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Accelerating Health Equity by Measuring and Paying for Results

With increased focus on transforming the health care system into one that rewards value over volume, the use of and reliance on quality measurement continues to grow. Measurement is used throughout the health care system to evaluate clinical outcomes, patient experiences, and the efficiency of care delivery; increasingly, quality measurement is used to help determine payments for providers. But measurement initiatives to date have largely failed to measure equity.

This paper will illustrate how not measuring and paying for equity is not only a significant missed opportunity to drive reductions in health disparities, but even risks worsening disparities. We also describe actionable opportunities for both state and federal governments to measure and pay for equity.

These state and federal opportunities are actionable, but they are not without implementation challenges. Alternative payment models that incentivize health equity will require accurate collection of race and ethnicity data and valid measures of equity. California and Oregon have begun serious work on these implementation challenges, as described below. If we as a country are going to move forward towards a more equitable health care system, it is time to take on these challenges in the actual design of these models at the state and federal level.

Individual providers, health care delivery systems, and health insurance plans must now report on a wide array of quality measures and, increasingly, they are financially rewarded—or penalized—depending on their performance on these measures. Despite the ubiquity of quality measurement initiatives, measurement remains an underused tool for reducing health disparities. It is often assumed that the delivery of high-quality care will necessarily be equitable, and that improving health care quality overall will, in itself, lead to a reduction in health disparities.[1]

However, the data show that improvements in health equity do not automatically follow improvements in health care quality. For example, state-level data show that some states that rank in the top quartile (that is, highest quality) for overall quality of care also rank in the bottom quartile (worst disparities) for disparities

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in quality of care for Black, Hispanic, and Asian people compared to whites.[2] Similarly, some of the wealthiest regions of California have the largest disparities in receipt of a blood glucose test, a key measure of the quality of care for people with diabetes. In those regions, high quality of care and good health outcomes are present for only some groups; in other regions of the state, the disparities are smaller because the overall health and quality of care are lower.[3]

As quality measurement is increasingly used to determine payments to providers and health plans, we must both measure health care disparities and directly incentivize their reduction. Quality measures first must be stratified by race and ethnicity at a minimum, as well as by language, disability, and other important factors. Delivery system and payment transformation efforts must directly incentivize the reduction of disparities by basing financial incentives not only on overall performance on quality measures, but directly on the reduction of existing disparities in these quality measures.

Measuring and Paying for Equity at the State Level

Leveraging Medicaid system transformation efforts: Lessons from Oregon

The system transformation efforts of state Medicaid programs present key opportunities to improve the use of stratified quality measures to directly support the advancement of health equity. As Medicaid covers 21 percent of the total population,[4] and 39 percent of all children,[5] the program has a powerful ability to shape the health care system and to affect health equity. In every state, the Affordable Care Act requires the collection of race and ethnicity information in Medicaid and the Children's Health Insurance Program (CHIP).[6] In states pursuing a Medicaid system transformation initiative, technical assistance or additional upfront financial support may be available as part of the initiative that providers could use to improve the collection and reporting of quality measures.[7] These initiatives may also include provisions in a Medicaid waiver or in value-based contracts with Medicaid managed care plans or providers to develop disparity reduction plans or partnerships with social and community services. These planning requirements are important, but they are inadequate to drive changes to care delivery: They must be informed and built upon through the availability of stratified quality measure data.[8]

Oregon's Medicaid system transformation, supported by an 1115 Medicaid waiver first obtained in 2012, offers an instructive lesson on how Medicaid system transformation efforts can be used to advance equity with improved measurement and reporting, in contrast to more general Medicaid quality improvement initiatives that do not focus on equity. Oregon's Medicaid system transformation is centered on Coordinated Care Organizations (CCOs). CCOs are networks of physical, behavioral, and oral health care providers that work collaboratively to improve health outcomes and reduce health care costs in specific geographic areas of the state, and that receive risk capitation contracts as Medicaid managed care plans. Along with per-member-per-month capitation payments, CCOs can receive additional performance-based payments depending on how well they do on certain quality measures.[9]

