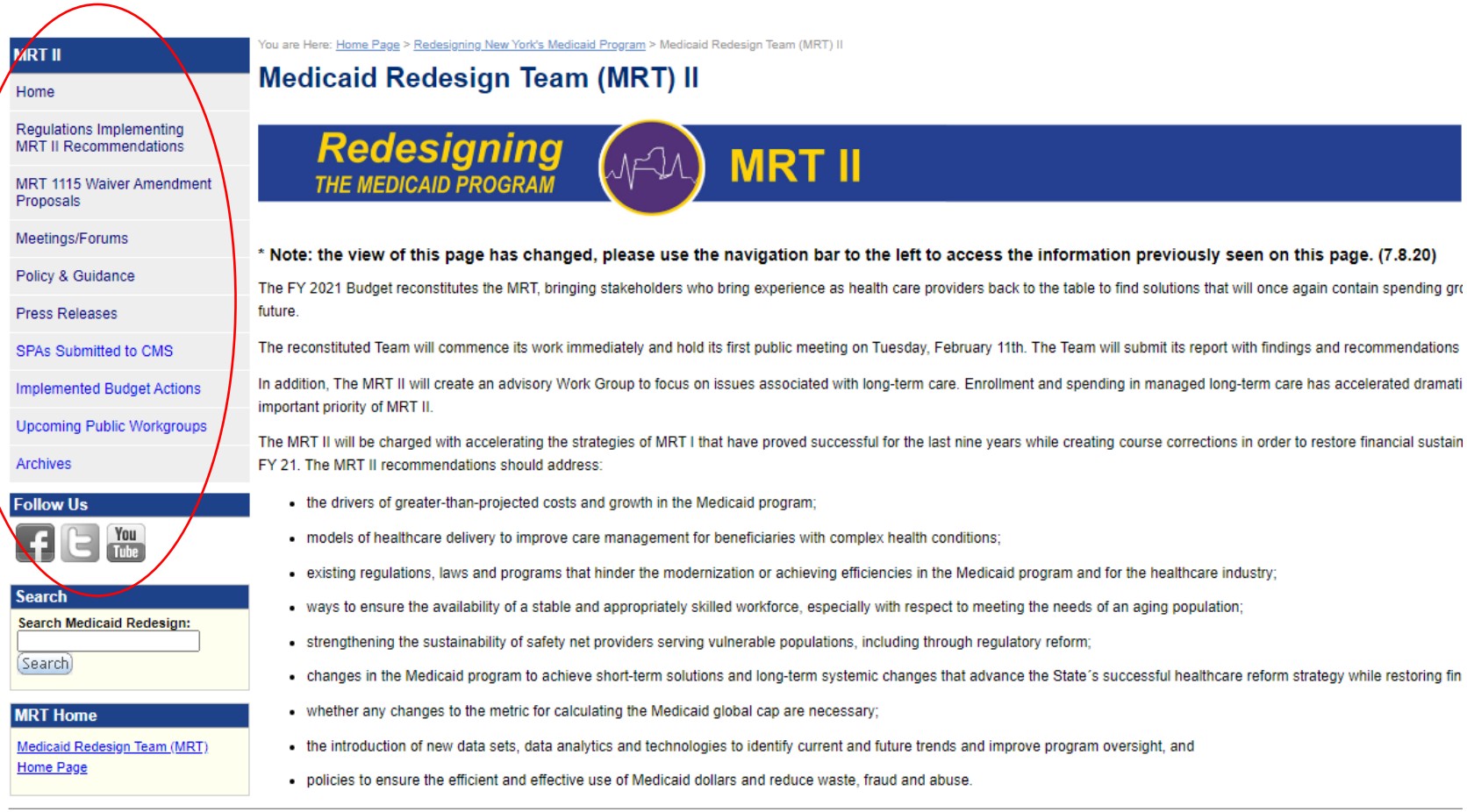
- the drivers of greater-than-projected costs and growth in the Medicaid program;
- models of healthcare delivery to improve care management for beneficiaries with complex health conditions;
- existing regulations, laws and programs that hinder the modernization or achieving efficiencies in the Medicaid program and for the healthcare industry;
- ways to ensure the availability of a stable and appropriately skilled workforce, especially with respect to meeting the needs of an aging population;
- strengthening the sustainability of safety net providers serving vulnerable populations, including through regulatory reform;
- changes in the Medicaid program to achieve short-term solutions and long-term systemic changes that advance the State´s successful healthcare reform strategy while restoring financial sustainability to ensure that benefits will always be available to those who need it;
- whether any changes to the metric for calculating the Medicaid global cap are necessary;
- the introduction of new data sets, data analytics and technologies to identify current and future trends and improve program oversight, and
- policies to ensure the efficient and effective use of Medicaid dollars and reduce waste, fraud and abuse.

MRT II – The Recommendations

Nearly all final MRT II recommendations advanced in the SFY 2021 Enacted Budget with an estimated $2.2 billion in state share savings

Spending Reductions by Area	# of MRT Recommendations Enacted	SFY 2021 Savings (State Share)
Hospitals	5	$297M
Care Management	13	$43M
Managed Care & Value Based Payment	7	$145M
Long Term Care	16	$669M
Pharmacy	2	$35M
Transportation	6	$75M
Program Integrity	2	$60M
Health Information Technology / Social Determinants of Health	3	$9M
General Savings	3	$130M
Continuation of SFY 2020 Medicaid Savings Plan Reductions	11	$739M
Total Spending Reductions	**68**	**$2,202M**

MRT II Implementation – Follow Us Here



MRT II

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MRT Home

Medicaid Redesign Team (MRT) Home Page

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Medicaid Redesign Team (MRT) II

Redesigning THE MEDICAID PROGRAM MRT II

*** Note: the view of this page has changed, please use the navigation bar to the left to access the information previously seen on this page. (7.8.20)**

The FY 2021 Budget reconstitutes the MRT, bringing stakeholders who bring experience as health care providers back to the table to find solutions that will once again contain spending gr future.

The reconstituted Team will commence its work immediately and hold its first public meeting on Tuesday, February 11th. The Team will submit its report with findings and recommendations

In addition, The MRT II will create an advisory Work Group to focus on issues associated with long-term care. Enrollment and spending in managed long-term care has accelerated dramati important priority of MRT II.

The MRT II will be charged with accelerating the strategies of MRT I that have proved successful for the last nine years while creating course corrections in order to restore financial sustain FY 21. The MRT II recommendations should address:

- the drivers of greater-than-projected costs and growth in the Medicaid program;
- models of healthcare delivery to improve care management for beneficiaries with complex health conditions;
- existing regulations, laws and programs that hinder the modernization or achieving efficiencies in the Medicaid program and for the healthcare industry;
- ways to ensure the availability of a stable and appropriately skilled workforce, especially with respect to meeting the needs of an aging population;
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MRT II Supporting Regulations

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Proposed and Final Regulations Implementing MRT II Recommendations

The following includes proposed amendments for statutory changes resulting from MRT II recommendations, as adopted in the State Fiscal Year 2020-21 Enacted Budget.

- Proposed Amended Regulations regarding Private Duty Nursing Services to Medically Fragile Children (18 NYCRR 505.8) (Web) - (PDF) - 7.08.20
- Summary of Express Terms for Proposed Amended Regulations regarding Personal Care Services and Consumer Directed Personal Assistance Program Services (CDPAS) (18 NYCRR 505.14 & 505.28) - (PDF) - 06.30.20

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MRT II Policy & Guidance

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Policies & Guidance

- MLTC Policy 20.02: Moratorium on Managed Long Term Care Partial Capitation Plans
- MLTC Policy 20.03: Non-emergency Transportation in the Consumer Directed Personal Assistance Program

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Fostering Equity

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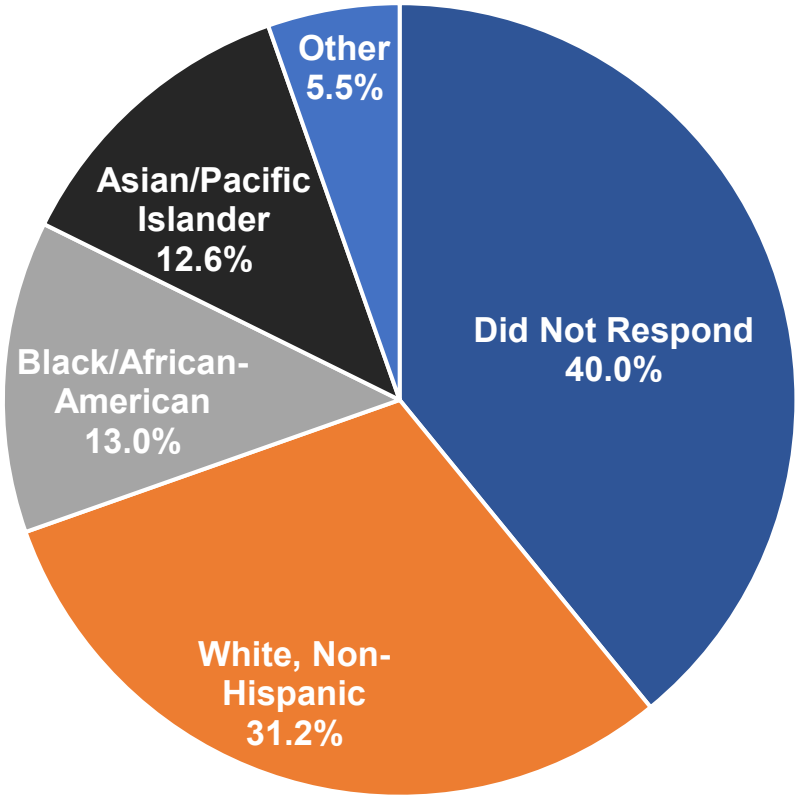
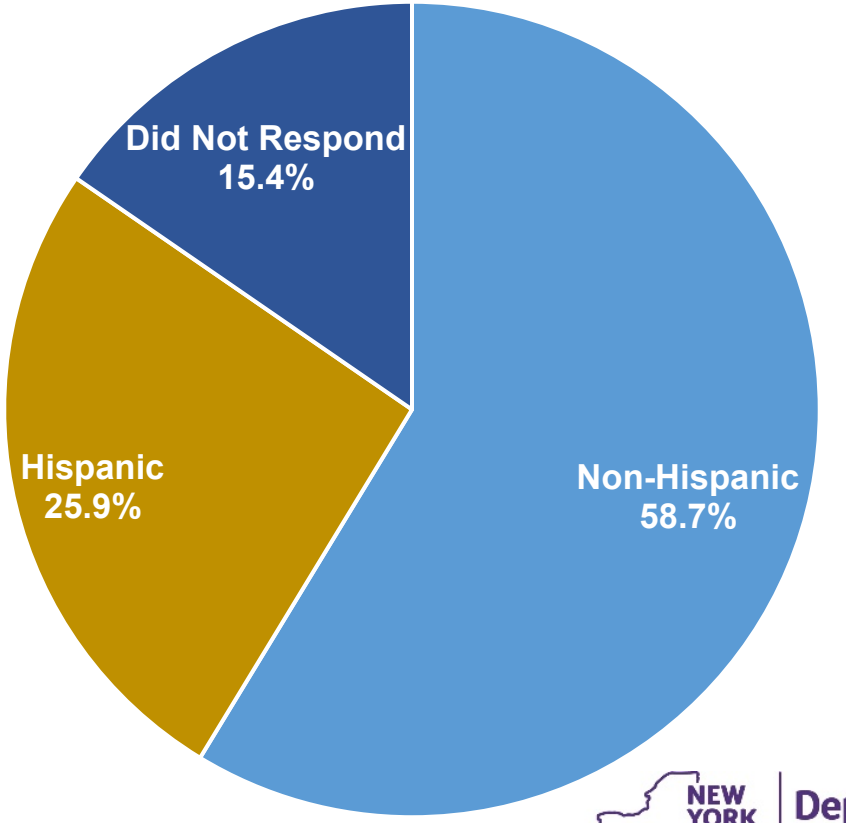
NY State of Health Enrollment
Self-Reported Race and Ethnicity

Marketplace Enrollees, by Race



Marketplace Enrollees, by Hispanic Ethnicity



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Expanding Language Access

Over the last four years, the NYSoH has prioritized language access materials and resources for consumers to ensure that we are meeting the needs for all New Yorkers.

- Marketing Materials: In 2015, NYSoH materials were offered in 7 required languages. Today, these materials are provided in 27 different languages.
- Language Assistance Services: We have attracted consumers who require language assistance through the call center in more languages. In 2015, customer service assisted individual in 92 different languages – growing to 101 different languages in 2019.
- Direct Outreach: The percentage of consumers identifying that they prefer to communicate with us in a language other than English has also increased over time (from 18% in 2015 to 22% in 2019). During this time we have also increased direct marketing and outreach to non-English speaking communities.

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Improving Prevention and Management of Chronic Diseases

- Evidence-based strategies and interventions to improve the health of members with chronic diseases including diabetes, hypertension, asthma, smoking cessation, osteoarthritis, chronic kidney disease, HIV/AIDS, and sickle cell disease
  - Expanding access to Self-care and Educational Resources
  - Improving adherence to established evidence-based practice guidelines among the provider community
  - Strengthening chronic condition management within Patient-Centered Medical Homes (PCMHs) and Health Homes

Integrated Care for Kids (InCK)

- Cooperative Agreement from the Center for Medicare and Medicaid Innovation with CMS
- Designed to test an alternative payment model for children
- Provides for a single point of contact for care coordination and care management for moderate- and high-needs Medicaid children and pregnant women in the Bronx
- New York received one of only 8 awards across the nation – $16 million, 7-year model with 2 Phases
  - Phase 1 – Two-year Planning (Pre-implementation) Phase
  - Phase 2 – Five-year Performance Phase
  - Performance-based Measure Milestones in Years 5-7
- Required to work with a Lead Organization, selected as a result of a statewide competitive process
  - Working with Montefiore Medical Center's Care Management Office led by Dr. Henry Chung
  - Model service area is 8 zip codes in the north-central Bronx

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Children's Preventive Care and Care Transitions

- Promote Behavioral Health Integration in Pediatric care with a 2-Generational Approach to Care
  - Leverage participation and dissemination of CMMI's Integrated Care for Kids (InCK) model and integration of medical, behavioral, and community-based care and resources.
- Improve Care Transitions for Children
  - Determine opportunities and strategies for improving continuity of care when children transition from Early Intervention to preschool and school-age services, to include communication with Primary Care practices.
  - Identify strategies for effective transition of children with Sickle Cell Disease from pediatric care to adult care settings.
  - Workgroups being convened for each of these.

Promoting Maternal Health

- Optimize the health of individuals of reproductive age through primary care, by encouraging discussions on comprehensive family planning and patient-centered care
- Improve access to quality prenatal care, free from implicit bias
- Ensure postpartum home visits are available to all individuals who agree to have a home visit after giving birth
- Improve access to childbirth education for pregnant individuals
- Support the participation of birthing centers in the Perinatal Quality Collaborative
- Continue the Centering Pregnancy pilot recommended by the First 1,000 Days Advisory Group where 6 obstetrical practices in targeted communities are enhancing pregnancy outcomes through a combination of prenatal education (gestational development, healthy behaviors) and social support

Social Determinants of Health and Global Value Based Payment Pilots

- Medical respite
- Street medicine
- Global value-based payment pilot in the Bronx to bridge hospitals, ambulatory care and community-based organizations

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Integrated Care for Dual Eligibles

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Improving Care for Persons Eligible for Both Medicare and Medicaid is Health Equity

- The number of persons dually eligible for Medicare and Medicaid continues to grow at a rate higher than the growth in the number of people eligible for Medicare only
- Persons eligible for both Medicare and Medicaid as compared to persons eligible for Medicare only are disproportionately younger and of minority race and ethnicity
- Nationally, in 2018, 47.5 percent of individuals dually eligible for Medicare and Medicaid are of minority race and ethnicity an increase of 6.5 as compared to 2006
- And, more than double the 21 percent of minority race and ethnicity in Medicare only

https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/DataStatisticalResources/Downloads/MedicareMedicaidDualEnrollmentEverEnrolledTrendsDataBrief2006-2018.pdf

Vision for Integration

- NYS 2020-21 Budget passed a series of initiatives promoting enrollment of dual-eligible members into Medicare and Medicaid integrated products.
- A multi-part enrollee marketing and education campaign on the benefits of integrated products is in development.

