Community Service Society | Fighting Poverty Strengthening New York

# Initiative to Reduce Racial Disparities in Health Coverage & Outcomes in Public Insurance Programs

**Community Service Society Roundtable**

David R. Jones, Esq., President & CEO

Elisabeth Ryden Benjamin, MSPH, JD, Director, Healthcare Restructuring Initiatives

Community Service Society

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# Outline of Presentation

- ❑ Background about CSS and our research
- ❑ New York's public insurance programs
- ❑ Description of CSS's reduction of racial & ethnic disparities initiative
  - Policy Proposal #1: Increase Coverage Through Improved Retention
  - Policy Proposal #2: Reduce Disparities In Health Quality & Outcomes
- ❑ Acknowledgments
- ❑ Appendix: Data Issues

# Community Service Society

# Background:

# Community Service Society

- CSS is a160 year-old organization which seeks to address the root causes of economic disparity
  - Mission is to promote policies that advance the economic security of the working low- and moderate-income New Yorkers by bringing their perspectives to the policy conversation
- CSS has a historical commitment to health care
  - Founded the Hospital for Special Surgery
  - Helped established the Primary Care Development Corporation
  - Leadership served on the board of the Health and Hospitals Corporation
  - Established multi-payer managed care ombudsprogram (MCCAP)

# CSS's Health Research

- CSS's research has identified health coverage as a central concern for low- and middle-income families
  - Health issues are a major barrier for employment
  - 2007 Statewide survey found health care to be:
    - Top personal worry & top issue for government action
    - Health hardships rampant
      - ✓ 22% of New Yorkers didn't get care for lack of money or insurance
      - ✓ 25% didn't get prescriptions for lack of money or insurance
- Between 2000 and 2007, insurance premiums in New York have increased by 81%, while median real wages only increased by 11%
  - CSS data shows that job-based insurance coverage for working poor people has declined by 15% during this same period
- Cornerstone for Coverage—CHP & FHP expansion

# New York's Public Insurance Programs

# New York's Health System

- New York spends $126 billion on health care, *more per capita* than any other state in the nation, yet:
  - 2.5 million (or 13% of population) are uninsured
  - Average health system performance (Commonwealth '07)
  - Rarely have top health outcomes & statistics (Kaiser '08)
  - Serious racial & ethnic disparities in health measures (SDOH Minority Health Surveillance Report '07)
- Money exists in our current system to fund health reform and reduce disparities, but is there the political will to do so?

**Sources: CPS data set; Commonwealth Fund, "Aiming Higher: Results from a State Scorecard on Health System Performance," June 2007; Kaiser Family Foundation, "50 State Comparison, available at: statehealthfacts.org/compare.jsp."; NYSDOH, Minority Health Surveillance Report, 2007.**

# Emerging Role of New York's Public Insurance Programs In Past Decade

- Total public insurance enrollment is well over 4.5 million
  - Medicaid Managed Care
    - 2.3 million enrollees statewide (1.6 downstate; 650k upstate)
  - Family Health Plus
    - 467,000 enrollees (346,000 downstate; 121,000 upstate)
  - Child Health Plus
    - 372,000 enrollees statewide
  - HealthyNY
    - 135,000 enrollees statewide
  - Other (fee-for-service Medicaid, Medicaid Advantage, SNPs)
- NY spends nearly $7.5 billion on managed care enrollees, excluding FFS Medicaid

# Lack of Insurance by Race/Ethnicity in New York State

| | White Only (non-Latino) | African-American Only (non-Latino) | Latino | Asian/Pacific Islander Only (non-Latino) | Other/Multiple Races (non-Latino) |
|---|---|---|---|---|---|
| **Count and Percentage** | | | | | |
| Count of Uninsured (19-64) | 896,711 | 384,376 | 603,489 | 217,767 | 21,487 |
| % of Race/Ethnicity Uninsured (19-64) | 12.5% | 22.4% | 31.3% | 22.2% | 21.0% |
| % of Total Uninsured (19-64) | 42.2% | 18.1% | 28.4% | 10.3% | 1.0% |
| **Percentage of Race/Ethnic Group Uninsured at Each Income Bracket** | | | | | |
| <150% of FPL | 30.5% | 29.9% | 34.4% | 32.8% | N sizes too small |
| 150-200% of FPL | 23.8% | 30.3% | 41.2% | 24.7% | |
| 200-300% of FPL | 16.3% | 25.2% | 36.7% | 29.7% | |
| 300-400% of FPL | 12.5% | 13.2% | 30.7% | 19.8% | |
| 400-500% of FPL | 8.4% | 21.4% | 21.4% | 12.8% | |
| 500%+ of FPL | 5.5% | 12.9% | 15.8% | 11.3% | |

