

Health Equity Incentives for Certain MassHealth Hospital, Managed Care, and Related Programs: MassHealth Request for Information (BD-22-1039-EHS01-ASHWA-68794)

Responding organization/contact person:

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Organizational interest / role in health care system:

The Center for Public Representation (CPR) is a national legal advocacy center dedicated to enforcing and expanding the rights of people with disabilities and others who are in segregated settings. CPR uses legal strategies, advocacy, and policy to design and implement systemic reform initiatives that promote integration and full community participation for people with disabilities and others who are devalued by society. CPR's work includes litigation under the federal Medicaid Act to secure medically necessary services for children and youth, and home and community-based services for adults. Throughout the COVID-19 pandemic, CPR has worked to ensure that people with disabilities, older adults, and communities of color have equal access to life-saving COVID-19 treatments.

Section 3: Enhancing Understanding of and Attention to Social Risk Factors

MassHealth, and Medicaid programs generally, have an important role to play in remedying structural inequalities, particularly as they impact access to health care. In June of 2020, the National Association of Medicaid Directors (NAMD) announced its commitment to health equity and working to improve the health and well-being of the 70 million people served by Medicaid and the Children's Health Insurance Program (CHIP). In so doing, they acknowledged that "[r]acism and racial injustices are barriers to health and to the ability for Black, Indigenous and People of Color [BIPOC] to access resources that support health."¹

Race is one of many important factors contributing to health disparities, and information about the intersection of income, race, ethnicity, gender, and disability within the Medicaid population is largely unavailable, both locally and nationally.² MassHealth's proposal to collect and analyze this data has the potential to broaden the Commonwealth's understanding of the scope of these issues and structural barriers to care in Massachusetts. When paired with a commitment to

¹ The National Association of Medicaid Directors' Statement on Inequities in Health and Health Care June 6, 2020; <https://medicaiddirectors.org/press-release/2020/06/namd-statement-on-inequities-in-health-and-health-care/>; see also, NAMD Medicaid Leadership Exchange: Season 2 Data Equity Strategies: Using Data to Empower Medicaid to Support Health Equity; <https://medicaiddirectors.org/medicaid-leadership-exchange-season-2/data-equity-strategies-using-data-to-empower-medicaid-to-support-health-equity/>.

² *Advancing Health Justice Using Medicaid Data: Key Lessons from Minnesota for the Nation* (hereafter "*Advancing Health Justice*"), AcademyHealth, in partnership with the Disability Policy Consortium, Ellen Breslin, M.P.P., Dennis Heaphy, M.Div. M.Ed. M.P.H., Tony Dreyfus, M.C.P., Anissa Lambertino, Ph.D., Jeff Schiff, M.D., M.B.A., p. 18-19, January 29, 2021; <https://academyhealth.org/publications/2021-01/minnesota-offers-lessons-advancing-health-justice-using-medicaid-data>

develop and implement responsive system reform, this data can result in the types of initiatives needed to secure equal access to care and improve members' health outcomes.

MassHealth is already providing coverage to communities that have been impacted by, and continue to experience, structural inequalities, racism, and discrimination in access to health care. It also is uniquely positioned to collect and analyze data on health care utilization, delivery, and outcomes for under-resourced populations and communities. MassHealth's attention to social risk factors (often referred to as social determinants of health) and solution-focused policy responses, also should inform the development of funding strategies including value-based purchasing and outcome/performance incentives for MassHealth providers and managed care contract entities.

What social risk factor data should MassHealth collect and/or require its contracted health system entities (e.g., MCOs, ACOs, CPs, hospitals, managed behavioral health vendor) to collect?

There is an undeniable intersection between poverty, race, age, and disability, all of which can create multiple, compounding barriers to care and negatively impact individual health. This has been particularly evident during the COVID-19 pandemic. For this reason, MassHealth's proposed data collection should include, at a minimum, income, race, age, and disability, as well as a capacity to analyze how specific factors – alone and in combination – may be impacting health care outcomes for members. We also suggest that MassHealth track health care access and outcomes data for other vulnerable or potentially marginalized populations including children, those in the custody of the child welfare system, members from linguistic minorities, and persons identifying as LGBTQ+.³

What benefits and/or risks to collecting social risk factor data on MassHealth members should MassHealth consider? If any risks, how should MassHealth mitigate those risks?