Vision for Integration

- Integrated product campaign goals:
  - Create general awareness about availability and benefits of integrated products.
  - Develop targeted communication for dual-eligible members enrolled in a health plan and about to become Medicare eligible.
  - Phase in enrollees in Medicaid fee-for-service.

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NY State of Health Private Pay Home Care Pilot

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NY State of Health Private Pay Home Care Pilot

- Offered through the NY State of Health, consumers would have the option to purchase personal care services from licensed home care services agencies (LHCSA) with private dollars.
- Will permit consumers to search for personal care workers in their area and, based on user-generated criteria including the level of need, language preference, or other criteria, “match” with available workers
- Once a personal care worker of their choice is selected, the consumer will schedule an in-home or telehealth evaluation with the selected LHCSA
- More information coming soon.

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You and your family have many low cost, quality health insurance options available through the Individual Marketplace.
GET STARTED
LOG IN
Get in-person help applying or enrolling
Compare plans & estimate cost
NYS Provider & Health Plan Look-Up
Home Care
Are you in search of a caregiver who is trained and certified to provide direct in-home care services for a friend, family member or loved one?
If so, NY State of Health now provides you with the ability to search, connect and match with a certified in-home care provider in your area.

Consumer Fact Sheets

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Communications and Outreach

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Additional Information is available at:

https://www.health.ny.gov/health_care/medicaid/redesign/mrt2/

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Advancing Equity in Maternal Health

@UnitedHospFund - #UHFMedicaid20

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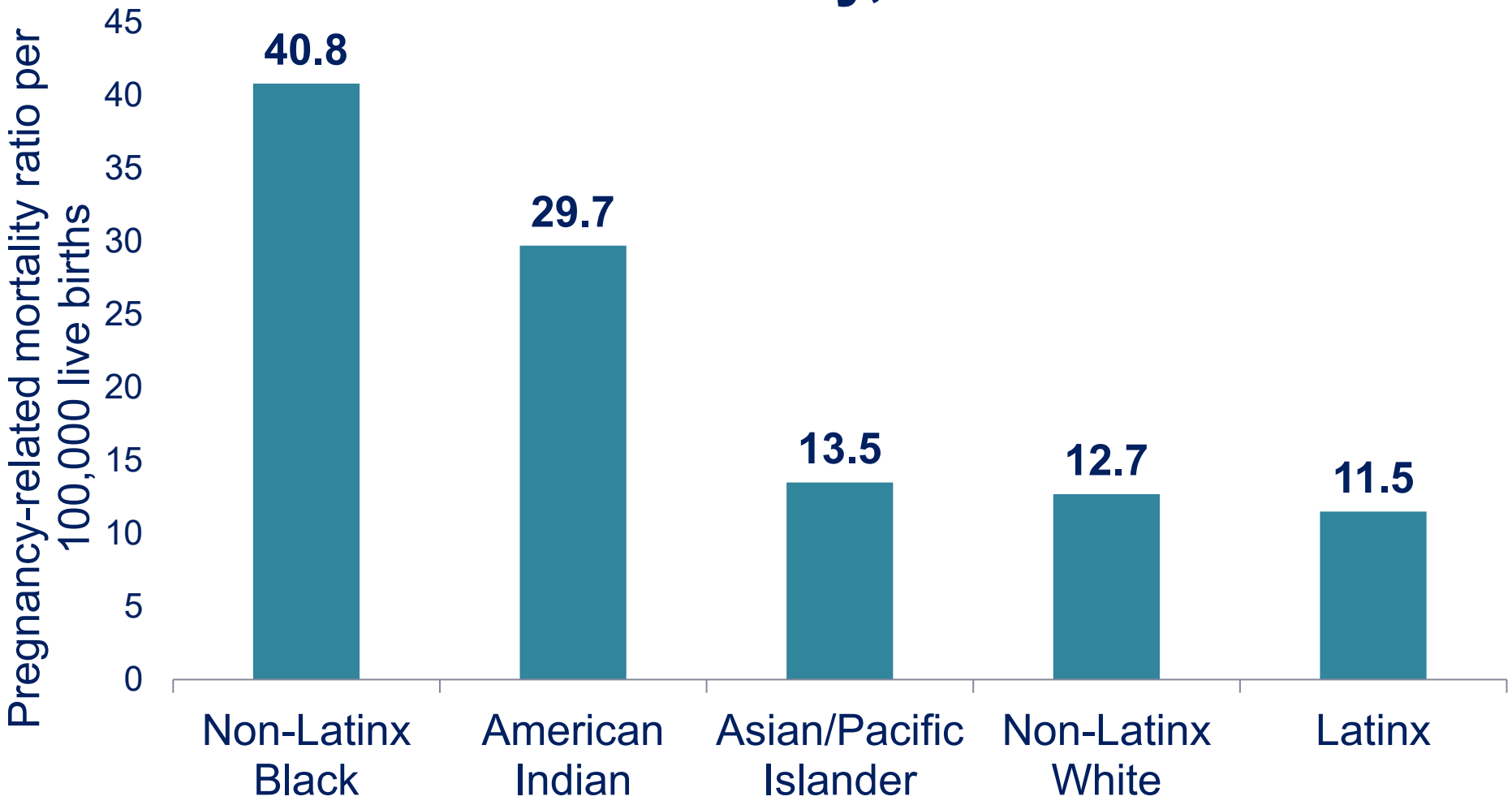
Maternal Health Equity in New York City

Elizabeth Howell MD, MPP
Director, Blavatnik Family Women's Health Research Institute
Icahn School of Medicine at Mount Sinai

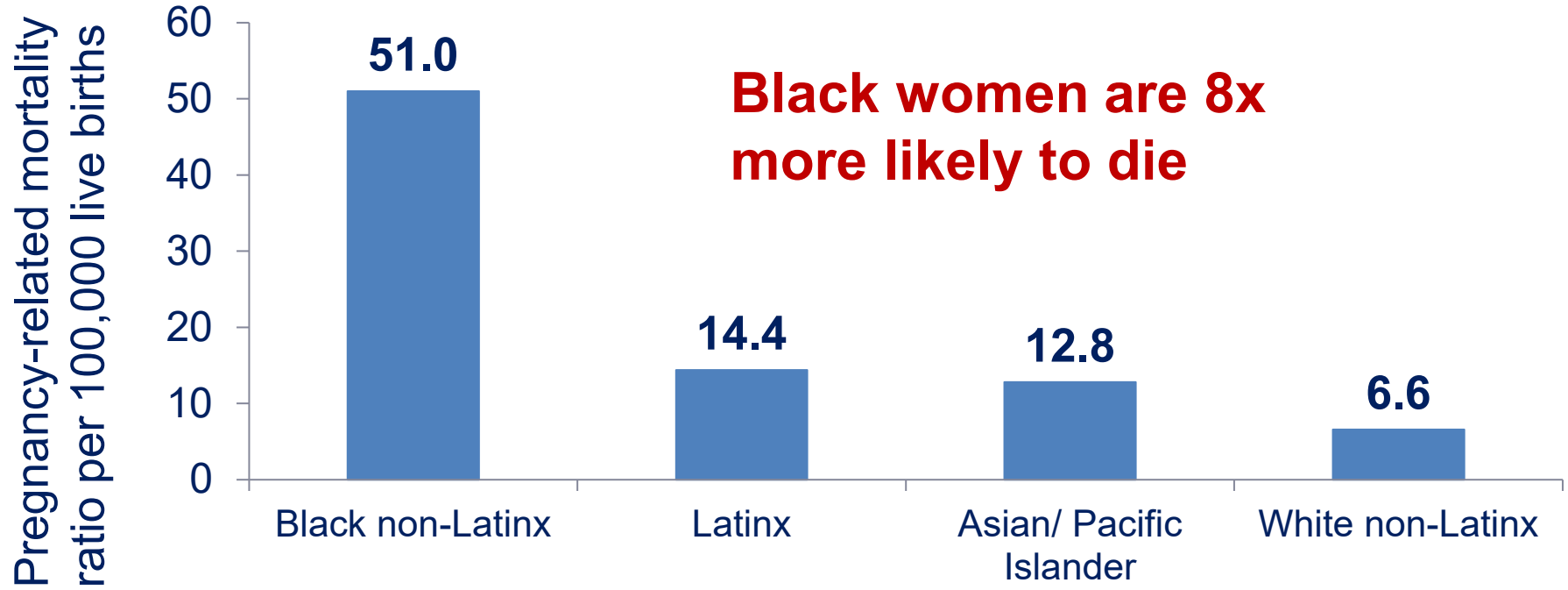
Chair Designee, Dept of Ob/Gyn, UPenn

Pregnancy-Related Mortality Ratios by Race-Ethnicity, 2007-2016



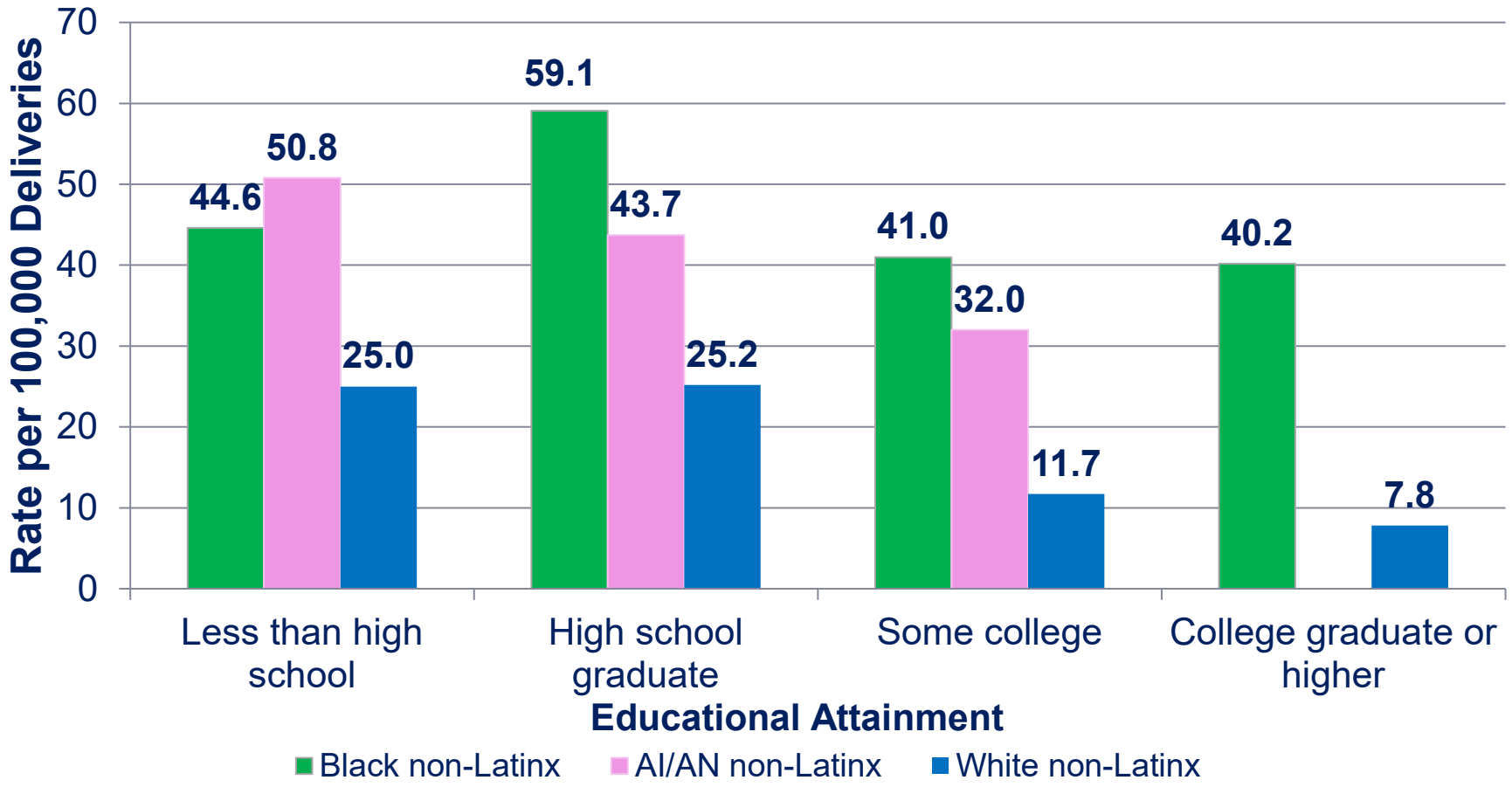
Petersen E et al. Racial/Ethnic Disparities in Pregnancy-Related Deaths – United States, 2007-2016. MMWR. Sept. 6, 2019. vol 68. no 35.

Disparities More Pronounced in New York City



New York City Department of Health and Mental Hygiene (2020). Pregnancy Associated Mortality in New York City, 2011-2015.

Pregnancy-Related Mortality Ratios by Educational Attainment, 2006-2017



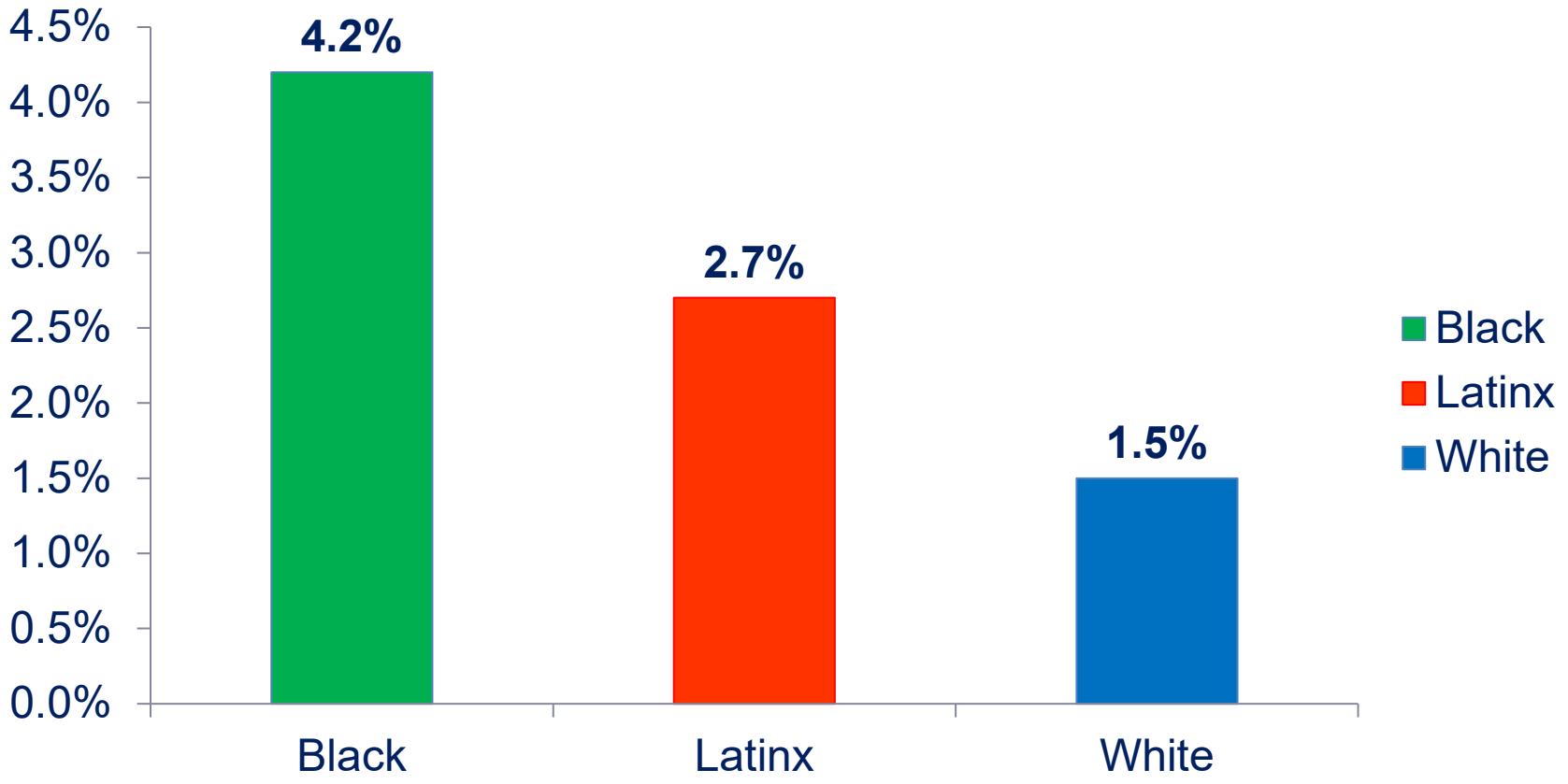
Source: Petersen E et al. Racial/Ethnic Disparities in Pregnancy-Related Deaths – United States, 2007-2016. MMWR. Sept. 6, 2019. vol 68. no 35.

