How CMS Is Working to Achieve Health Equity

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CMS Office of Minority Health
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“Working to Achieve Health Equity”
Offices of Minority Health Within HHS

“Working to Achieve Health Equity”
CMS Health Equity Framework

Increasing understanding and awareness of disparities
Developing and disseminating solutions
Implementing sustainable actions

“Working to Achieve Health Equity”
Addressing Health Disparities at All Levels

Increasing Understanding and Awareness of Disparities
Changes in Quality of Care Disparities Over Time: Summary by Race and Ethnicity, 2014

- Black vs. White: 46% Improving, 0% Same, 8% Worsening
- Asian and PI vs. White: 31% Improving, 69% Same, 0% Worsening
- American Indian/Alaska Native vs. White: 22% Improving, 74% Same, 4% Worsening
- Hispanic vs. Non-Hispanic White: 44% Improving, 52% Same, 5% Worsening

NOTES: “Improving” means disparity is becoming smaller over time; “worsening” means disparity becoming larger over time. Data on all measures are not available for all groups. Totals may not add to 100% due to rounding. Time period differs by measure and includes oldest and newest years of available data.

Mapping Medicare Disparities (MMD) Tool

## Mapping Medicare Disparities

**September 30, 2015**

<table>
<thead>
<tr>
<th>Parameter</th>
<th>Value</th>
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<tbody>
<tr>
<td>Year</td>
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</tr>
<tr>
<td>Geography</td>
<td>County</td>
</tr>
<tr>
<td>Measure</td>
<td>Prevalence</td>
</tr>
<tr>
<td>Condition</td>
<td>Acute Myocardial</td>
</tr>
<tr>
<td>Analysis</td>
<td>Base Measure</td>
</tr>
<tr>
<td>Gender</td>
<td>Any</td>
</tr>
<tr>
<td>Age</td>
<td>Any</td>
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<td>Dual</td>
<td>Any</td>
</tr>
<tr>
<td>Race</td>
<td>Any</td>
</tr>
<tr>
<td>Comparison Race</td>
<td>Any</td>
</tr>
</tbody>
</table>

### Prevalence (%)

- **< 0.00 %**
- **0.00 to 0.00**
- **0.00 to 0.31**
- **0.31 to 0.52**
- **0.52 to 0.68**
- **0.68 to 0.88**
- **0.88 to 1.10**
- **1.10 to 1.57**
- **1.57+**

Shading Indicates urban counties.
CMS released Medicare Advantage HEDIS and CAHPS scores for different racial and ethnic groups at the level of individual Medicare contracts and is intended to be used to improve quality and accountability.
<table>
<thead>
<tr>
<th>Contract Code</th>
<th>Contract Name</th>
<th>Appropriate Monitoring of Patients Taking Long-Term Medications</th>
<th>Colorectal Cancer Screening</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>API  Black  Hispanic  White   API  Black  Hispanic  White</td>
<td></td>
</tr>
<tr>
<td>N/A</td>
<td>Average of all reported contracts³</td>
<td>93%  92%  92%  91%   68%  61%  63%  61%</td>
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<tr>
<td>H5896</td>
<td>AMERIGROUP MARYLAND, INC.</td>
<td>NA  93%  NA  90%¹  NA  57%  NA  46%</td>
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<tr>
<td>H2108</td>
<td>BRAVO HEALTH MID-ATLANTIC, INC.</td>
<td>94%  94%  94%  93%  NA  66%  NA  61%</td>
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<tr>
<td>H2111</td>
<td>UNITEDHEALTHCARE INSURANCE COMPANY</td>
<td>NA  94%  NA  97%  NA  36%  NA  30%</td>
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<tr>
<td>H2112</td>
<td>AETNA HEALTH, INC. (PA)</td>
<td>93%  92%  NA  90%  NA  70%  NA  66%</td>
<td></td>
</tr>
<tr>
<td>H2150</td>
<td>KAISER FNDN HP OF THE MID-ATLANTIC STS</td>
<td>95%  95%  94%  95%  88%  86%  89%  84%</td>
<td></td>
</tr>
<tr>
<td>H5652</td>
<td>UNITEDHEALTHCARE INSURANCE COMPANY</td>
<td>NA  NA  NA  98%  NA  NA  NA  77%</td>
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<tr>
<td>H6609</td>
<td>HUMANA INSURANCE COMPANY</td>
<td>92%  94%  94%  92%  NA  NA  NA  66%</td>
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</table>

Disparities in Clinical Care by Race/Ethnicity and Gender

Percent of clinical care measures (n=24) for which men or women of select racial or ethnic groups experienced better, worse or similar care than white men or women.