Collecting data on social risk factors and member outcomes will allow MassHealth to establish specific health equity goals and to prioritize among various health care initiatives and policy changes. This data should be incorporated into routine evaluation and monitoring of key agency functions and used to measure the efficacy of its reform strategies over time.

Importantly, collecting social risk factor and related outcomes data also allows the agency, its members, and stakeholders to advocate for additional resources and public funding to mitigate and readdress health care inequities impacting MassHealth members.

In the collection and use of this data, MassHealth should take care to maintain member confidentiality and to guard against any misuse of social risk factor data in individual health care delivery. Data should be collected in a culturally competent way, accompanied by explanations regarding the potential and intended uses for this information.

³ *Advancing Health Justice* at 42-45 (discussing risk factors specifically related to children, including those with child protection involvement, and related data collected within the Minnesota Medicaid program).

Before complete self-reported data are available, should MassHealth consider alternative approaches to estimating social risk factors at the individual and/or population levels? (Why or why not?)

There are a variety of resources on health disparities among specific Medicaid populations which can be used to estimate the need for targeted reforms at the population level, and to jumpstart the development of responsive policy changes and health equity initiatives.

Research studies and social risk factor data collected in other state Medicaid programs, like Minnesota, provide important models for data collection, analysis and reporting, as well as resulting policy implications.⁴ These findings also highlight populations with higher incidents of social risk factors, like disability status.

The January 2021 report titled *Advancing Health Justice Using Medicaid Data: Key Lessons from Minnesota for the Nation*, points out that disability is more prevalent in certain populations, including low-income communities and those within certain racial demographics:

Adults with income at or below 50 percent of the Federal Poverty Level (FPL) are seven times more likely to have a disability than adults with income above the FPL; adults who are U.S. born Black or African American are 100 percent more likely to have a disability than White adults.

Id. at 2.

Persons with disabilities also are known to be at increased risk for serious, comorbid conditions, chronic illness, and death.⁵ These conditions are often exacerbated by limited access to care, prolonged institutionalization, stigma, the pathologizing of physical symptoms, and side effects related to excessive and prolonged use of psychotropic medications. And as the pandemic has painfully illustrated, unequal and discriminatory treatment can be based on conscious and unconscious bias within the medical profession, including the devaluing of people with disabilities, and the mistaken assumption that people with disabilities experience a poor quality of life.⁶

By identifying and improving outcomes for members with chronic, co-morbid conditions, as well as those genetic and acquired disabilities, MassHealth can also improve health outcomes for low-income members and members of color, given the disproportionate level of disability in these populations. This data could be identified at the time of application, through the MassHealth Disability Supplement, or through diagnostic reporting and claims data collected once members are enrolled.⁷

⁴ See *Advancing Health Justice*, n. 2, *infra*. Other States acknowledged for their efforts related to health disparity analysis include Ohio, Oregon, Pennsylvania and Washington. *Id.* at 23, 26.

⁵ For example, a key finding from Minnesota's health disparity was that adults with a disability had the highest mortality rates of all population groups. *Advancing Health Justice* at 47-48.

⁶ See, e.g., *Physicians' Perceptions Of People With Disability And Their Health Care*, Lisa I. Iezzoni, Sowmya R. Rao, Julie Ressler, Dragana Bolcic-Jankovic, Nicole D. Agaronnik, Karen Donelan, Tara Lagu, and Eric G. Campbell, *HEALTH AFFAIRS* 40, NO. 2 (2021): 297–306. Available at <https://pubmed.ncbi.nlm.nih.gov/33523739/>.

⁷ *Advancing Health Justice* at 28 (highlighting research on disability as both a social risk factor and a health outcome).

MassHealth can also look to other federal agencies that have documented the prevalence of health disparities and begun to identify responsive strategies. Since 2011, the CDC Health Disparities and Inequalities Reports (CHDIR) and the Strategies for Reducing Health Disparities reports have highlighted effective public health programs that have reduced disparities.⁸

In addition, the Centers for Medicaid and Medicare Services (CMS) have specifically identified the dually eligible population as “vulnerable” to disparities in access to quality care. *Advancing Health Justice* at 15. This group of MassHealth members is likely to be more racially diverse than the general Medicaid population and in need of specialized care due to disability or other chronic health conditions. *Id.*

What are the most critical health and/or health care inequities that are experienced or observed by you, your organization, or your community?