Severe Maternal Morbidity (SMM)

- For every maternal death, 100 women experience severe maternal morbidity
- Life-threatening diagnosis or life-saving procedure
  - organ failure (e.g. renal, liver), shock, amniotic embolism, eclampsia, septicemia, cardiac events
  - ventilation, transfusion, hysterectomy
- Rates are increasing

Callaghan. Obstet Gynecol 2012;120:1029-36.

Severe Maternal Morbidity Rates in New York City

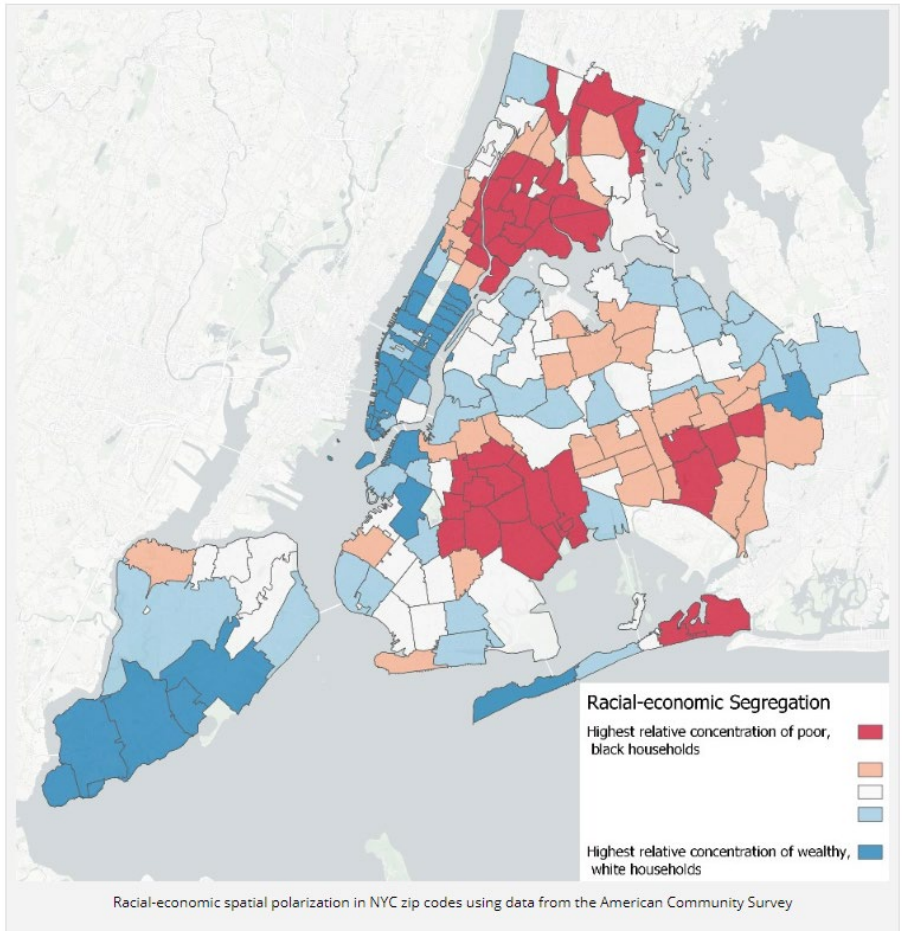


Howell Am J Obstet Gynecol. 2016 Aug;215(2):143-52; Howell. Obstet Gynecol. 2017 Feb;129(2):285-294.

Structural Racism Shaping Disadvantage

Structural Racism and Coronavirus in NYC—What Will be the Toll on Maternal Health Equity?

May 8, 2020 | BFWHRI, Diversity and Inclusion, Women's Health |



Racial-economic spatial polarization in NYC zip codes using data from the American Community Survey

SMM >2x for women living in poor Black neighborhoods in NYC

Janevic T. Health Affairs. 2020

https://health.mountsinai.org/blog/structural-racism-and-coronavirus-in-nyc-what-will-be-the-toll-on-maternal-health-equity/

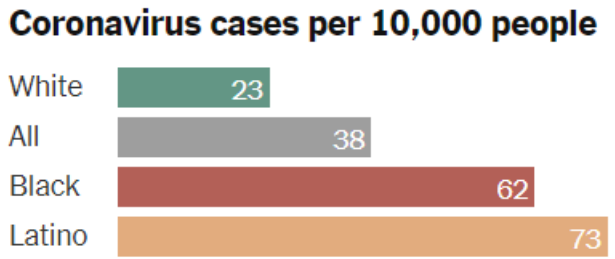
The New York Times

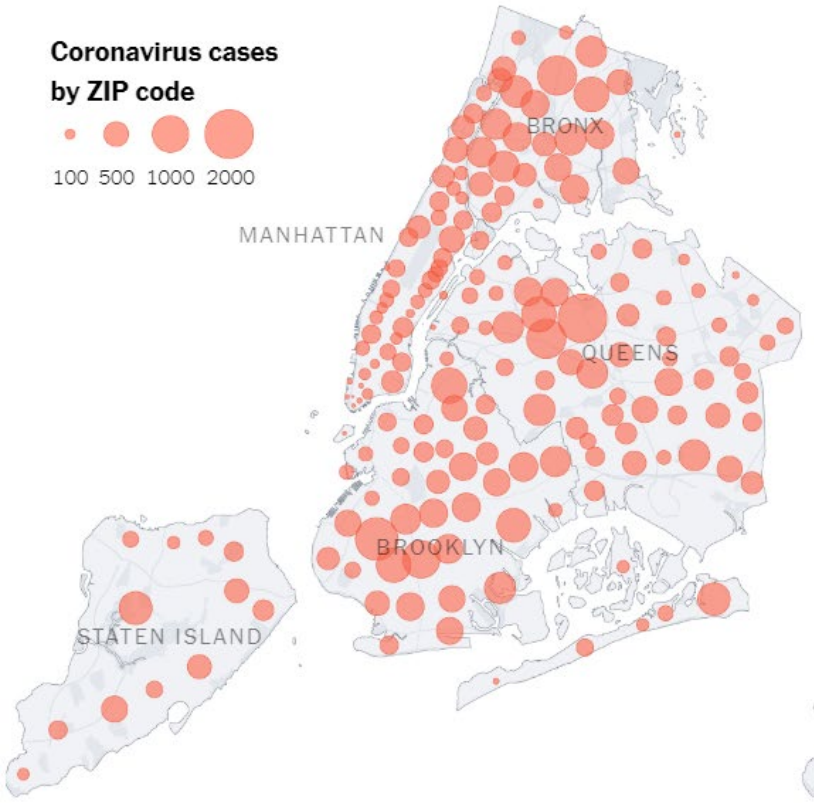
Virus Is Twice as Deadly for Black and Latino People Than Whites in N.Y.C.

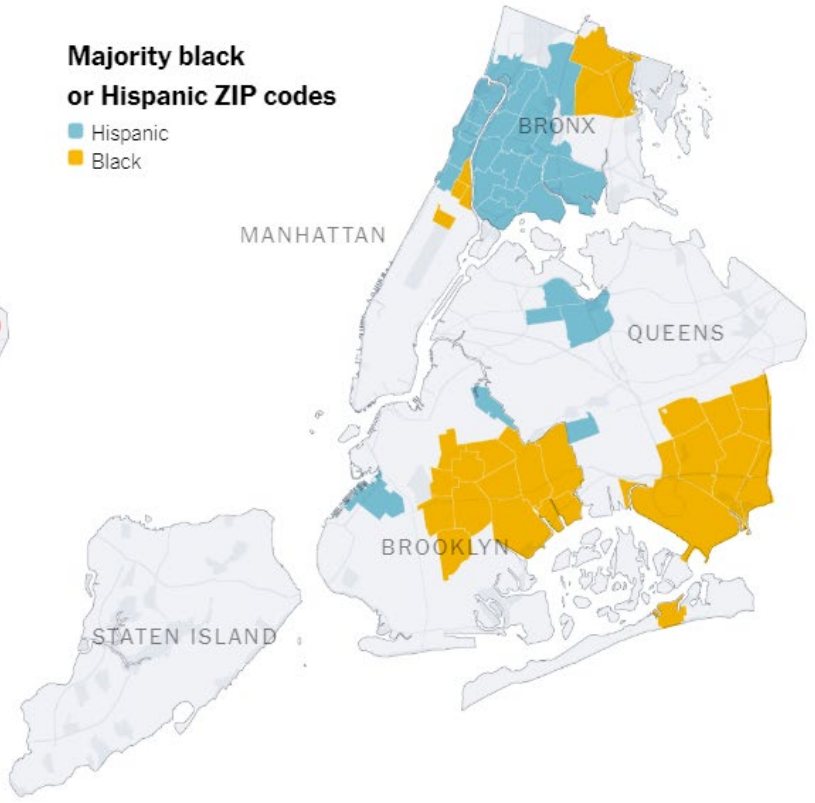
April 8, 2020

The New York Times

July 5, 2020

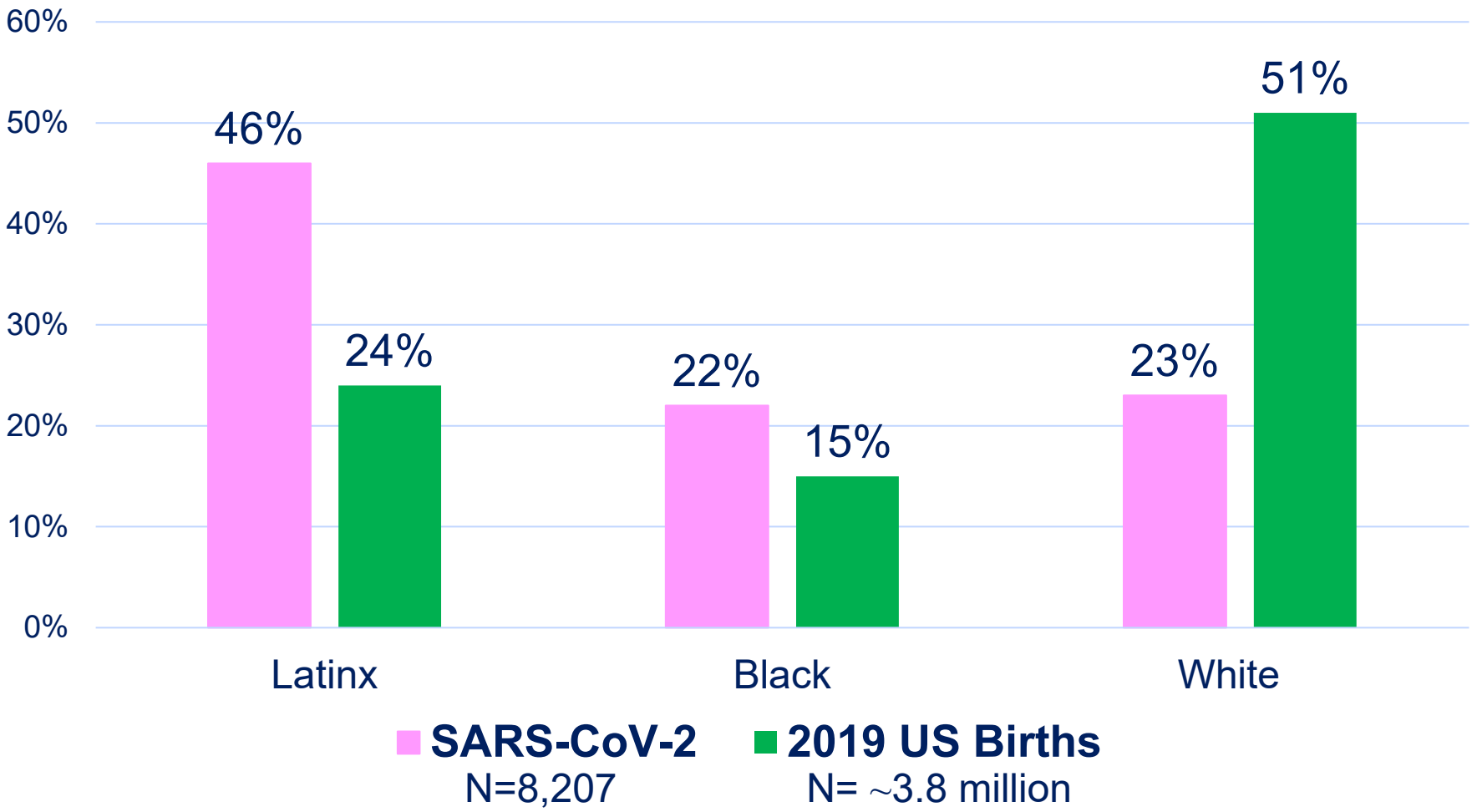






Sources: New York City Department of Health and Mental Hygiene; U.S. Census Bureau; socialexplorer.com • By The New York Times

Covid-19 and Maternal Health Disparities: SARS-CoV-2 Infection During Pregnancy



CDC MMWR Weekly / Vol. 69 / No. 25; US Data, Jan 22–June 7, 2020;

Racism & Discrimination

Patient Factors
- Socio-demographics: age, education, poverty, insurance, marital status, employment, language, literacy, disability
- Knowledge, beliefs, health behaviors
- Psychosocial: stress, weathering, social support