**2008 Current Population Survey, Annual Social and Economic Supplement, weighted by 2006-2008 ASEC.**

# Coverage Counts:

# Insurance Helps Reduce Disparities

- Nationally, insurance found to be the most or one of the most significant mechanisms for reducing health disparities
- Among individuals with insurance coverage and a regular health care provider, racial and ethnic disparities are considerably reduced in:
  - Childhood immunization rates
  - Preventive screening rates & preventive care reminders
  - Receipt of quality of care for heart attacks (comparing African American and White Medicare patients)
- CSS Cornerstone proposal addresses coverage

Sources: McDonough, J. et al. A State Policy Agenda to Eliminate Racial and Ethnic Health Disparities. The Commonwealth Fund. June 2004; Mead, H. et al. Racial and Ethnic Disparities in U.S. Health Care: A Chartbook. The Commonwealth Fund. Volume 27. March 2008; Smedley, B. et al.. Identifying and Evaluating Equity Provisions in State Health Care Reform. The Commonwealth Fund. April 2008; Beal, AC. Policies to Reduce Racial and Ethnic Disparities in Child Health and Health Care. Health Affairs. Volume 23, Number 5. September 2004.

# CSS's Reduction of Racial & Ethnic Disparities Initiative

# CSS's Racial & Ethnic Disparities Initiative – Goals

- Statement of the Problem:
  - Racial and ethnic disparities exist both in overall coverage rates and in health outcomes in New York
- Goals: Are there concrete policy changes that would leverage the State's purchasing and regulatory power in its public health insurance programs to reduce racial and ethnic disparities?
  - Can we address?
    1. Disparities in retention?
    2. Disparities in health care outcomes?

Policy Proposal #1:
Reduce Disparities in Retention

# Background on Retention

- Availability of public insurance has eroded some disparities in coverage at lowest income levels (slide 10)
  - 22% of the public insurance enrollment is African American
- New York loses over 40% of its publicly insured enrollees every year at "recertification" or renewal
- Retention matters because:
  - Important for quality of care
  - Important for continuity of care
  - Disruptive to providers located in underserved communities
  - Administrative efficiency

# SDOH Retention Data

- SDOH conducted a 13-month analysis of MMC plans member retention between July 2006 and July 2007
  - Only 1.5 million out of 2.4 million beneficiaries had continuous coverage during the study period
  - Average of a 61% member retention rate

- SDOH considered adding a member retention component to criteria for the Medicaid Managed Care plan Quality Incentive Score (QIS), but dropped the idea because:
  - Variation in retention rates was multi-factorial
  - Largely out of the control of the plans

# Retention Findings Overall

- Wide variation in overall retention rates across plans, e.g. Plan 1 (74%) to Plan 24 (46.8%)
- Other retention differences
  - Large plans, with more than 100,000 members, do better than smaller plans, with less than 50,000 members (63% v. 56%)
  - Aid categories:
    - Children do better than adults (66% v. 57%)
    - SSI enrollees have highest retention (79%), followed by TANF (63%), then Family Health Plus and Safety Net enrollees (55%)
  - Regional differences
    - New York City does better than elsewhere (63% v. 57%)
    - Large enrollment counties do much better than smaller ones (62% v. 40%)
    - Mandatory counties do better than voluntary (61% v. 48%)

