Commonwealth of Massachusetts
Health Disparities Council

SENATOR
SUSAN FARGO
Co-Chair
♦
State House
Room 504
(617) 722-1572

REPRESENTATIVE
BYRON RUSHING
Co-Chair
♦
State House
Room 121
(617) 722-2006

RECOMMENDATIONS ON PAYMENT/SYSTEM DELIVERY- REFORM

Broad Statement:

Health disparities affect a large portion of the Massachusetts population. Payment Reform represents our greatest opportunity to impact disparate care and health outcomes. In addressing these inequities, health care reform can be a key avenue for addressing racial and ethnic disparities while realizing significant cost savings.

Payment and system delivery reform legislation should incorporate and/or address the following General Principles:

1. Physical and mental health are both an integral part of a person's health and well-being. Legislation must address physical and mental health disparities for both its impact on access to care and clinical outcomes of care, as a priority.

2. Payment and system delivery reform should not continue or exacerbate the system inequities that lead to health disparities. For instance, to ensure that global or other risk-based payments don't encourage adverse selection or redlining of patients, especially those with complex health needs, we should require adequate risk adjustment, including for socio-economic factors such as race, ethnicity, disability, housing, income level, primary language usage, educational attainment, and sexual orientation, etc.

3. Reducing provider payment disparities and improving market function must be key objectives in any payment and system reform effort. In that regard, payment methods should reward the elimination of racial and ethnic health disparities achieved through quality benchmarks and ACO system design evaluations.

4. Non-clinician services contribute to health and wellness and legislation should address how to support and capture the value of these types of community services. Non-clinical providers, like community health workers, patient/systems navigators and medical interpreters, should be explicitly integrated into payment reform since these services have a direct impact on clinical outcomes and the cost of care.

5. Assessments or monitoring of state health planning/system capacity must address the impact on health disparities, including ensuring adequate access to primary care providers and behavioral health providers and providers of all types with cultural and linguistic competence. There must be a focus on adequate workforce diversity in hospitals and in the educational preparation for physicians and other providers.

6**.** Ensure that the payment reform bill supports community-wide prevention efforts with an emphasis on the social determinants of health. Linkages should be built between clinical health services and community public health initiatives. ACO quality measures should reflect the importance of such linkages. Funding for expanded community health and public health initiatives should be identified as part of payment reform.

Specific Recommendations in Relation to H. 1849, Governor's Legislation:

1. Specifically recommend to HDC that racial and ethnic health disparity experts be included as part of the new agency infrastructure and appointed to key councils and committees such as the Health Information Technology Council in line 170 at SECTION 5(b); Department of Public Health, Health Planning Council in line 231 at SECTION 10(b); Health Care Innovation Advisory Committee in line 473 at SECTION 14, Section 2(c); and ACO organizational structures at line 582 in SECTION 14, Section 5(d)(4).

2. There may be unintended consequences for racial and ethnic minorities as a result of SECTION 19 & 20, Clinician-Patient Communication and Grievance Resolution/ Treatment of Provider Apology in Litigation; therefore, we specifically recommend that an analysis of apology data be conducted with sensitivity to racial, ethnic and linguistic demographics and periodically report back to the HDC an "impact statement".

3. Specifically recommend that the Coordinating Council who appoints the Behavioral Health Care Taskforce members use the following criteria to establish a membership capable of forging this essential integration: a health service provider with cultural insight program experience, a provider with expertise in the mental health needs of hard to reach populations, an academic responsible for teaching mental health cultural competence, a health plan expert responsible for determining adequate access to appropriately skilled network providers, a public health practitioner with experience developing culturally appropriate services for dually diagnosed patients (substance abuse and mental health), at least two consumer advocates and users of behavioral health services with at least one of whom shall be a representative of a population experiencing health disparities and a mental health group with experience in contracting with health plans to provide culturally competent behavioral health services.

4. Specifically recommend that ACOs be required to calculate the return on investment made in compensating non-clinician services and community activities, **particularly those efforts with an emphasis on the social determinants of health**, that integrate community public health interventions and which have been proven to improve health and well-being over the long term.