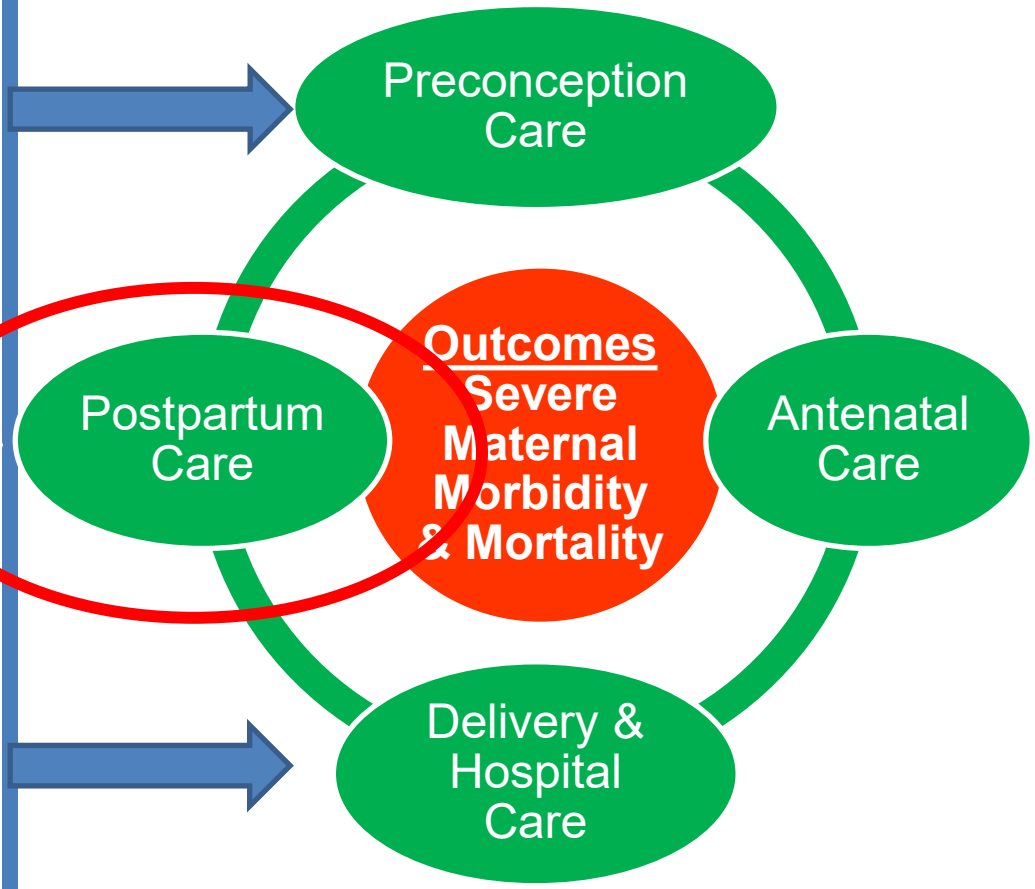
Community/ Neighborhood
- Community, social network
- Neighborhood: crime, poverty, built environment, housing

Clinician Factors
- Knowledge, experience, implicit bias, cultural competence, communi-cation

System Factors
- Access to high quality care, transportation, structural racism, policy

Health status: comorbidities (e.g. HTN, DM, obesity, depression); Pregnancy complications

Figure 1: Pathways to Racial and Ethnic Disparities in Severe Maternal Morbidity & Mortality



Adapted from Howell EA. Clin Obstet Gynecol. 2018 Jun;61(2):387-399

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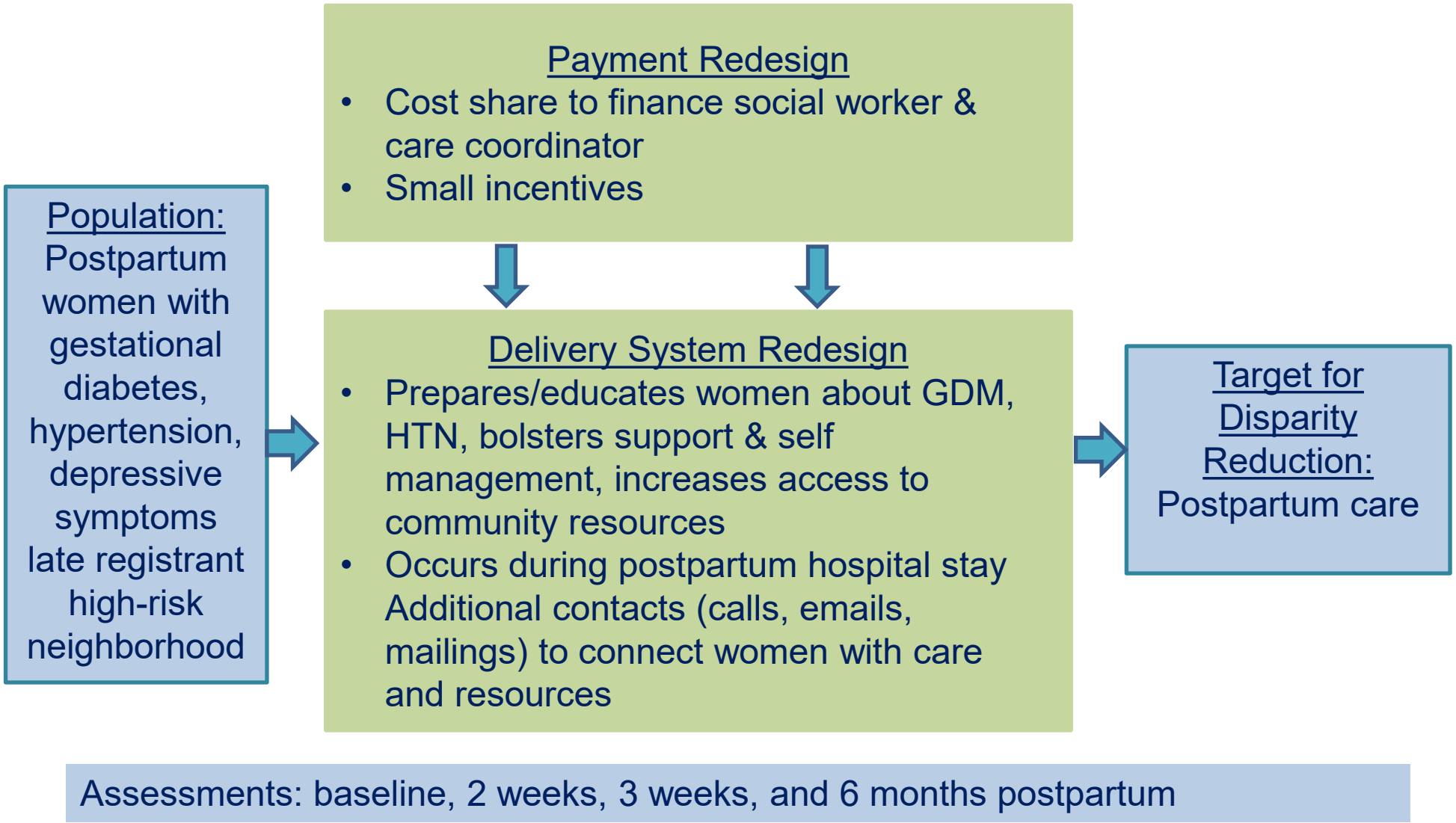
Partnership to Reduce Disparities in High Risk Postpartum Care

- Combined delivery system reform with payment reform to improve quality and reduce disparities in high risk postpartum care
- Funded by RWJF
- Partnered with a Medicaid payer
- Primary aim was to increase rates of timely postpartum visits among high risk obstetrical patients
- Utilized evidence-based intervention

Elements of Delivery and Payment Redesign



Wendy Wilcox, MD, MPH, MBA, FACOG

Chair, OBGYN

NYC H+H/Kings County

Clinical Director,

NYC H+H Maternal Mortality Reduction Project

NYC HEALTH+ HOSPITALS

Maternal Medical Home

for patients who are ‘At-risk’ during pregnancy or Postpartum

Pre-COVID-19

- Increased screening for clinical, psychosocial and environmental factors which can increase risk during pregnancy
- Improves outreach to patients and facilitates patient engagement
- Improves specialty referrals and care navigation
- Improves support and BH referrals
- Improved referral network to specialty care and community services

During COVID-19

- Improved patient outreach
- IMPROVED patient navigation (esp. with televisits)
- Extra layer for postpartum discharges
- COVID+ surveillance and tracking

Aimee Smith, DO

Clinical Director of Maternal Medicine

The Institute for Family Health

IMPLICIT Leadership Council

- **Maternal Health Advocates**
  - Track all pregnant patients and assist them with insurance, community programs and referrals
  - Assist with scheduling prenatal, postpartum, and newborn visits
  - Provide individual counseling and education regarding prenatal health, birth, contraception, and newborn care
  - Co-facilitate Centering Pregnancy and Centering Parenting groups
- **IMPLICIT Interconception Care** – Provide screening for all mothers at well child visits up to 2 years old, whether or not they are our patients, for:
  - Depression
  - Smoking
  - Family planning and birth spacing
  - Multivitamin with folic acid use

Ngozi Moses
Executive Director
Brooklyn Perinatal Network, Inc.
Convener, Brooklyn Coalition for Health Equity for Women and Families

PATHWAYS COMMUNITY HUB MODEL

Background:

- Method for "community-owned" restructuring of human services to integrate with healthcare within a shared, equity driven framework
- CBOs are convened within a network and coordinated by a central HUB
- HUB facilitates referrals, oversees CHW training, manages quality and negotiates contracts from health payers and other funders
- HUB data informs population health planning for the targeted community

Model involves:

- HUB administers outcome-based contracts with multiple payers for the CBO network
- CHWs in each CBO use the Pathways Health Risk Screening Tool to identify the comprehensive array of interrelated risk factors (Pathways) for each member of a family
- Payment is based on the CHW's performance mitigating the risks (closing the Pathways)
- National certification center ensures fidelity to the model

In one HUB in Michigan in one year:

- 2,545 medical referrals
- 97 BH connections to care
- 568 medical home connections
- 224 housing referrals
- Over 8,003 successful connections to address SDOH needs

Evidence: Quality and Cost Effectiveness

- **60% reduction in low birth weight**
- Cost savings of $5.59 for every $1 spent on the model for high risk maternal population
- 236% ROI found in Ohio HUB

Advancing Equity in Maternal Health: Additional Slides

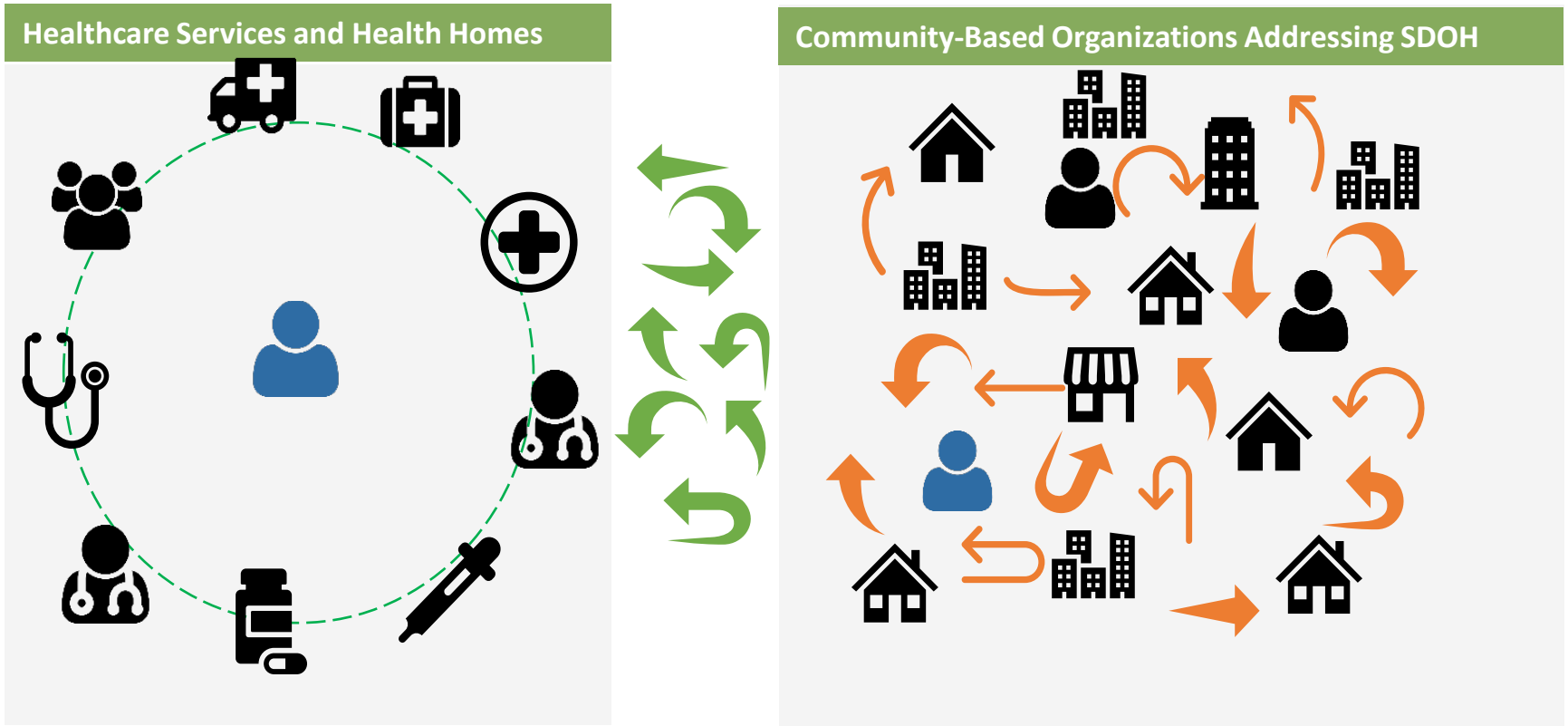
@UnitedHospFund - #UHFMedicaid20

Presented with Support From The Commonwealth Fund

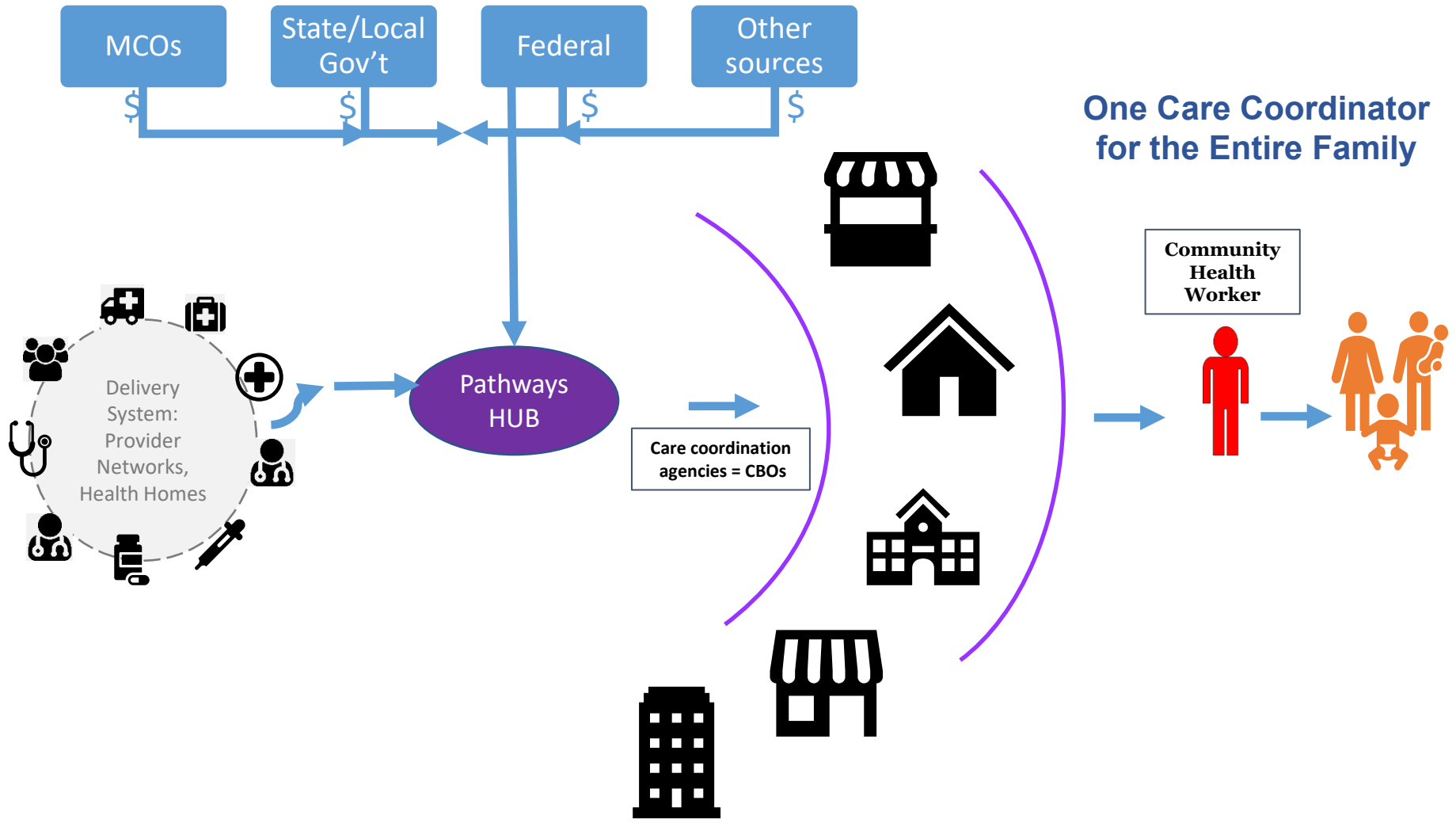
United Hospital Fund

Ngozi Moses
Executive Director
Brooklyn Perinatal Network, Inc.
Convener, Brooklyn Coalition for Health Equity for Women and Families