Importantly, health equity is an explicit focus of this initiative. In their contracts with the Oregon Health Authority (OHA), CCOs are committed to eight transformation areas, including "Developing a quality improvement plan focused on eliminating racial, ethnic, and linguistic disparities in access, quality of care, experience of care and outcomes." Additionally, as part of the waiver, OHA is committed to publicly reporting performance on quality measures, many of which are stratified by race and ethnicity.[10]

This stratification of quality measures has allowed for the identification of disparities within certain quality measures. For example, one measure linked to financial incentives for CCOs is the rate of emergency department utilization, with lower rates rewarded as an indicator of more appropriate use of care. For 2017, the statewide performance on this measure was 46.7, a decrease from 61.0 in 2011, demonstrating significant improvement on this measure overall. Yet in 2017, the rate for African Americans was still 67.6, even higher than the statewide rate in 2011 (figure 1, page 4).[11]

Oregon has taken an important step in capturing plan performance using stratified measures, but it is not yet paying plans based on the results. CCOs earn a performance-based payment by meeting the benchmark on these incentive measures in the aggregate rather than in their stratified form. Yet even when the benchmark is met overall, Oregon's stratification of quality measures by race and ethnicity shows some groups remain below the benchmark. For example, in 2017 all CCOs met the benchmark of 20 percent for the percentage of children between 6 and 14 years old who received a dental sealant. Yet the percentage for Hawaiians and Pacific Islanders still fell below the benchmark, at 18.1 percent (figure 2, page 4).[12]

Stratifying performance measures can reveal how disparities shrink or grow over time. For example, between 2016 and mid-2017, statewide performance on the percentage of beneficiaries who received a follow-up visit after a hospitalization for mental illness increased nearly 3 percent; Asian Americans experienced the greatest improvement, from 80 percent to 90 percent. Conversely, the percentage of African Americans receiving a follow-up visit declined from 82 percent to 70 percent (figure 3, page 5). (For this measure, race and ethnicity data were missing from nearly 26 percent of Medicaid beneficiaries for this mid-2017 measurement, and thus should be analyzed with caution.[13])

