Key Policy Issues in Incorporating Health Equity into Health Care Reform

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Federal State Discourse on Building an Equitable Health Care Delivery System
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ACA’s Vision to Advance Health Equity

• Monitoring health care reform from a health equity lens since 2007

• Our 2010 Report found that *working to advance health equity is central to the ACA.*
Definition of Health Equity

“Health equity is assurance of the conditions for optimal health for all people. Achieving health equity requires valuing all individuals and populations equally, recognizing and rectifying historical injustices, and providing resources according to need. Health disparities will be eliminated when health equity is achieved.”

- Camara Jones, CDC, 2011
Over 60 provisions in the ACA that explicitly or through more broader initiatives intend to advance health equity

**Affordable Care Act**

**Health Insurance Marketplace**
- Culturally & linguistically appropriate marketing, outreach, and education
- Non-discrimination
- Special provisions for American Indians

**Health Care Safety Net**
- Medicaid
- CHIP
- Health Centers
- DSH Payments
- Community Health Needs Assessment

**Health Care Workforce**
- Underserved Areas
- Workforce Diversity
- Cultural Competence Training
- Model Cultural Competence Curricula

**Research, Quality & Innovation**
- National Quality Strategy
- PCORI
- NIH/NIMHD
- Innovation Center
- ACOs
- Medical Home
- Agency OMhs
- Race/Ethnicity Data Standards

**Public Health & Prevention**
- Prevention & Public Health Fund
- CTGs
- Obesity
- Cancer
- Diabetes
- Oral Health
- Indian Health Care Improv. Act.
Overall Progress of ACA’s Health Equity Objectives

Implementation Progress of ACA's Equity Provisions October 2013 (N = 56 Provisions)

- More Fully Funded or Implemented: 48%
- Partially Funded or Implemented: 29%
- Not Funded or Implemented: 23%

Health equity advancing provisions that have seen the greatest progress are generally those related to health insurance reforms.
Health Insurance Marketplaces

- Marketplaces will cover nearly 30 million
  - 42% (12 million) projected to be non-white
  - 25% projected to have limited English proficiency (LEP)

- Overall Open Enrollment 1:
  - 6.7 million successfully enrolled in marketplace
  - Approximately 28% of potential population enrolled

- Enrollment by race, ethnicity, and language (REaL):
  - Enrollment experience varied REaL
  - Estimates are very rough as reporting REaL data was optional
  - Generally, Hispanics/Latinos, African Americans, LEP populations lagged in enrollment
  - “Low hanging fruit” phenomenon
Medicaid & Coverage Gap

Percent of Non-White Population in the Coverage Gap, 2014

Medicaid has covered at least 5 million new individuals. However, states not expanding are disproportionately disenfranchising non-whites.

Safety-Net Systems at a Crossroads:
How to be providers of choice while continuing to serve their mission?
Monitoring Safety-Net Systems Transformations at Public Hospitals in Medicaid Expansion States

- Supported by Blue Shield of California Foundation

- **Goal**: Identify delivery system transformation models, experiences, challenges, and lessons learned in adapting and responding to health care reform

- **Study hospitals**: AEH public hospitals and select other safety-net systems in Medicaid expansion states with at least 50% Medicaid and self pay mix.

- Also reviewing transformations through Medicaid 1115 Waiver Programs (e.g. DSRIP)
## Study Safety-Net Hospitals

<table>
<thead>
<tr>
<th>Hospital Name</th>
<th>State</th>
<th>Provider Type</th>
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</thead>
<tbody>
<tr>
<td><strong>AEH Member Public Hospitals</strong></td>
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<tr>
<td>Boston Medical Center</td>
<td>MA</td>
<td>Public Hospital</td>
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<tr>
<td>Cambridge Health Alliance</td>
<td>MA</td>
<td>Public Hospital</td>
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<tr>
<td>Cook County Health &amp; Hospitals Corp</td>
<td>IL</td>
<td>Public Hospital</td>
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<tr>
<td>Hennepin County Medical Center</td>
<td>MN</td>
<td>Public Hospital</td>
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<tr>
<td>Maricopa Integrated Health System</td>
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<td>Public Hospital</td>
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<tr>
<td>MetroHealth System</td>
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<td>Public Hospital</td>
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<td>Mount Sinai Hospital of Chicago</td>
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<td>Public Hospital</td>
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<tr>
<td>NYCHHC - Elmhurst Hospital</td>
<td>NY</td>
<td>Public Hospital</td>
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<tr>
<td>UK HealthCare Hospital System</td>
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<td>Public Hospital</td>
</tr>
<tr>
<td>UW Harborview Medical Center</td>
<td>WA</td>
<td>Public Hospital</td>
</tr>
<tr>
<td><strong>Other Safety-Net Providers</strong></td>
<td></td>
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<tr>
<td>Clinica Family Health Services</td>
<td>CO</td>
<td>FQHC</td>
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<tr>
<td>Maui Memorial Hospital</td>
<td>HI</td>
<td>Public Hospital</td>
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<tr>
<td>Yuma District Hospital</td>
<td>CO</td>
<td>Critical Access</td>
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</tbody>
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KEY FINDINGS

1. “Turning the dial” away from fee-for-service, and transitioning toward capitated approaches that reward population health outcomes.