FAMILIES ARE FALLING THROUGH THE CRACKS

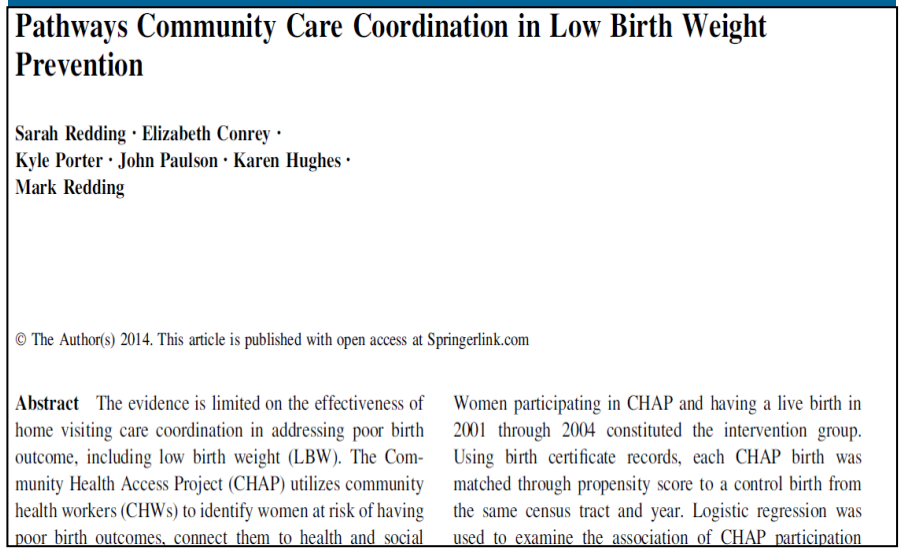


PATHWAYS HUB IN ACTION



OUTCOME IMPROVEMENT AND COST SAVINGS

Journal of Maternal and Child Health: 60% reduction in low birth weight and 500% return on investment



Pathways Community Care Coordination in Low Birth Weight Prevention

Sarah Redding · Elizabeth Conrey · Kyle Porter · John Paulson · Karen Hughes · Mark Redding

Abstract The evidence is limited on the effectiveness of home visiting care coordination in addressing poor birth outcome, including low birth weight (LBW). The Community Health Access Project (CHAP) utilizes community health workers (CHWs) to identify women at risk of having poor birth outcomes, connect them to health and social

Women participating in CHAP and having a live birth in 2001 through 2004 constituted the intervention group. Using birth certificate records, each CHAP birth was matched through propensity score to a control birth from the same census tract and year. Logistic regression was used to examine the association of CHAP participation

Centene's Buckeye Plan: Newborns born to mothers at risk for low birthweight delivery

- High risk: PMPM cost savings of $403
- Medium risk: PMPM cost savings of $252
- Low risk: PMPM cost savings of $171

94%

High risk have highest cost savings through inpatient services

$379

High risk: inpatient PMPM cost savings

PATHWAYS HUB RECOGNITION

Medicaid's Role in Advancing Health Equity

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United Hospital Fund

United Hospital Fund (UHF) Medicaid Conference

Tekisha Dwan Everette, PhD

July 15, 2020

HEALTH EQUITY SOLUTIONS

Tekisha Dwan Everette, PhD

Executive Director

Health Equity Solutions

Vision:

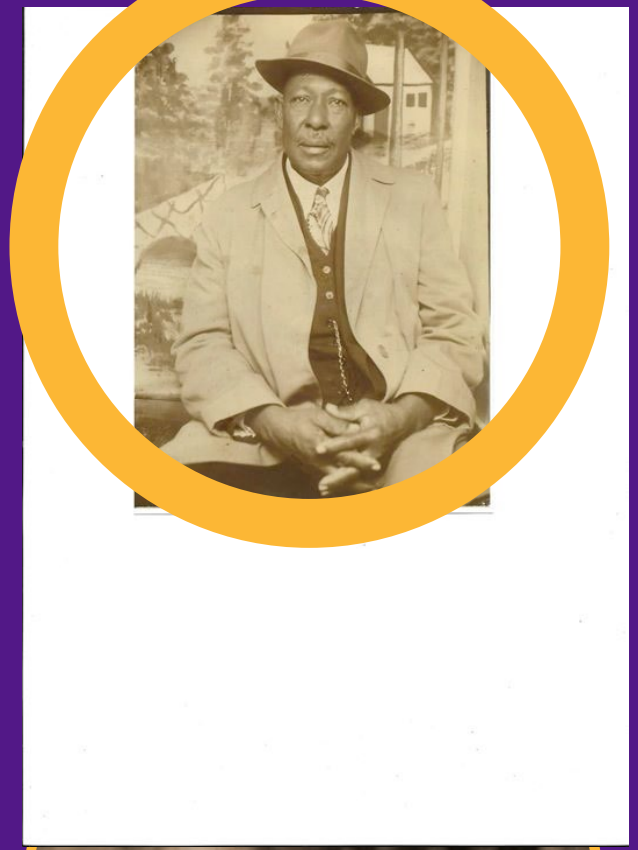
For every Connecticut resident to attain optimal health regardless of race, ethnicity, or socioeconomic status.

Mission:

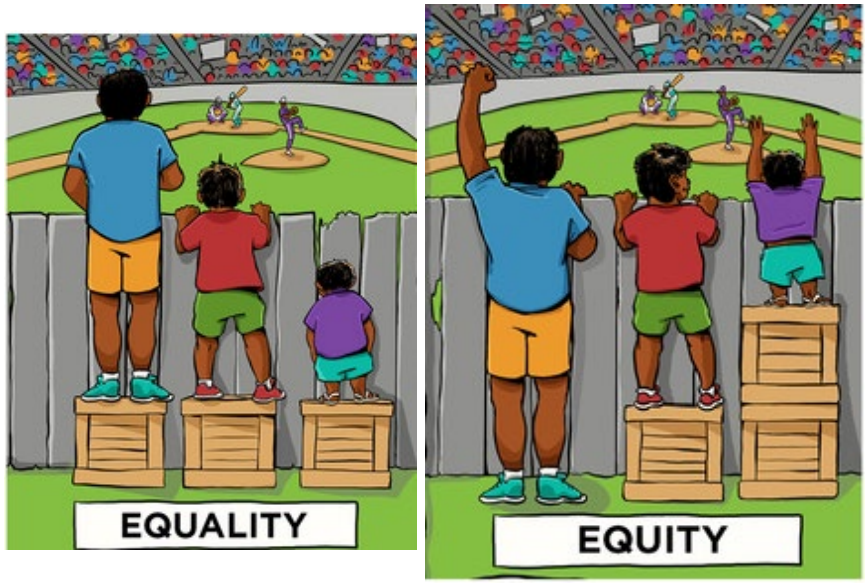
To promote policies, programs, and practices that result in equitable health care access, delivery, and health outcomes for all people in Connecticut

HEALTH EQUITY SOLUTIONS

My Story, My Why



What Is Health Equity…



- Process
- Way of Being/Doing
- Endpoint Goal

Image from Story Based Strategy
http://www.storybasedstrategy.org/blog/the4thbox

HEALTH EQUITY SOLUTIONS

SDOH ≠ Health Equity

- Big focus on social determinants/drivers/influencers, BUT
  - health equity ≠ social determinants

    RATHER
  - How do we leverage current programs like Medicaid to advance health equity by addressing SDoH

- To fully achieve health equity, we need to:
  - Name the underlying problem/root cause
  - Examine how inequity is fostered
  - Use data to understand & address the gaps

HEALTH EQUITY SOLUTIONS

- Structural
- Institutional
- Interpersonal
- Internalized

Fostering Inequity & Injustice

Layer/Level	Examples
Language	• "The patient is non-compliant." • "I don't need to hear about equity. I treat all my patients the same."
Institutional Policy	• Not engaging Medicaid members • Treating people with one size fits all solutions
Systems	• Norming healthcare to White population (research studies/clinical trials/standards of care) • Reducing Medicaid eligibility
Health Delivery	• Implicit Bias/Unconscious Bias • Lack of cultural humility (individual & organization level) • Diagnosis without dialogue

Why is Medicaid poised to address equity?

- Medicaid is a lever for equity by design
- Provides coverage to significant population
- Building on past initiatives
- Leveraging partnerships

Opportunities for Advancing Health Equity

1. Equity and Inclusion
2. Improving and Streamlining Access
3. Promoting Equity in Outcome

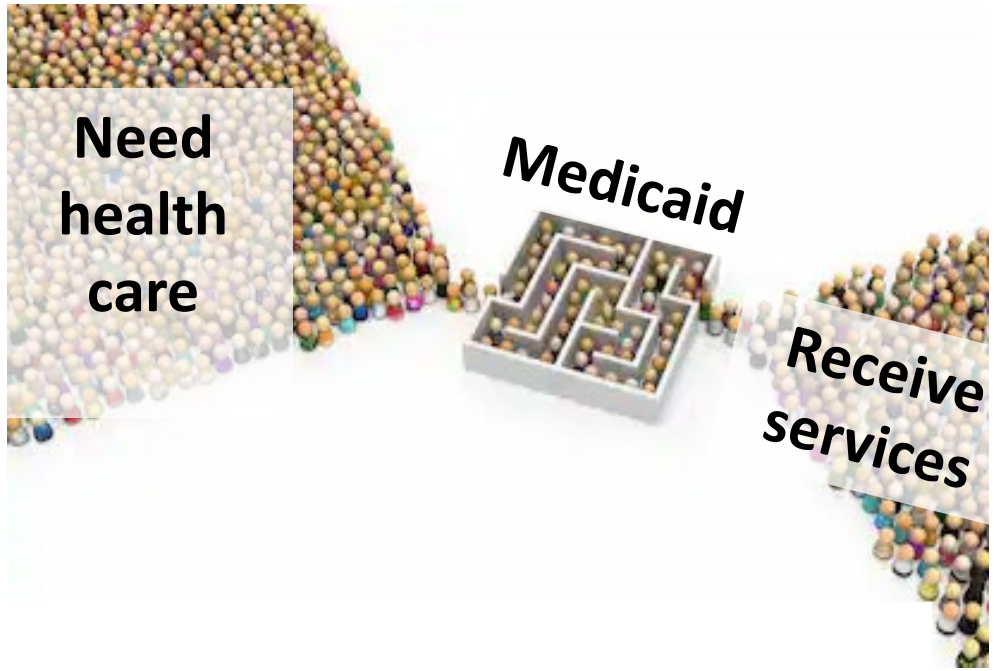
Promoting Inclusion & Embedding an Equity Lens

- Health Disparities Work Group (Medicaid Redesign Team)
  - 2011 Final Recommendations report

Looking forward:

- Standing equity group
- Authentic consumer engagement
- Evaluation and accountability
- Feedback loop

Improve & Streamline Access



- Streamline social services applications
- Telehealth access
- Equity audit on Medicaid
  (e.g. providers accepting new patients or practices limit members access)

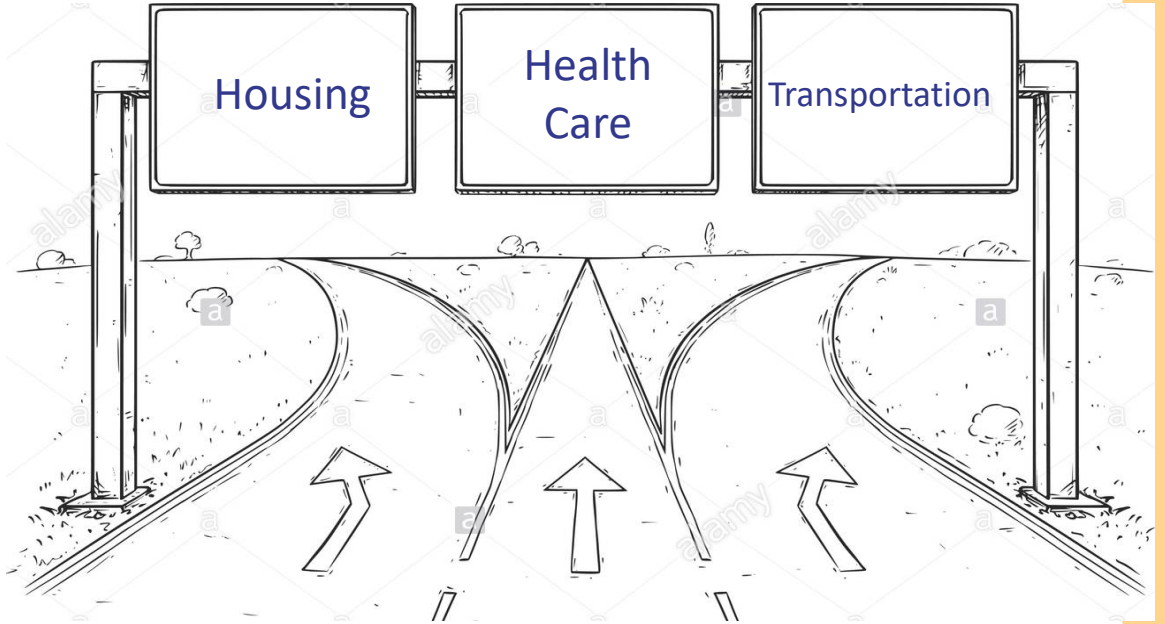
HEALTH EQUITY SOLUTIONS

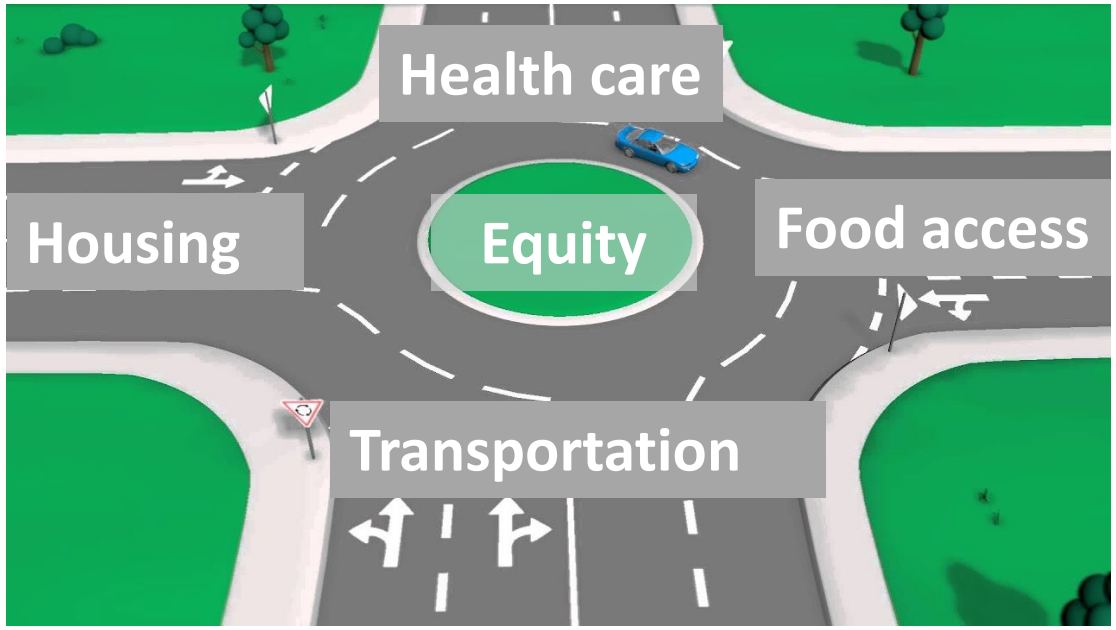
Equity in Outcomes

Look at data differently

Devise equity measures & drive toward meeting those outcomes

Institutionalizing learnings from DSRIP





www.hesct.org 175 Main Street | 3rd Floor | Hartford, CT @HealthEquityCT Facebook.com/HealthEquityCT

Primary Care as a Catalyst for Equity

@UnitedHospFund - #UHFMedicaid20

Presented with Support From The Commonwealth Fund

United Hospital Fund

Primary Health Care as a Catalyst for Health Equity

UHF 2020 Medicaid Conference

July 15,2020

Laurie Zephyrin, M.D., M.B.A., M.P.H.