FIGURE 1

Oregon emergency department utilization rates, 2017

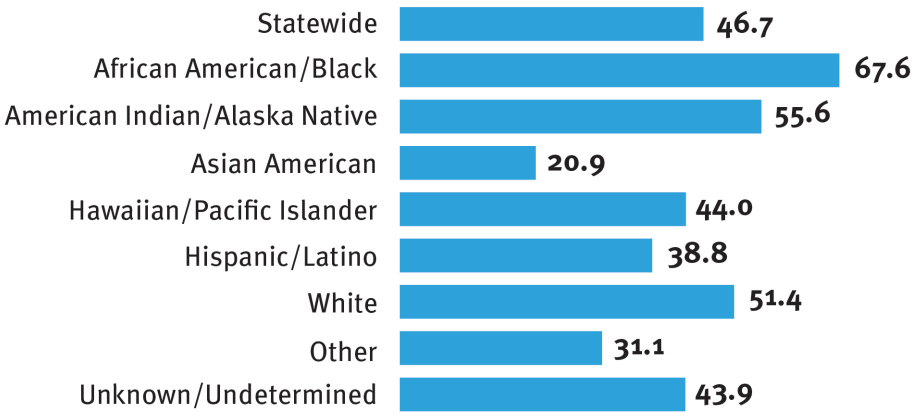


FIGURE 2

Oregon dental sealants on permanent molars for children, 2017

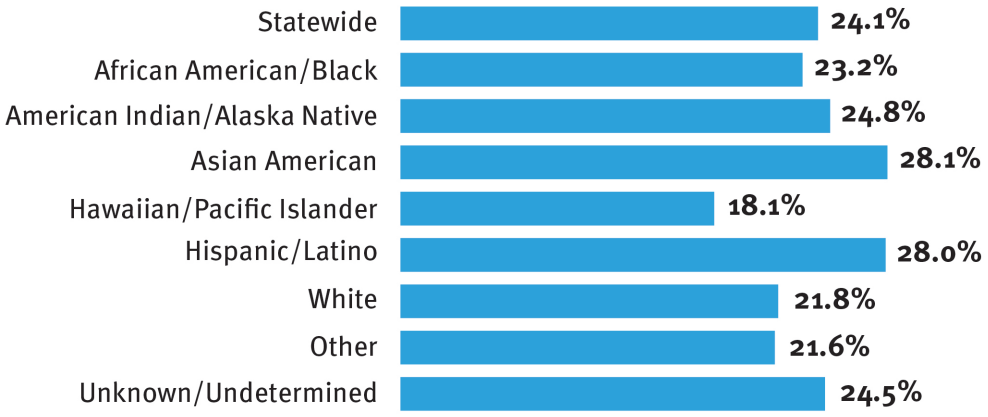
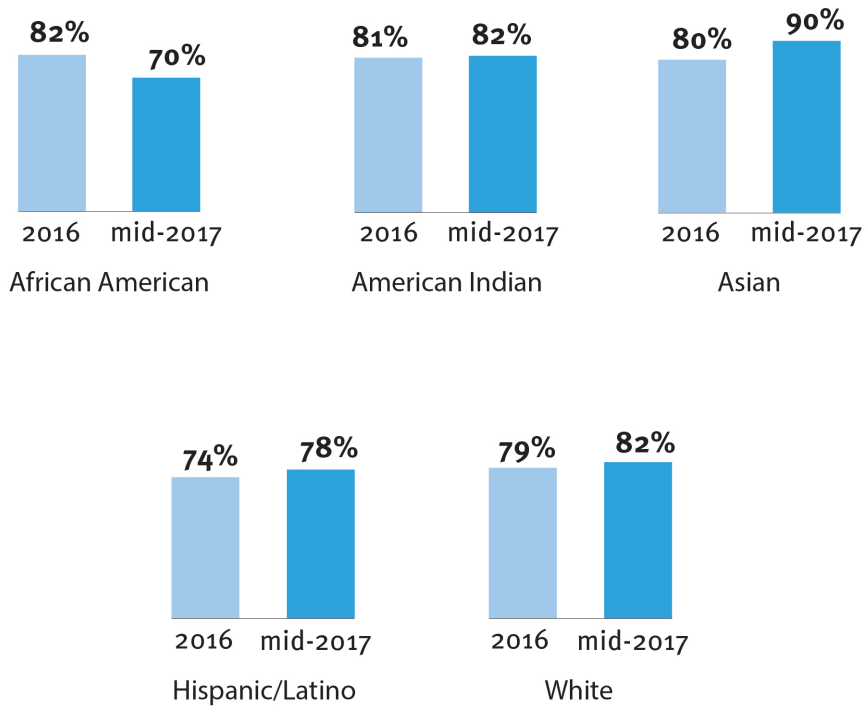


FIGURE 3

Follow-Up After Hospitalization for Mental Illness



Like several other states,[14] Oregon has required Medicaid managed care plans or other accountable entities to design and implement quality improvement plans for reducing disparities. Even in the absence of payment based on narrowing disparities, merely capturing these stratified quality measures can help inform CCOs' equity plans. And measure stratification can itself produce more equity-focused plan interventions: Given CCOs' financial incentives for improving their aggregate performance on quality measures, they may use the additional information from stratified quality measures to focus their resources and strategies on the communities with the most room for improvement.

But Oregon now has the potential to take further action—to utilize its stratified measurement to pay plans based on stratified performance. The OHA has