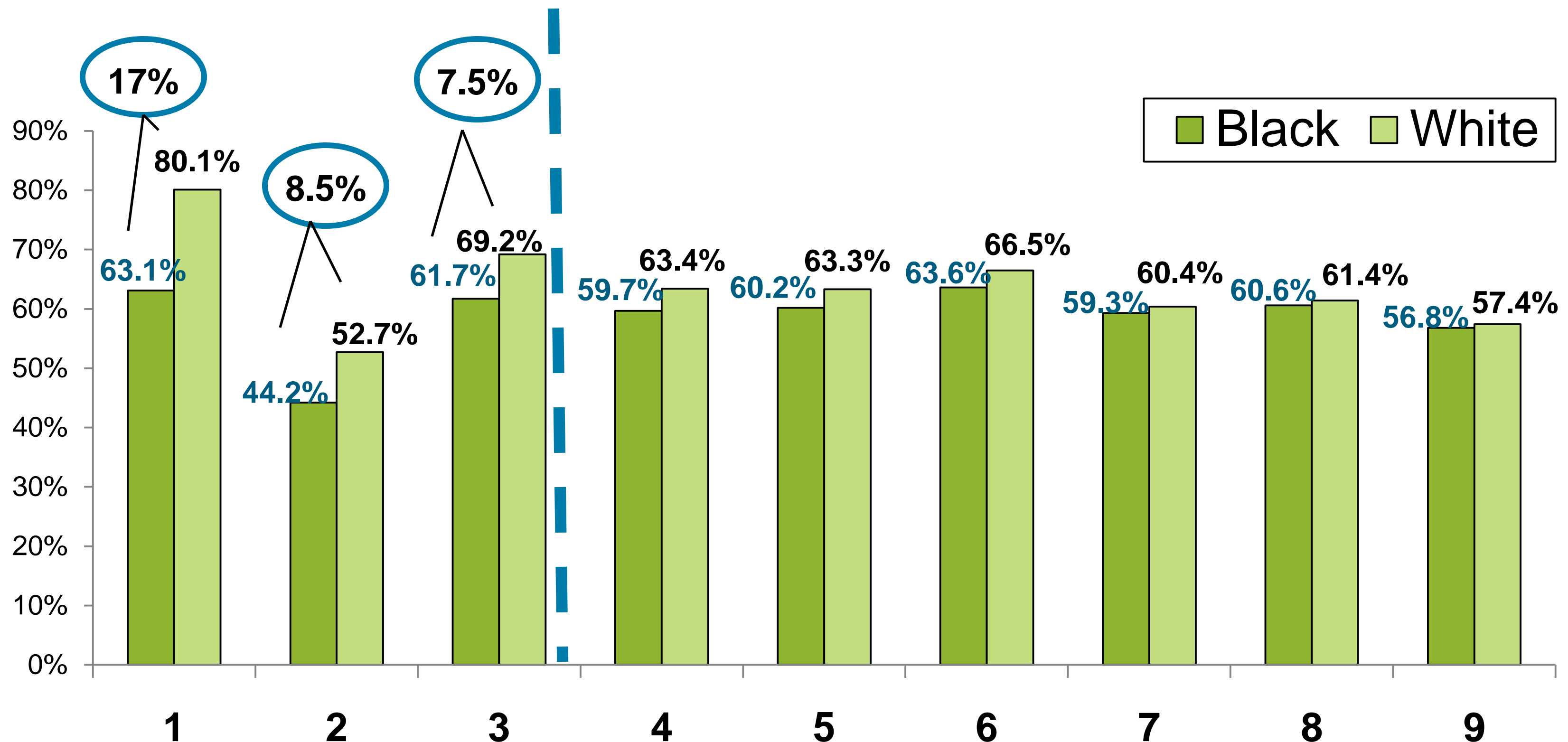
# Race-Based Retention Findings

- CSS reviewed SDOH's retention data with eye towards health equity
- Racial disparities in retention exist, particularly for African Americans
  - Overall average & white average was 61%
  - Asian Pacific Islander average 65%
  - Latinos average 62%
  - African Americans average 59%

# CSS' Retention Findings

| Retention by Race and Plan Size and Region of Operation, Statewide, June 2006-July 2007 | | | | | | |
|---|---|---|---|---|---|---|
| | Race * | | | | | White vs. Black Pct Point Diff |
| **Plan Characteristics** | **Asian** | **Black** | **Hispanic** | **White** | **Total** | |
| Plan Region of Operation | | | | | | |
| NYC | 61.3% | 58.5% | 63.6% | 72.1% | 63.2% | 13.6% |
| Upstate | 58.1% | 61.3% | 58.5% | 54.3% | 57.0% | -7.1% |
| Both | 66.6% | 58.1% | 61.1% | 61.1% | 61.1% | 3.0% |
| Plan Size | | | | | | |
| >100K Members | 66.0% | 59.3% | 62.7% | 65.5% | 62.7% | 6.2% |
| 50-100K Members | 64.3% | 56.7% | 59.3% | 56.4% | 58.3% | -0.3% |
| 25-50K Members | 55.7% | 56.4% | 57.5% | 53.2% | 55.0% | -3.2% |
| <25K Members | 54.0% | 61.5% | 52.5% | 54.4% | 55.9% | -7.2% |
| TOTAL | 65.4% | 58.7% | 61.6% | 61.2% | 61.0% | 2.6% |

# Nine out of 24 plans had lower African American retention rates than whites*




*Thirteen out of 24 plans had higher African American than white retention rates.