Vice President, Delivery System Reform

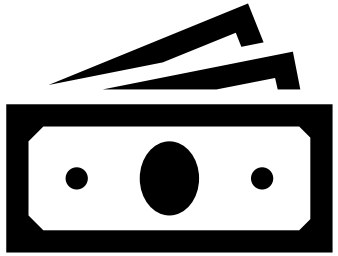
The Commonwealth Fund

The Commonwealth Fund

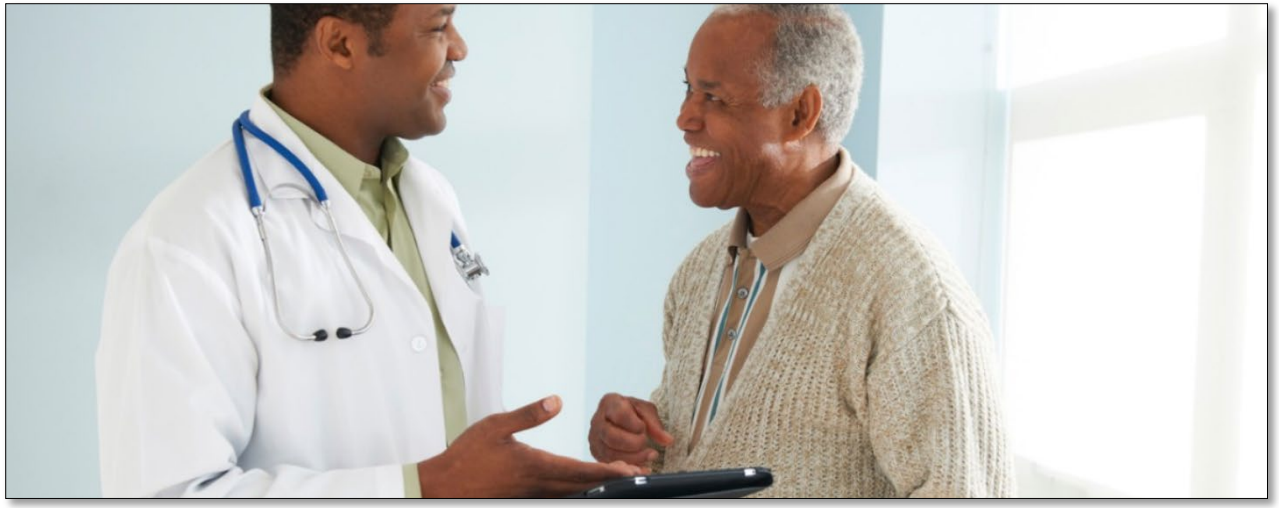
Evidence shows that high-quality primary health care is associated with…

Improved Health Outcomes

Decreased Health Disparities



Reduced Health Care Costs

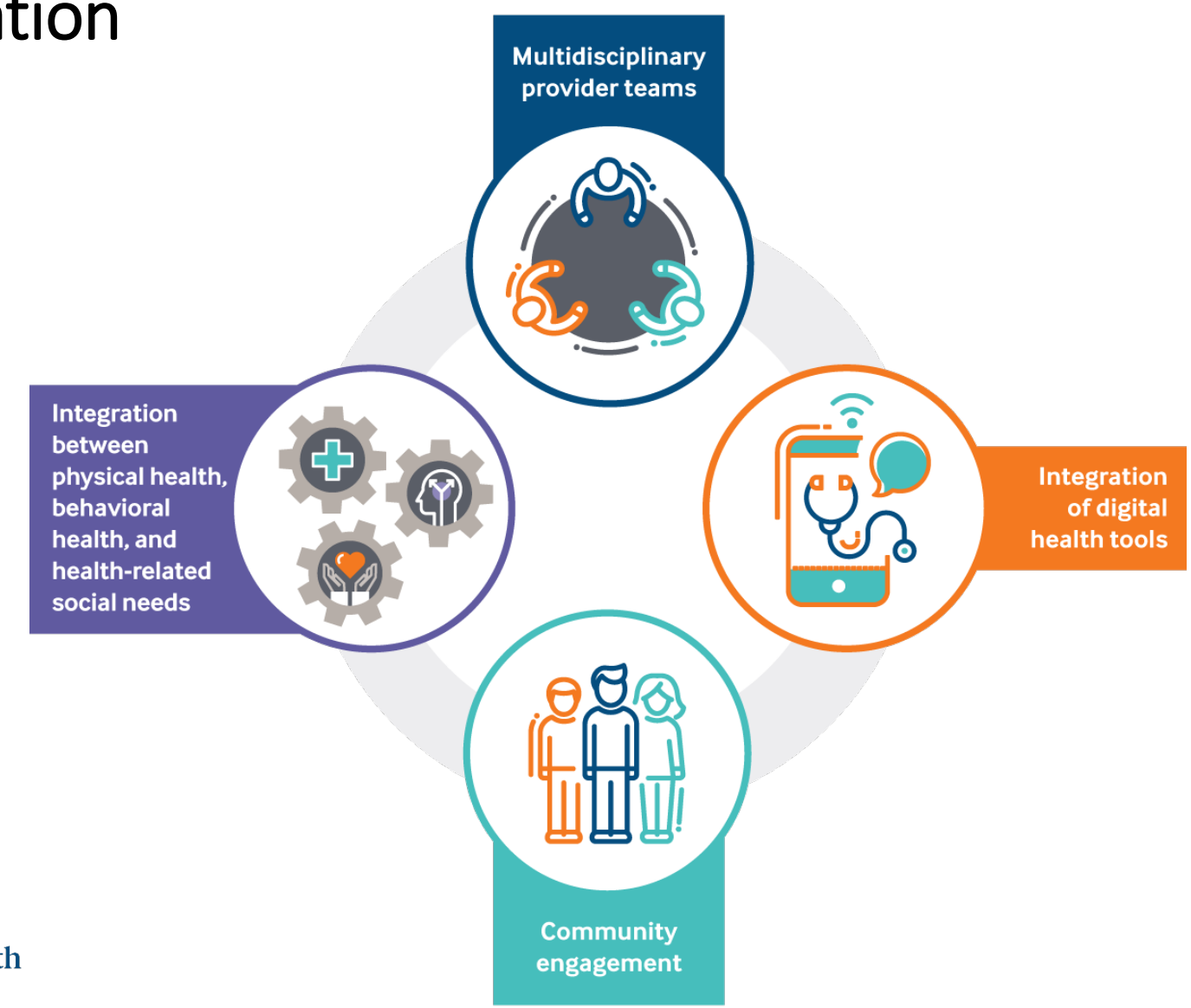


The Commonwealth Fund

Sources: Leiyu Shi, *The Impact of Primary Care: A Focused Review*. Hindawi. Dec, 31, 2012

Arnett, et al, *Race, Medical Mistrust, and Segregation in Primary Care as Usual Source of Care: Findings from the Exploring Health Disparities in Integrated Communities Study*. Journal of Urban Health. 2016

Primary health care with these key attributes can reduce fragmentation



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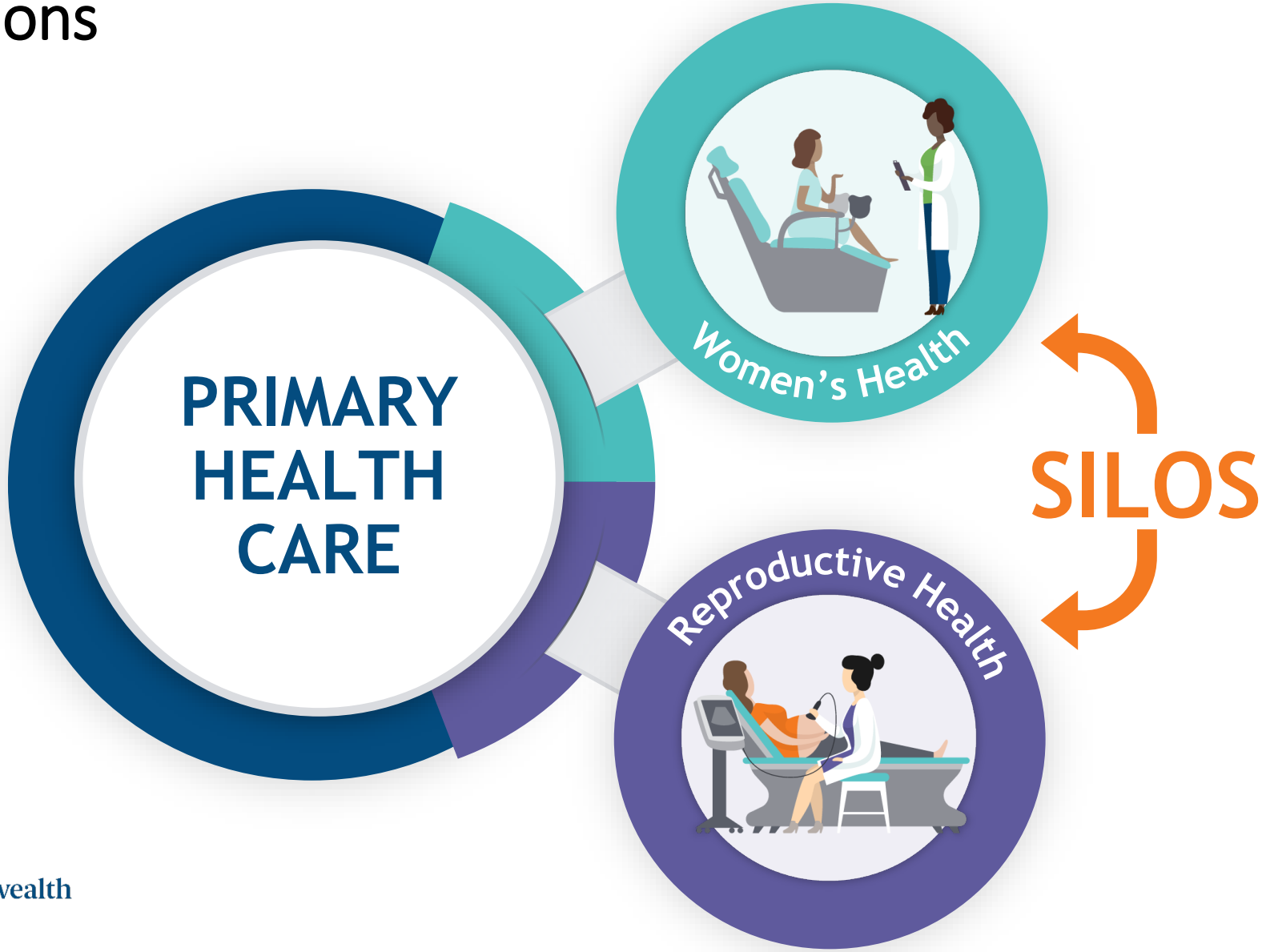
Primary health care can be tailored to meet the needs of specific populations



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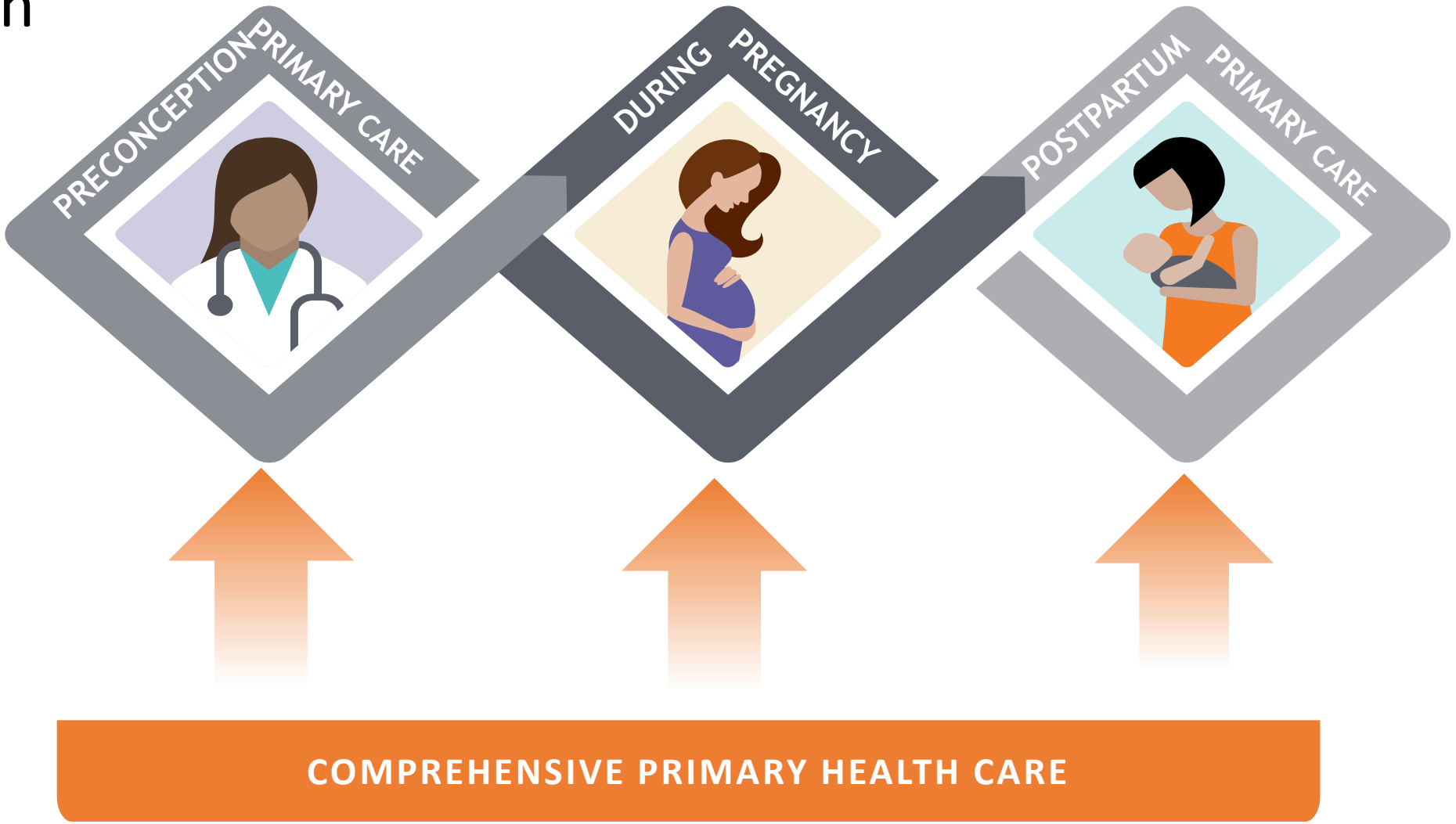
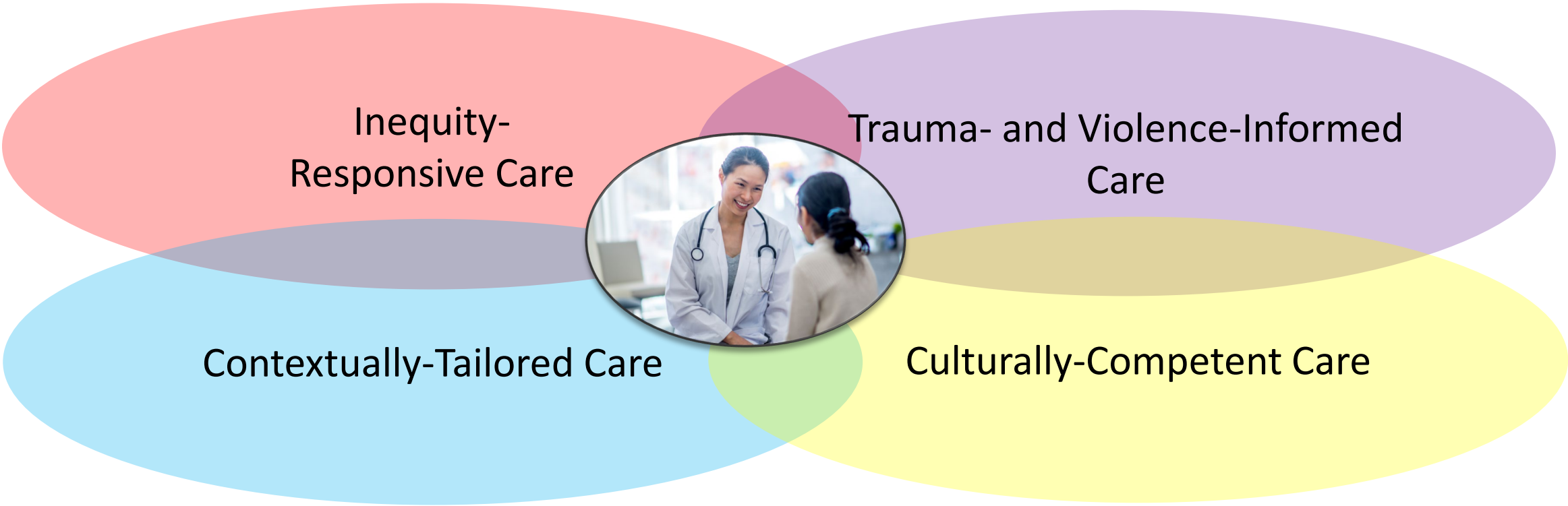
Primary health care can be a catalyst to equity in maternal health