- **Worse than Whites**
- **Similar to Whites**
- **Better than Whites**

**Women**
- Asian/PI vs. White: 13%
- Black vs. White: 33%
- Hispanic vs. White: 29%
- Total: 46%

**Men**
- Asian/PI vs. White: 21%
- Black vs. White: 46%
- Hispanic vs. White: 38%
- Total: 42%

Developing and Disseminating Solutions
1) Expand the collection and analysis of standardized data

2) Evaluate disparities impacts and integrate equity solutions across CMS programs

3) Develop and disseminate promising approaches to reduce health disparities

4) Increase the ability of the health care workforce to meet the needs of vulnerable populations

5) Improve Communication and Language Access for Individuals with Limited English Proficiency and Persons with Disabilities

6) Increase physical accessibility of health care facilities
Building an Organizational Response to Health Disparities

To help plans reduce health disparities:

• Resources
  – Readmissions Guide
  – Data Collection
  – Disparities Action Statement

• Health Equity Technical Assistance
Guide to Preventing Readmissions Among Racially & Ethnically Diverse Medicare Beneficiaries

- **Background and Overview of key issues** and strategies related to readmissions for diverse populations
- **Recommendations** for addressing readmissions for diverse populations
- **Case studies** that illustrate how organizations are addressing avoidable readmissions for vulnerable populations in hospital and home-based settings
Disparities Action Statement

A Quality Improvement Tool to help you:

1. **Identify** health disparities faced by populations you serve
2. **Prioritize** and set SMART aims
3. **Plan** your actions to reduce disparities
4. **Monitor** your progress and improve

**Diagram:**

- **STEP 1** Identify vulnerable population(s) & their disparities
- **STEP 2** Set SMART Aims
- **STEP 3** Develop an Action Plan
- **STEP 4** Monitor, Improve & Disseminate
Health Equity Technical Assistance

Learn how to identify, prioritize, and take action on health disparities. Personalized technical assistance focused on strengthening your quality improvement program through a series of consultations from subject matter experts. Specifically, you can access:

• A team of health equity experts
• Personalized TA, coaching, resources based on your needs
• Specialized assistance to help with the DAS process, step by step

To learn more, contact HealthEquityTA@cms.hhs.gov
Current CMS OMH Efforts:  
*From Coverage to Care (C2C)*

- C2C is an effort to help educate consumers about their new coverage and to connect them with primary care and preventive services that are right for them so they can live long, healthy lives.

- Resources online and in print include the Roadmap, Discussion Guide, videos, and more.

- C2C builds on existing networks of community partners to educate and empower newly covered individuals.
From Coverage to Care (C2C) Resources

- Roadmap to Better Care and a Healthier You
- 5 Ways to Make the Most of Your Coverage
- Managing Your Health Care Costs
- Videos
- Enrollment Toolkit
- Prevention Resources
- Partner Toolkit
- Community Presentation

Visit [http://go.cms.gov/c2c](http://go.cms.gov/c2c)
Connected Care
The Chronic Care Management Resource

• An outreach and education campaign targeting professionals and consumers in underserved rural areas, and racial and ethnic minorities.

• CMS established separate payment under billing codes for the additional time and resources spent to provide the between-appointment help to Medicare patients with two or more chronic conditions.

• Services may include:
  • At least 20 minutes a month of chronic care management services
  • Personalized assistance to create a care plan
  • Coordination of care between pharmacy, specialists, testing centers, hospitals, and more
  • Phone check-ins between visits
  • 24/7 emergency access to a health care professional
  • Expert assistance with setting and meeting health goals

Visit: go.cms.gov/ccm
• Decrease Health Disparities in the Quality of Care that Vulnerable Populations Receive
• Promote access to high-quality and culturally competent health care services
• Analyze enrollee data to identify disparities among their enrollees and undertake quality improvement and outreach activities to increase enrollee engagement
Implementing Sustainable Action
Embedding A Focus on Health Equity in CMS Programs

- Accountable Health Communities Model
- Hospital Innovation Initiative Network/Partnership for Patients
- Transforming Clinical Practice Initiative
- Quality Payment Program – Merit-Based Incentive Program
- Everyone with Diabetes Counts
- End Stage Renal Disease Quality Improvement Program

“Working to Achieve Health Equity”
Consists of 3 parts:

- **Statement of Need** – Compares the proposed model population to the broader community population by health status, access to care, and the social determinants;

- **Action Plan** – Provides a plan for engaging with and retaining the subpopulations of focus during model implementation, including potential impact of the model on health disparities, and;

- **Performance Assessment & Data** – Describes how data will be used to track changes in disparities and address them through continuous quality improvement.
In the MIPS and APMs RFI, we requested recommendations on the inclusion of the following five potential new subcategories:

- **Promoting Health Equity and Continuity**, including (a) serving Medicaid beneficiaries, including individuals dually eligible for Medicaid and Medicare, (b) accepting new Medicaid beneficiaries, (c) participating in the network of plans in the FFM or state exchanges, and (d) maintaining adequate equipment and other accommodations to provide comprehensive care for patients with disabilities.

- **Social and Community Involvement**, such as measuring completed referrals to community and social services or evidence of partnerships and collaboration with the community and social services.