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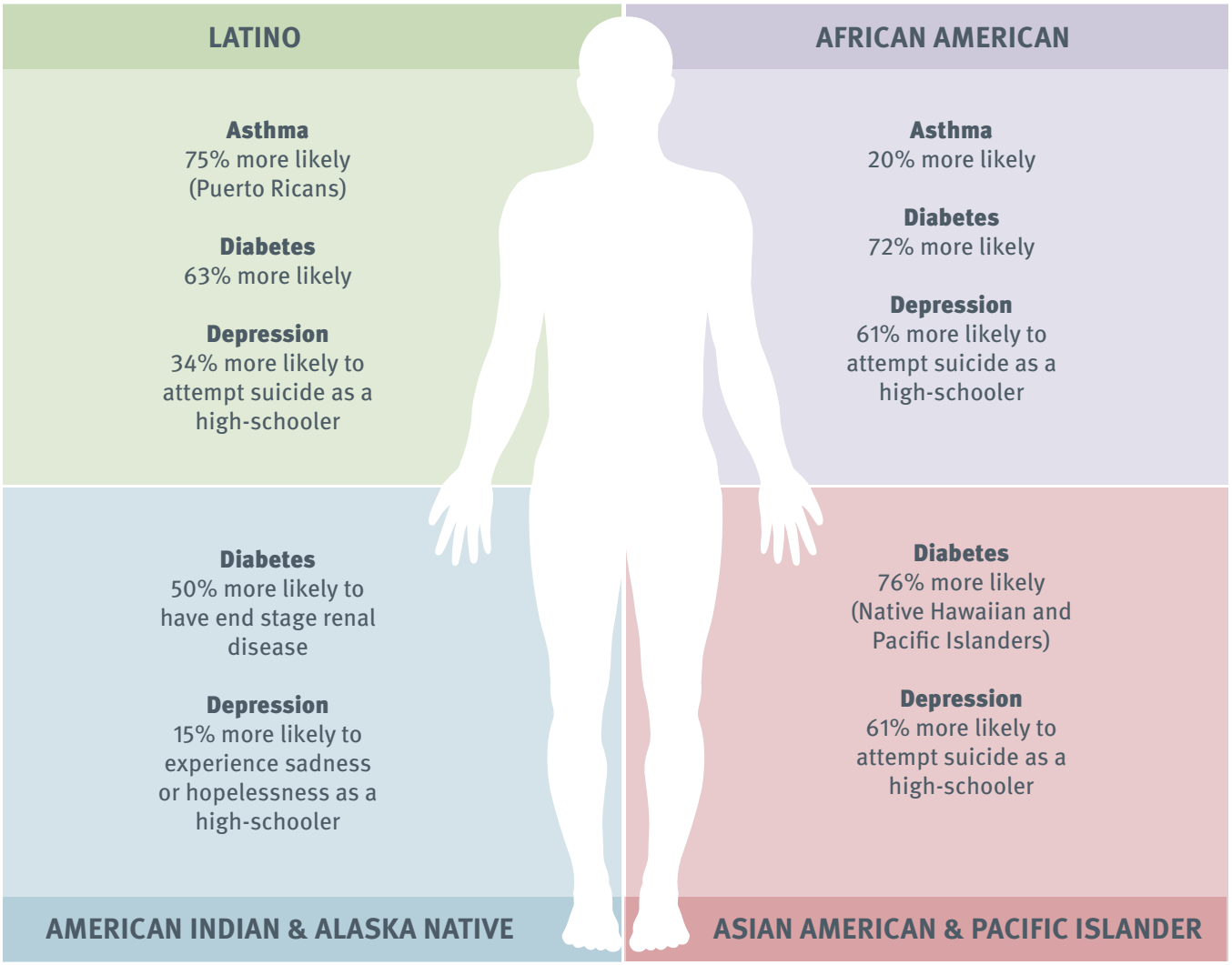
indicated that the next phase of system transformation ("CCO 2.0") will include additional financial incentives that are more directly tied to achieving health equity. The Request for Applications from organizations seeking to serve as CCOs in this next phase notes that the OHA will establish the Social Determinants of Health-Health Equity Capacity-Building Bonus Fund, which will provide additional bonus payments for CCOs that meet related performance milestones.[15] These milestones could include process measures, such as forming community partnerships, as well as outcome measures for successfully addressing social determinants of health and health equity issues, as captured by stratified quality measures.[16] Oregon has formed a work group focused on finalizing and implementing payment incentives for improved health equity in its CCO program, including ways to ensure sufficiently robust information on race and ethnicity of Medicaid beneficiaries. This is a critical opportunity for Oregon to directly incentivize and reward CCOs that demonstrate actual reductions in health disparities.