The Commonwealth Fund

Beyond integration, we need to consider the many dimensions of equity-oriented primary health care services



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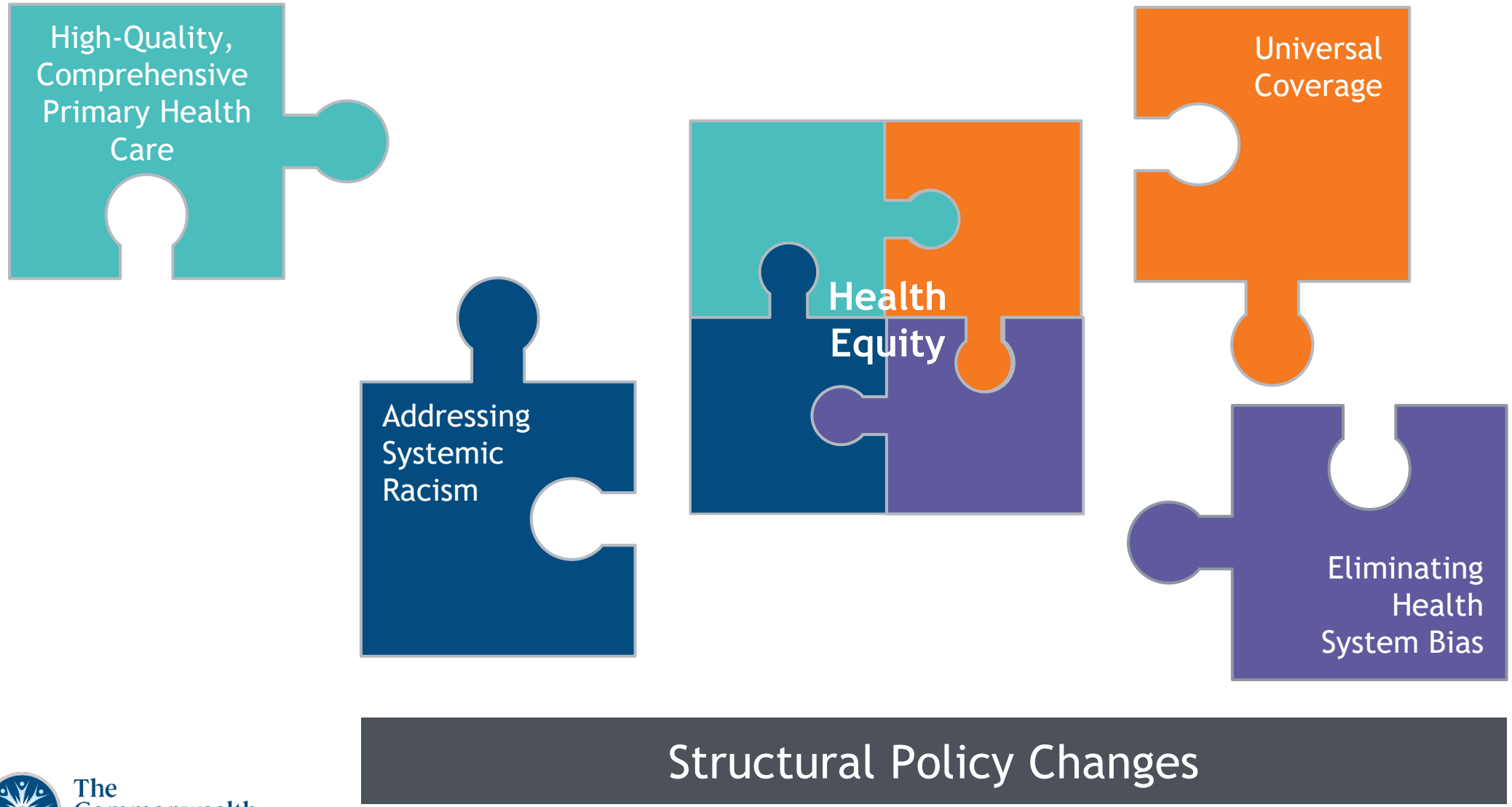
Source: Annette Browne, et al., *Closing the health equity gap: evidence-based strategies for primary health care organizations.* International Journal for Equity in Health. October 2012.

Primary health care is still only one piece of the puzzle



The Commonwealth Fund

MVP HEALTH CARE

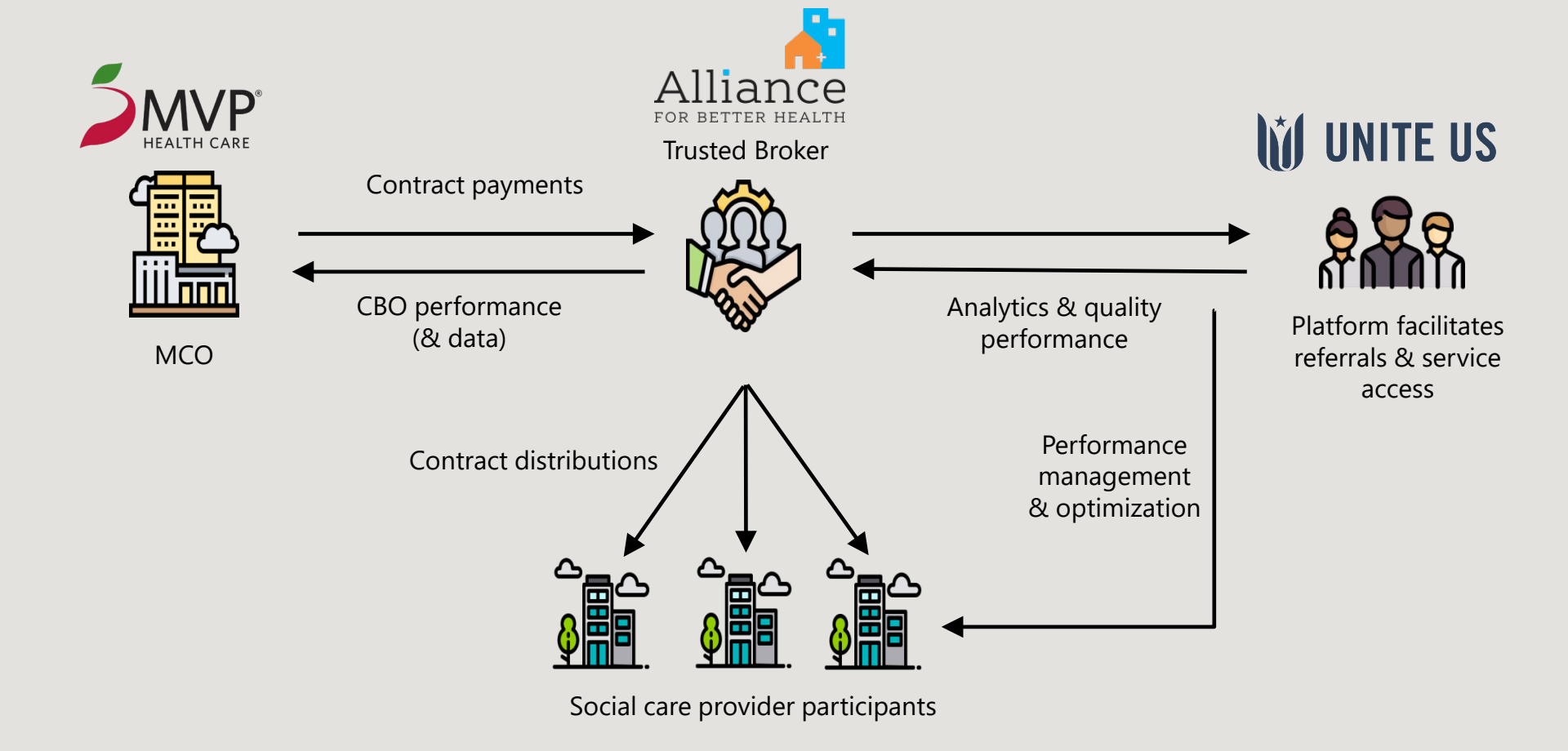
health insurance
built around
me

1million+
Doctors, specialists and hospitals
from coast-to-coast

"At MVP, we understand the important role that social factors can have on a person's overall health and how those influences can effect short and long-term outcomes.

Investing in the underlying social, economic, and environmental factors that contribute to an individual's health, reinforces our commitment not only to the overall health and wellness of our members, but to the entire community." -Christopher Del Vecchio, CEO

First-of-its-Kind Partnership to Fund CBOs to Address Social Determinants of Health



MVP's CBO Partners

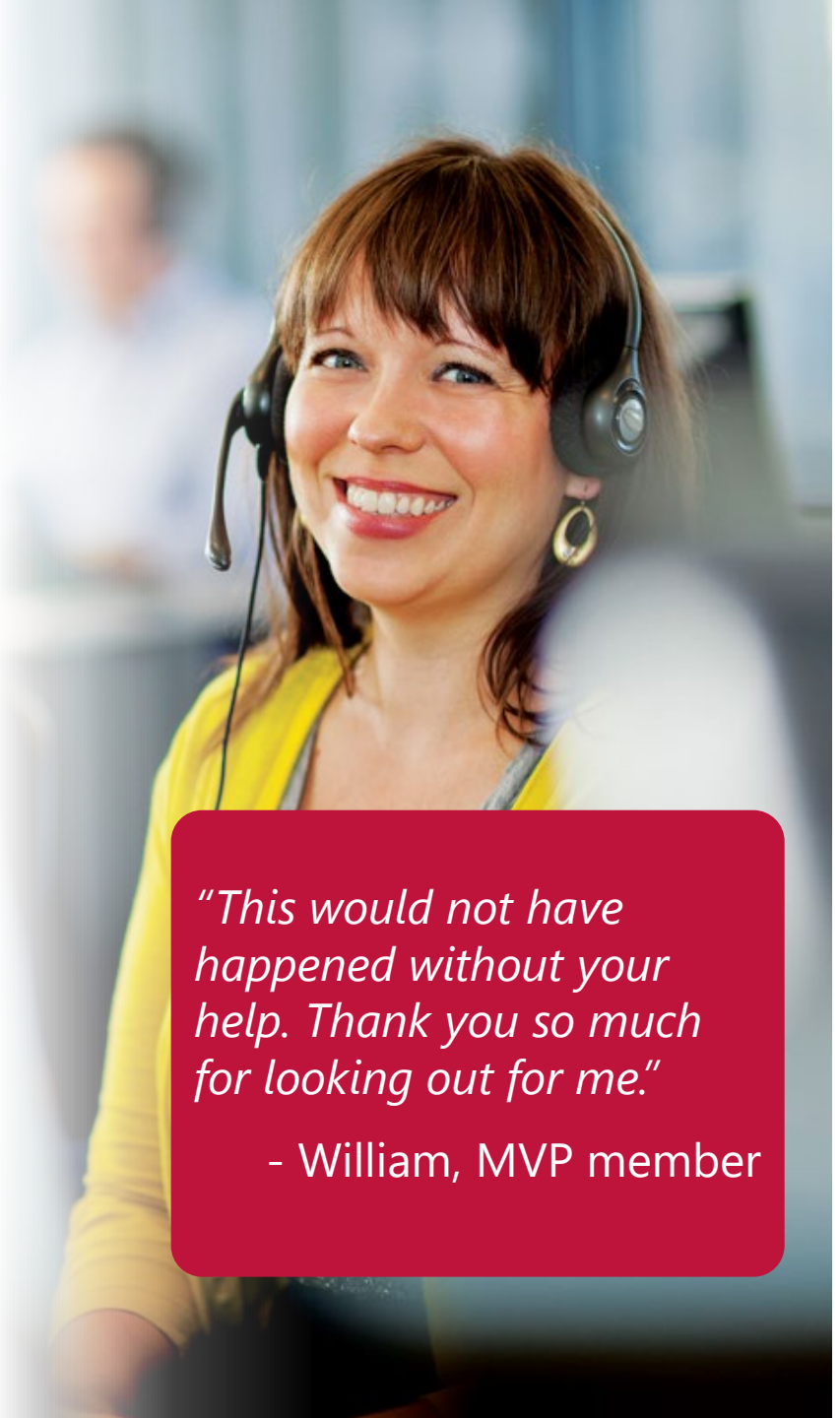
Center for Disability Services — Where people get better at life
equinox
Legal Aid Society — Northeastern New York
Northern Rivers — Northeast Parent & Child Society, Parsons Child & Family Center, Unlimited Potential
City Mission
Trinity Alliance — of the Capital Region — Empowering People for Brighter Futures
unity house — Making Life Better