- Nearly all providers have already or will soon move away from fee-for-service payment and delivery in favor of capitation.

- More than half of interviewed hospitals are currently part of Accountable Care Organizations (ACOs).

- Shift toward capitation occurring gradually—i.e., systems in a “two canoe situation”
KEY FINDINGS

2. Redesigning primary care to be better coordinated, patient-centered, multidisciplinary, & team-based.

- Shift to Patient Centered Medical Homes (PCMHs)

- Team-based care approaches
  - Encouraging “top of the license” practice
  - Adding non-medical staff to teams—e.g., lay health workers
  - Increasing billable time—e.g., Clinica’s FLIP visits

- Addressing “social determinants” in primary care setting
  - “Health Corridor” connecting health, housing, and transit across five neighborhoods (e.g., MetroHealth)
  - Team-Based “Coordinated Care Center” for complex patients with frequent hospitalizations, chronic conditions, and socioeconomic challenges (e.g., Hennepin)
KEY FINDINGS

3. Undertaking strategies to be more competitive, especially to retain patients.

- Safety-net executives say long-term viability depends on retaining patients in competitive environment

- Strategies to respond to competition include:
  - Culturally and linguistically appropriate services
  - Investing in outreach & enrollment efforts
  - Re-branding campaigns to be perceived as providers of choice, not providers of last resort
  - Undertaking “collaborative” vs “competitive” efforts
KEY FINDINGS

4. Embracing change through leadership.

- Leadership transitions have occurred in at least 4 hospitals, accompanied by changes to improve the financial position of the system, including:

  1. Assuming short-term risk for long-term savings
     - Investment in medical homes or accountable care arrangements

  2. Consolidation
     - Co-locating and downsizing facilities (e.g., BMC)

  3. Management restructuring
     - “Hierarchical” to “flat” structure facilitates efficient decision-making (e.g., Cook County)
KEY FINDINGS

5. Undertaking cost-cutting strategies

- Reducing waste and unnecessary costs
- Streamlining administrative processes
- Adopting transparency in pricing for common inpatient & outpatient services
  - Hospital can reduce uncompensated care when uninsured patients can realistically evaluate their ability to pay (e.g., Maricopa)
Opportunities through 1115 Medicaid Waivers

States that experienced success in their payment and delivery system reforms shared 5 key elements --

1. Focus on patient-centered medical homes

2. Primary care & behavioral health integration

3. Collecting and sharing data

4. Moving ambulatory care out of ED and into community-based settings

5. Transition to capitated approaches, away from fee-for-service

Reform ≠ reinventing the wheel!

Basics already exist:
- Medical homes
- Health IT
- Community health teams
- Stakeholder engagement
What Keeps Hospital Executives Up at Night?

- **Uncertain role and relevance of safety-net institutions**: “where do we fit in the puzzle” and “what is going to define us”

- **Challenges associated with shifting delivery and payment structures**: especially for already struggling institutions that may not have capital or resources to take on added “risk”

- **Financial viability/vulnerability**: looming federal DSH reductions, new penalties, state/local budget cuts, primary provider for low-income and uninsured

- **Challenges with transitioning staff**: especially with resistance to change from some systems that are highly unionized, as well as from physicians and other providers.
Moving Ahead: Points for Consideration

- Assuring patients and communities are at the heart of new delivery and payment reforms
  - “Whole person” care
  - Addressing social determinants
  - Accountable Care Communities

- Managing transformation will require a unified vision, leadership, and innovative collaborations
  - Championing leadership
  - Revisiting vision and objectives to assure relevance in evolving health care environment
  - New partnerships—e.g., UW Medicine & Boeing
Moving Ahead: Points for Consideration

- Transitioning and supporting health care workforce
  - Education and training on evolving delivery and payment system, with evolving roles
  - Importance of “whole person” and “social determinants”

- Monitoring transformations to assure they do not exacerbate disparities
  - At the community level
  - Among providers
  - Between patient populations
Health Equity & Marketplace Report Card

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**Goal:** Develop and administer a report card to assess marketplace progress and performance in advancing racial and ethnic health equity.

**Objectives:**
1. Identify how, and to what extent, health equity is integrated into marketplace plans and operations.
2. Document progress and outcomes of efforts to advance health equity, identifying program successes and gaps.
3. Identify opportunities to enhance efforts to advance health equity through health insurance marketplace.
Health Equity & Marketplace Report Card Dimensions

- Marketplace Structure & Governance
- Equity Related Financing & Resources
- Collaboration & Community Engagement
- Marketing & Communication
- Consumer Assistance Programs
- Measurement & Evaluation
- Consumer Enrollment and Satisfaction
- Access to Care
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