Leveraging quality measurement requirements in health plans: Lessons from California

States can also use their oversight and regulation of health plans to drive reductions in health disparities through equity-focused quality measurement. They can use their contracts with plans serving as Medicaid managed care plans or serving consumers on a state-based marketplace to require the collection and reporting of particular quality measures and to implement value-based payment arrangements that reward plans that meet certain performance targets for quality measures. States can choose to contract only with plans that that have a history of best serving communities of color and other communities that experience health disparities.

Covered California—California's state-based marketplace—is using these opportunities to promote health equity, with a focus on four chronic conditions (asthma, depression, diabetes, and hypertension), each of which has documented racial and ethnic disparities. Covered California initially required each qualified health plan (QHP) to report quality measures for these conditions by race and ethnicity and by sex—not just for Marketplace enrollees but also for enrollees in that plan's Medicaid managed care and employer



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coverage products, beginning in 2017.[17] Importantly, it also required plans to demonstrate reductions in disparities in quality measures related to each of these conditions.[18] Covered California also required plans to maintain self-reported[19] race and ethnicity data for at least 80 percent of their enrollees by 2019,[20] which will help address a critical challenge in stratifying quality measures and in holding plans or providers accountable for reducing disparities. California's effort shows that accurate measure stratification is not a minor undertaking: The challenges of collecting accurate plan level disaggregated data in a state with county-level plans have led to delays in implementing these reporting and disparities reductions requirements.[21] If California and other states are to move forward effectively in improving health equity, learning to build accurate systems for direct accountability for reporting and reducing health disparities is clearly a necessary condition.

Advocate and Policymaker's Checklist: Improving Quality Measurement to Achieve Equity

Although this checklist is designed for state-level advocates and policymakers, these questions can also be used to assess gaps and identify opportunities in federal health care programs and system transformation efforts.

What quality measure reporting programs exist in your state?

- What measures do QHPs and Medicaid managed care plans report?
- Do any Medicaid waivers, Delivery System Reform Incentive Payment (DSRIP) initiatives, or other value-based or alternative payment models have different quality measure requirements?

Are any of the quality measures stratified by race and ethnicity?

- Do the race and ethnicity categories capture the diversity of your state or community?*
- Are the stratified quality measures reported publicly?
- How else should these measures be stratified (e.g., by language, disability, gender identity, etc.)?

Are plans and providers incentivized to reduce disparities?

- Do any incentives or requirements exist for plans or providers to appropriately collect and report race and ethnicity data?
- Are there bonus payments for providers or plans that reduce disparities?
- Do plans that reduce disparities receive any benefits that could boost their enrollment or better position them for state contracts?

*Race and ethnicity data are often reported only by broad racial or ethnic categories (e.g., Latino, Asian American). Collecting and reporting quality measures at a more detailed level (e.g., Puerto Rican or Korean American) ensures that important disparities are not overlooked.

Measuring and Paying for Equity at the Federal Level

The federal government has two large, and interrelated payment levers for health equity: the Medicare program, and Medicare and multi-payer demonstrations run by the Center for Medicare and Medicaid Innovation (CMMI). We describe them below.

Leveraging system transformation efforts: Current status and potential next steps for CMMI

Through CMMI, the federal government is a significant driver of the movement toward a more value-based health care system. CMMI, which was created by the Affordable Care Act, is charged with testing new ways to deliver and pay for health care services through Medicare, Medicaid, and CHIP that are designed to lower costs and improve the quality of care.

To date, CMMI's efforts on health equity have focused on planning at the agency and awardee levels, although it should be noted that reducing disparities is not an explicit part of its statutory charge. In 2015 the Centers for Medicare and Medicaid Services (CMS) released "The CMS Equity Plan for Improving Quality in Medicare," which included a goal for integrating equity across CMS programs, including CMMI. One outcome of this plan was the development of a Disparities Action Statement, a tool that can help organizations identify and address disparities. Three recipients of the Health Care Innovation Awards, which CMMI administers, committed to using the tool. CMMI included a similar assessment tool, the Health Resource Equity Statement, in the scored part of the application for the Accountable Health Community model. Including equity planning in the scoring for Accountable Health Community funding is consistent with the model's focus on addressing the social determinants of health, which is an important aspect of achieving health equity.[22]

Although assessment tools and plans that seek to integrate a health equity lens throughout an organization or particular care delivery model are welcome and necessary, these approaches still fail to directly measure the impact of new delivery and payment models on disparities or to link performance on disparities to the financial incentives embedded in many of these models.