COVID-19 Member Outreach Campaign

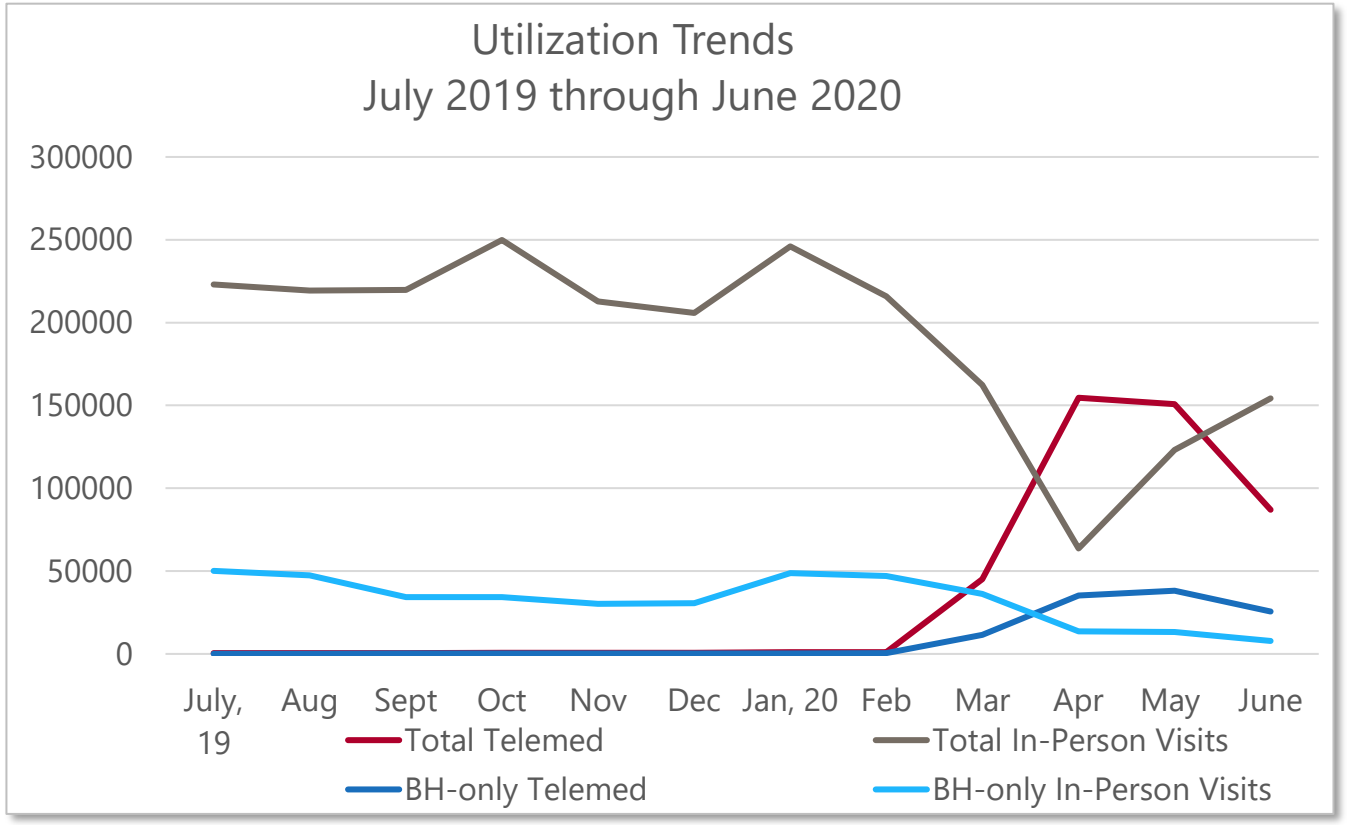
Providing Education; Helping Address Needs

- More than 100 employees trained on Psychological First Aid, then called members to discuss:
  - How are you doing?
  - COVID-19 preventive measures
  - Medication, supply needs
  - Food, transportation, and family support
  - Connect with resources, supply food and care packages

- Calls placed to >70,000 at-risk members in 8 weeks
  - Medicare
  - Medically Fragile
  - Utilizing adult day health, private duty nursing or home care
  - Use of ventilator, tracheostomy, or oxygen
  - Transplant program participants



COVID-19 Utilization Impact: Telemedicine vs. In-person



MVP waived member cost-share for all telemedicine visits, including mental health

Data includes:

- Provider-based telemedicine, telemental health, and telephonic visits
- 24/7 telemedicine services like myVisitNow® and myERnow℠ for urgent care services and COVID-19 symptoms

Primary Care As A Catalyst for Equity

Provider Group Perspective

Navarra Rodriguez, MD

President and Chief Medical Officer

AdvantageCare Physicians

AdvantageCare PHYSICIANS

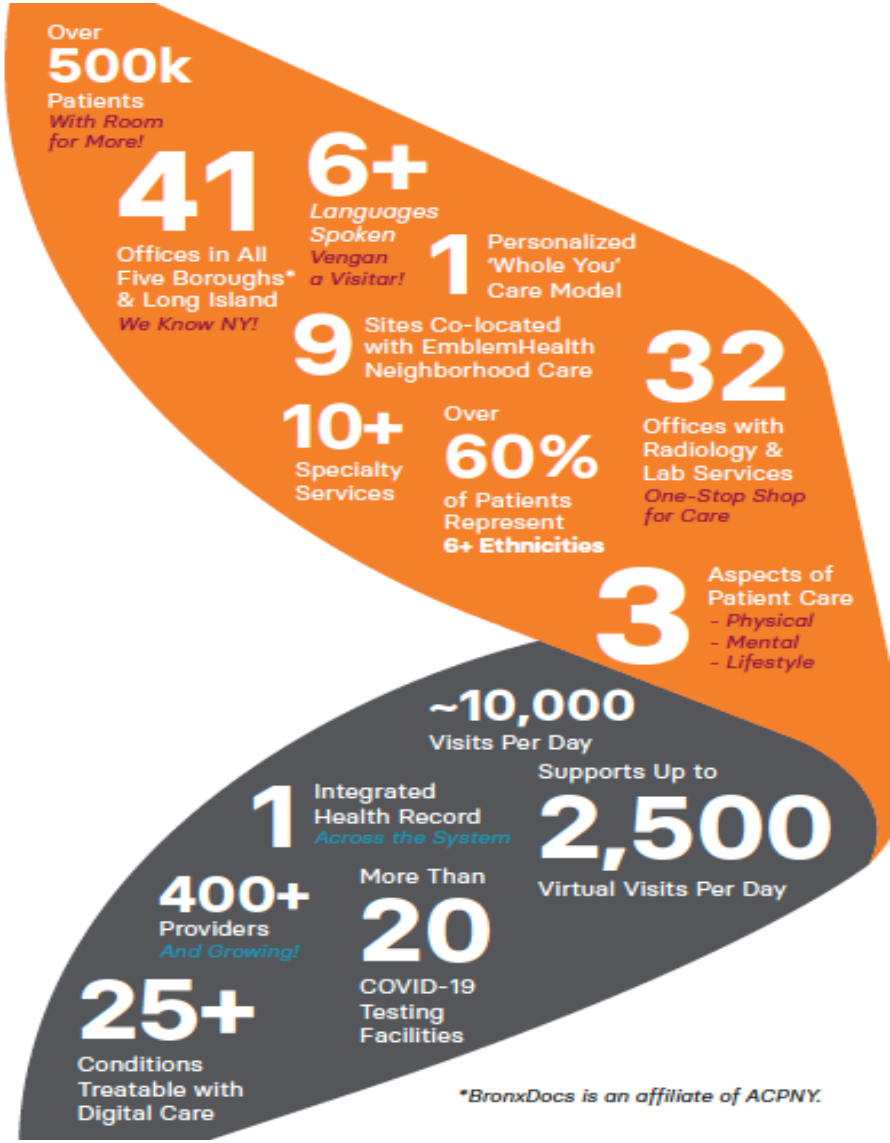
AdvantageCare PHYSICIANS + Each individual patient
Each special family
Each unique neighborhood = Healthier Communities

The Formula for Healthier Communities

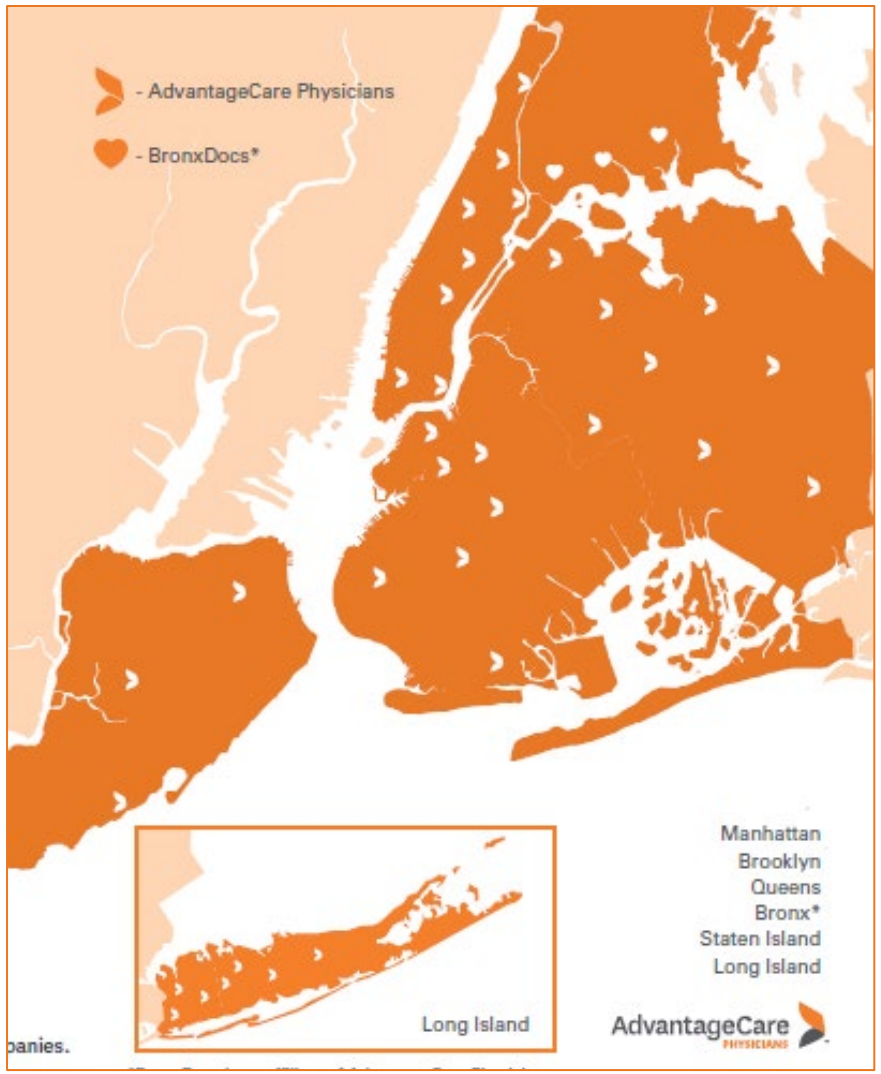
AdvantageCare Physicians *by the Numbers*

AdvantageCare Physicians (ACPNY) medical offices provide communities with access to timely primary and specialty care. With a wide range of services that reflect the needs of our diverse patients, including preventive services and chronic care management, ACPNY keeps residents healthy in settings that are convenient and woven into the fabric of each unique community.

Caring for the Whole You.



INNOVATION THAT PROMOTES HEALTH EQUITY



The hallmark of our approach is personal and neighborhood-based primary and specialty care, including:

- **Continuous care—**the benefit of having a personalized Care Team that follows up with individuals to promote wellness and address acute or chronic needs;
- **Comprehensive care—**access to the Specialty Care Providers and services patients need most;
- **Convenient care—**we're right in many neighborhoods, easy to get to; and
- **Community—**we can connect patients to valuable local services and resources.

ACPNY's integrated care teams include primary care physicians, advanced practice clinicians, such as nurse practitioners or physician assistants, registered nurses, and care team associates.

COVID-19'S BIGGEST CHALLENGE TO PRIMARY CARE'S ROLE IN ADVANCING EQUITY: ACCESS TO CARE

Telehealth

- ACPNY quickly implemented virtual visits, providing access to care during the NYS "PAUSE" to support COVID-19 screening, testing, and management of other acute and chronic conditions.

- Leveraging technology made care easier and safer to access for most patients, while we continued to address urgent health needs through in-office care.

- Telehealth improved access and allows us to maintain the health of vulnerable members of the community, but also poses a challenge to health equity.

- Previously, we relied on our presence in the community to engage and provide care to vulnerable community members, ensuring ongoing disease management and addressing social determinants of their health. Telehealth requires us to be more proactive – it is challenging to engage patients who cannot engage virtually, due to incompatible devices or connection issues.

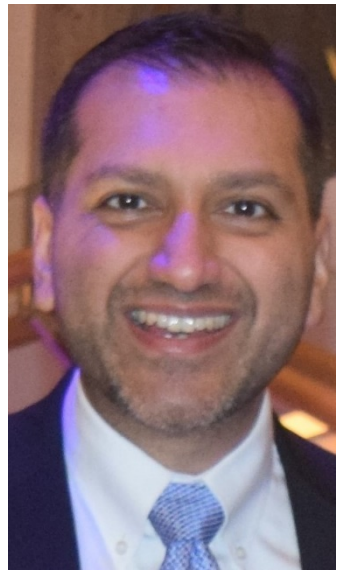
- A recent survey of 1,000 New Yorkers conducted by EmblemHealth and ANA Research found that both low-income and Black/African American New Yorkers are more likely than the general population to have access to only one technology device at home. While the majority of the general population (82%) reported having access to regular and adequate internet at home during COVID-19, almost a quarter of low-income households and nearly a third of Black/African American New Yorkers reported having inadequate internet access.

- We are exploring additional ways to engage with patients at home, through additional digital tools, home monitoring devices, and interventions through our community partners.

Community Healthcare Network

Promoting Equity During COVID-19 at a Large Urban FQHC

Sachin Jain, MD MPH
Chief Clinical Transformation Officer
Community Healthcare Network



UHF Medicaid Conference
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Community Healthcare Network

- FQHC with 12 primary care clinics, 2 school-based health centers, and mobile units covering Brooklyn, Queens, Manhattan and Bronx
- Serve nearly 80,000 patients annually
- Provide primary medical care, HIV treatment, PEP, PrEP, transgender care, social work, health education, family planning, psychotherapy, nutrition, dentistry, podiatry, psychiatry, care coordination, medico-legal partnerships

Innovation: Community Partnerships & COVID-19

Testing	• Community-based COVID-19 testing initiative in Jamaica • Collaboration with First Presbyterian Church (Rev Patrick O'Connor) • Tested nearly 2000 clients from the surrounding community • Many without primary care established care with CHN post-testing • Sponsored by New York State Governor Cuomo's office
Food distribution	• Distributed food baskets in Long Island City, Queens • Collaboration with Hour Children (Johanna Flores) • Mostly LGBTQIA+ food-insecure recipients affected by COVID-19
SDOH linkage	• UHF grant to develop SDOH screening and linkages in Jamaica • Altman Foundation grant supporting Lower East Side and Jamaica to strengthen SDOH linkages with CBOs

Opportunity: Reimbursement

Care Provision

- Telemedicine when clinician is offsite
- Technology for patients/staff
- E-consults
- Home visits

Care Management

- Secure bi-directional messaging
- Remote patient monitoring
- Data/Analytics to identify and engage unseen patients
- Home-based COVID testing

CHCS Center for Health Care Strategies, Inc.

Advancing innovations in health care delivery for low-income Americans

Tricia McGinnis, MPP, MPH

Executive Vice President and
Chief Program Officer
Center for Health Care Strategies
July 15, 2020

CHCS' Work Supporting Primary Care

- CHCS provides technical support to state Medicaid agencies, health plans, and providers to improve care delivered to low income individuals
- Select CHCS primary care and equity initiatives:
  - *Advancing Primary Care Innovation in Medicaid Managed Care*
  - *Advancing Health Equity Initiative*
- Promising policies—payment reform:
  - Prospective payment models to primary care practices serving diverse populations
  - Reward all staff for reductions in health disparities

State and Plan Levers to Improve Health Equity

- Michigan's Capitation Withhold for Health Plans
  - Health equity component: rewards plans with equitable care in four metrics
  - Health improvement component: rewards plans that have improved performance in five metrics
- Community Health Care Network's VBP arrangement
  - Provider organization receives monthly capitated payment
  - Team members receive monthly incentives of up to 3% salary for performance in metrics and processes of care for conditions that have disparities
  - Teams receive mid-month metric reports

Biggest COVID-19 Challenge to Primary Care

Fee for Service Payments:

- COVID-19 has underscored the financial instability of FFS payment models, especially for safety net practices
- This includes more advanced value-based payment models like shared savings and shared risk that rely on FFS