As noted above, persons with disabilities are known to be at increased risk for serious, comorbid conditions and chronic illness, and tend to have higher mortality rates as a result. Their conditions are often exacerbated by limited access to care, excessive and prolonged use of psychotropic medications, the provision of substandard or inadequate medical care in institutional settings, and the dismissal or pathologizing of physical symptoms – particularly when people with psychiatric or cognitive disabilities present for emergency room care.

These factors are further complicated by the loss of autonomy and personal medical decision-making experienced by many people with disabilities under the guardianship system, and a distrust in health care providers and systems that include, and may overly rely upon, involuntary treatment. Finally, individuals with disabilities are often denied equal access to medical care and treatment because health care delivery locations and specialized medical equipment are not available to provide them with preventative or specialized care.

Including disability as a social risk factor – alone and in combination with other factors – would allow MassHealth to better understand the magnitude of these issues, the populations affected, and the potential for policy and provider network level changes to improve member outcomes. It also creates an opportunity to delve deeper into the specific barriers members face, to identify and incentivize responsive systemic changes, and to measure the extent to which those changes are improving treatment access and reducing risk.

How should MassHealth hold its contracted health system entities (e.g., MCOs, ACOs, CPs, hospitals, managed behavioral health vendor) accountable for promoting health equity?

A. Contract requirements

MassHealth has considerable experience using its managed care contracts to track, collect, analyze, and report on systems level data regarding the delivery of services to members, as well as the extent to which those services conform with specific performance standards and outcomes. The resources of these entities, and their ability to provide oversight and technical assistance to MassHealth provider networks, should be leveraged as part of a more comprehensive strategy to

⁸ CMS Equity Plan for Improving Medicare (2015); Centers for Disease Control and Prevention. Health Disparities and Strategies Reports. Available at <https://www.cdc.gov/minorityhealth/chdir/index.html>.

examine member risk factors and implement strategies to improve health outcomes, including through the monitoring of incentive-based performance measures.

B. Public reporting

Public reporting is critical to maximizing the utility of health outcomes data, both as a strategy for increasing equity and as a mechanism for mobilizing state and federal resources. This level of transparency also increases public understanding of the purpose and importance behind self-reporting specific demographic and risk factors.

Minnesota's use of Medicaid data to identify and address health care inequities is several years ahead of Massachusetts, and the results can be seen in multiple public reports, including reports to the Minnesota legislature.⁹

How should “success” in reducing inequities be defined for the five-year period between CY2023 to CY2027?

A successful health equity initiative is one that quickly moves the MassHealth program beyond data collection and reporting to specific actions and systemic investments. These actions should: (1) increase health care access and reduce identified barriers to care; (2) prevent and mitigate risks associated with specific social determinants of health; and (3) promote positive health outcomes through the availability of community-based, long-term services and supports.

However, the measure of success should ultimately be defined by the populations intended to benefit from these initiatives. MassHealth's plans to enhance engagement with its members, including those with lived experience of inequity, racism, and discrimination, should include specific strategies to involve members and their advocates in the development of data collection strategies, as well as the interpretation and analysis of their results. Most importantly, members should be at the table when health disparity and outcome data are translated into specific goals and interventions and seen as important partners in the implementation and monitoring of those initiatives going forward.

⁹ See An Account of Health Disparities in Minnesota's Medicaid Population: Which Populations Within the Medicaid Program Experience the Greatest Health Disparities and Poorest Health Outcomes? Report to the Minnesota State Legislature, June 2018; Breslin, Heaphy, Dreyfus, Lambertino. Available at https://www.healthmanagement.com/wp-content/uploads/MN-SummaryReport-to-Legislature_DHS_HMA_DPC_08.01.17_6.11.18.pdf. See also, Accounting for Social Risk Factors in Minnesota Health Care Program Payment, Legislative report supplement, December 2018. Minnesota Department of Human Services. Available at: <https://edocs.dhs.state.mn.us/lfsrver/Public/DHS-7834-ENG>.