# Three out of 24 plans driving the racial disparity in enrollment

- Three plans have significantly higher retention of whites than African Americans
  - Plan 1:  80% white, 63% African American
  - Plan 2: 53% white, 44% African American
  - Plan 3:  69% white, 62% African American
  - **Nearly 450,000 enrollees in these three plans**
- *But* Plan 1's and Plan 3's African American retention rate is higher than over all retention rate of 61%
- When these three plans are removed from overall retention analysis, the white/African American disparity disappears

# No Precedents for Addressing Retention

- CSS's national research has found no state models for incentives for managed care plans to:
  - Improve coverage of eligible but uninsured (overall or for racial and ethnic minorities)
  - Promote retention of individuals enrolled (overall or for racial and ethnic minorities)

# CSS's Preliminary Policy Recommendations on Retention

- SDOH should consider seeking federal approval for 2 year continuous enrollment
  - Administrative/ex parte renewal (CHIPRA does this for kids)
- SDOH should annually analyze retention data, controlling for race, county, plan and aid category
  - Use data to improve functioning of enrollment center, counties, renewal sites
- SDOH should report and disclose stratified retention data by plan in QARR report and other meaningful categories in other venues
- SDOH should share analysis with plans
  - SDOH should meet with the plans that have racial and ethnic disparities
    - Test a variety of interventions for overall high retaining plans
    - Consider issuing statements of deficiencies & corrective action for low performing plans if no change over time

Policy Proposal #2:
Reduce Disparities in
Health Quality & Outcomes

# Background:

# New York's Quality Data

- Quality Assurance Reporting Requirements (QARR) is New York's system for collecting qualitative data from commercial and public insurance managed care plans
  - Indicators set annually, hybrid measures rotate regularly
  - Reported on SDOH Website
- Quality Incentive Score – Bonus payments began in 2002 up to 1% of premium, increased to 3% of premium in 2004
  - $62,000,000 awarded annually to 50%-90% of plans, depending on measures
  - HEDIS, CAHPS, Compliance measures

# Background:

# New York's Quality Data

- Between 2002 and 2007, rates of performance in public insurance programs have improved significantly
  - Complete immunizations rose from 64% to 73% ('02-'06)
  - Well child visits
    - Between 0-15 month rate rose from 58% to 65% ('02-'06)
    - Between 3-6 years rate rose from 71% to 76% ('02-'07)
    - Adolescents (12-21 years) rate rose from 45% to 49% ('02-'07)
  - Diabetes in poor control decreased from 42% to 35% ('04-'07)
  - Four historically lower performing plans have left over past five years
- Certain measurements started to approach commercial performance: mental health, diabetes, postpartum, satisfaction

# Past SDOH Data Analysis on Racial & Ethnic Disparities in Health Quality

- In May 2008, SDOH analyzed disparities in health outcomes for children and adolescents in Medicaid Managed Care plans
- Looked at two types of quality data (clinical and administrative)
  - Studied: immunizations, lead tests, well child visits (0-15 mos & 3-6 yrs), adolescent well care (12-21 yrs), appropriate treatment of upper respiratory infections, Asthma medications, annual dental visits
- Findings
  - African-American children fared worse than whites on 5/8 measures
  - Latino & API children fared better than whites on half the measures

# CSS Analysis of QARR Data

- CSS requested QARR data from SDOH in the following clinical areas for Medicaid Managed Care enrollees, comparing racial/ethnic groups
  - Children's Health
  - Cardiovascular and Respiratory Conditions
  - Women's Health
  - Diabetes
- Found statistically significantly disparities for African Americans vs. total population on 10 out 12 measures
  - Asian/PI population did statistically significantly better than total on 10 out of 12 measures
  - Latinos did better on 5 out of 12
  - Whites had mixed results