- **Achieving Health Equity**, such as for MIPS eligible clinicians or groups that achieve high quality for underserved populations, including persons with behavioral health conditions, racial and ethnic minorities, sexual and gender minorities, people with disabilities, people living in rural areas, and people in geographic HPSAs.

- **Emergency preparedness and response**, such as measuring participation in the Medical Reserve Corps, registration in the Emergency System for Advance Registration of Volunteer Health Professionals, relevant reserve and active duty uniformed services activities, and clinician or group volunteer participation in domestic or international humanitarian medical relief work.

- **Integration of primary care and behavioral health**, such as measuring or evaluating such practices as: Co-location of behavioral health and primary care services; shared/integrated behavioral health and primary care records; or cross-training of MIPS eligible clinicians or groups participating in integrated care.

We are **finalizing the following additional subcategories**: “Achieving Health Equity,” “Integrated Behavioral and Mental Health,” and “Emergency Preparedness and Response.”
Established in 2016, the CMS Rural Health Council focuses on embedding a rural lens in all of the agency’s work with an eye toward improving three dimensions in rural communities:

1. Access to high quality health care,
2. Innovation in care delivery, and
3. Addressing the unique economics of rural health care.
Next Steps on the Path to Health Equity
Looking Ahead

• Continuing to Implement a Dynamic Plan
• Expanding Our Horizons to Include New Areas of Work.
• Strengthening Partnerships
• Evaluating Progress
Potential Opportunities to Focus on the Social Determinants of Health

ASPE Report to Congress on Social Risk Factors and Performance in Medicare VBP Programs, December 2016

• STRATEGY 1: Measure and Report Quality for Beneficiaries with Social Risk Factors
  • Consideration 2: Consider developing and introducing health equity measures or domains into existing payment programs to measure disparities and incent a focus on reducing them.

• STRATEGY 3: Reward and Support Better Outcomes for Beneficiaries with Social Risk Factors
  • Consideration 1: Consider creating targeted financial incentives within value-based purchasing programs to reward achievement of high quality and good outcomes, or significant improvement, among beneficiaries with social risk factors.
  • Consideration 2: Consider using existing or new quality improvement programs to provide targeted support and technical assistance to providers that serve beneficiaries with social risk factors.
Median Per Capita Income among Medicare Beneficiaries by Race/Ethnicity, 2014

Median per capita income among all beneficiaries: $24,150 (Total), $27,450 (White), $16,150 (Black), $12,800 (Hispanic)

Median Per Capita Savings among Medicare Beneficiaries by Race/Ethnicity, 2014

Median per capita savings among all beneficiaries: $91,950

<table>
<thead>
<tr>
<th>Race/Ethnicity</th>
<th>Median Savings</th>
<th>% w/savings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total</td>
<td>$63,350</td>
<td>92%</td>
</tr>
<tr>
<td>White</td>
<td>$91,950</td>
<td>95%</td>
</tr>
<tr>
<td>Black</td>
<td>$12,350</td>
<td>80%</td>
</tr>
<tr>
<td>Hispanic</td>
<td>$9,800</td>
<td>76%</td>
</tr>
</tbody>
</table>

Median among those with savings:
- Total: $78,850
- White: $102,500
- Black: $22,200
- Hispanic: $23,000

Join Us On The Path To Health Equity!
Examples of Colleagues Working with Us To Achieve Health Equity

- CMS Centers and Offices
- HHS Offices of Minority Health
- Federal Office of Rural Health Policy
- National Center for Health Statistics
- Census Bureau
- RAND
- NCQA
- NORC
- National Quality Forum Disparities Standing Committee
- Institute for Diversity in Health Management
Learn More About CMS OMH

CMS Office of Minority Health

Mapping Medicare Disparities Tool

CMS Equity Plan for Medicare

Chronic Care Management Services

Stratified Reporting: New Data

Health Equity Blog

Spotlight

Chronic Care Management Services

Learn about the latest changes to Medicare’s payment policy for physician services related to chronic care management.

Details

CMS Office of Minority Health

The CMS Office of Minority Health offers a comprehensive source of information on eliminating health disparities and improving the health of all minority populations, like racial and ethnic minorities, people with disabilities, members of the lesbian, gay, bisexual, and transgender community, and rural populations.

go.cms.gov/omh
Get Involved!

www.cms.gov

• CMS Open Door Forums – Find out about upcoming changes and get your questions answered.

• Medicare Learning Network and MLN Connects® Provider eNews – Get provider resources on CMS programs, policies and initiatives, such as Medicare Shared Savings Program.


• NPRMs and RFIs – Tell us what you think!

• Join the Listserve - https://www.cms.gov/Newsroom/Newsroom-Center.html
Conclusion

“A journey of a thousand miles begins with a single step.” (Lao-tzu, 604 BC - 531 BC)

Together we can ensure that all Americans have access to quality affordable health coverage, and that health disparities are eliminated.