# African–Americans' Health Measures are Statistically Significantly Worse on Most Major Measures

| Measure | Race Group | | | | | |
|---|---|---|---|---|---|---|
| | Asian | Black | Hispanic | Other | White | Total |
| Preventive Care/Care Mgmt | | | | | | |
| Child Immunization | 80% | 78% | 83% | 78% | 75% | 79% |
| Dental Visit (2-21yo) | 47% | 36% | 48% | 43% | 51% | 45% |
| Child Asthma (5-17yo) | 95% | 90% | 92% | 92% | 94% | 92% |
| Adult Asthma (18-56yo) | 95% | 87% | 89% | 90% | 91% | 90% |
| Mammography (42-69yo) | 68% | 57% | 71% | 64% | 57% | 64% |
| | | | | | | |
| Management of Diabetes | | | | | | |
| HbA1c Testing | 90% | 84% | 87% | 89% | 86% | 86% |
| Poor HbA1c Control | 27% | 41% | 36% | 33% | 34% | 35% |
| Lipid Profile | 89% | 78% | 85% | 87% | 82% | 83% |
| Lipids Controlled | 46% | 34% | 42% | 41% | 39% | 40% |
| Blood Pressure Controlled | 36% | 25% | 32% | 32% | 34% | 31% |
| Dilated Eye Exam | 72% | 56% | 62% | 64% | 61% | 62% |
| Nephropathy Screening | 83% | 82% | 83% | 84% | 80% | 82% |

# CSS's Preliminary Policy Recommendations on Quality

- ❑ SDOH should monitor plan quality indicators by race/ethnicity
- ❑ SDOH should publicly disclose results of racial and ethnic disparities in health outcomes by plan
- ❑ SDOH could use it's purchasing power to:
  - Design a pay-for-performance "quality bump" for all plans that meet benchmark quality standards (would discourage cherry picking)
    - Could adopt benchmarks that are stratified by race/ethnicity
  - Design a pay-for-performance "quality bump" for plans with top-ranking outcomes for targeted indicators (plans would compete for best outcomes)
  - Issue statements of deficiencies and corrective action plans
  - Provide seed funding for targeted, innovative interventions that could be replicated if successful

# Acknowledgments

# Thanks !

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- The New York State Department of Health
  - Office of Minority Health
  - OHIP, Office of the Medical Director
  - OHIP, Division of Quality and Evaluation
  - OHIP, Division of Managed Care
- Dr. Anne Beal, Commonwealth Fund
- The plans, providers and experts interviewed for this project
- Manatt Health Solutions
- Community Catalyst

## Discussion:

## 3 Pronged Approach to Reduce Disparities

- ❖ Coverage
  - ✓ Expand coverage
- ❖ Retention
  - ✓ Federal Waiver
  - ✓ Analyze, report, disclose, and monitor
- ❖ Quality
  - ✓ Analyze, report, disclose, P4P and monitor

# Appendix

# Data Issues

# Quality of Data Generally

- Literature review indicates lots of concern with quality of race and ethnicity data
  - Historical reasons for low race reporting
  - Difficult question to ask and answer
  - Data accuracy issues
    - Self-reported v. observed
    - Interpreting “other”
    - Accuracy of capturing multi-racial people, and ethnic sub-groups (e.g. Puerto Rican, Vietnamese)
    - Inaccurate understanding of legal framework

# New York State Department of Health Data Collection and Review

- Data Review: NYS DOH has begun to assess racial/ethnic disparities among Medicaid managed care beneficiaries through data review
  - SDOH follows census rules: African American, White, Asian, Latino, and "other"
  - In 2007, NYSDOH analyzed quality of MMC race data (cross-walked WMS and CAHPS data sets for past 6 years ~90% for Latino, 75-80% for AA, API, W, 77% overall accuracy)
  - 3/08 NYSDOH added race data to Plan rosters of enrollees
- "Other" is 9% of the population, 5.7% is multi-racial, 2.8% is unknown race, and the rest is American Indian

# Possible Data Improvement Solutions

- Targeted education campaign to highlight the importance of capturing race data
  - Counties & SDOH
  - Unions
  - Plans
  - Facilitated enrollers
  - Providers
  - Beneficiaries
- Financial support to plans & FEs for improving data collection