Many of the new delivery and payment models implemented by CMMI incentivize participating providers to improve coordination and management of their patients' chronic conditions in order to reduce costs while still meeting specified targets for quality measures. The models differ, but generally, if participating providers or organizations meet both the cost savings and quality measure targets, participants can keep a portion of those savings. For some models, participating providers must also pay financial penalties to CMS if they do not meet those targets.[23]

However, these quality targets are based on overall, aggregated performance on quality measures. Aggregated targets cannot measure whether model participants are effectively reducing disparities in quality measures, or even letting some racial and ethnic groups fall further behind. CMMI's practice of using aggregated measurement even applies to its program evaluations: Publicly released annual and final evaluation reports do not stratify quality outcomes by race and ethnicity,[24] and publicly available data files for the Medicare Shared Savings

Aggregated targets cannot measure whether model participants are effectively reducing disparities in quality measures, or even letting some racial and ethnic groups fall further behind.

Accountable Care Organizations (ACOs)—the largest CMS value-based payment program—include only an ACO's overall performance on a quality measure.[25] Even the evaluation of the ACO Investment Model—a program specifically designed to foster ACO development in underserved areas—did not stratify outcomes based on race and ethnicity.[26]

CMMI's failure to either stratify measurement or incentivize equity is a significant missed opportunity to advance equity, and might even mask widening disparities. This is particularly worrisome given evidence that ACOs that serve higher proportions of beneficiaries of color score lower overall on quality measures, and that beneficiaries who were already at low risk may be benefiting more than higher-risk beneficiaries in ACOs.[27, 28] CMMI should require the stratification and public reporting of quality measures by race and ethnicity throughout its models, and it should introduce payment incentives for the reduction of disparities in the Medicare Shared Savings ACO program.

Leveraging quality measurement requirements in health plans: Lessons from Medicare Advantage

Just as with states, the federal government could use its regulation and oversight of health plans to drive reductions in health disparities with more equity-focused quality measurement requirements that are directly tied to plan payment or other core incentives for plans (such as consumer-facing ratings). CMS now offers three exchange or marketplace-type structures in which it pays plans and offers consumers a choice of plans: QHPs on the federally-facilitated marketplace, Medicare Advantage (MA) plans, and Medicare Part D Prescription Drug Plans (PDPs). CMS has taken important steps in recent years to increase transparency regarding disparities in quality measures for MA plans and PDPs.[29] Beginning in 2016, CMS began releasing a national-level report that looked at disparities in clinical care and experience of care. As of 2018, the report now reports on disparities by race and ethnicity, sex, and the intersection of race and ethnicity and gender.[30] Each year, CMS provides downloadable spreadsheets that stratify these quality measures by race and ethnicity at the contract level for MA plans and PDPs, and by state for traditional Medicare. However, no

data are available for many of these measures except for white beneficiaries, due to small sample sizes or other data reliability issues for other race and ethnicity categories.[31]

As part of its effort to measure quality, CMS has designed similar star ratings programs for QHPs, MA plans, and PDPs. These programs rate a plan's performance overall and within specific quality categories. The system assigns five stars to the highest-performing plans, down to one star for the lowest-performing plans.[32] These ratings are reported publicly to help consumers choose the plans they deem best for themselves.

The star ratings program for MA plans is a potentially powerful example of how quality measurement in these federal health care programs could be improved to address health equity more directly. Four- and five-star plans receive bonus payments from Medicare; billions of dollars are at stake through these bonuses.[33] Five-star plans can also enroll new members throughout the year, not only during open enrollment or special enrollment periods,[34] giving these plans an advantage in increasing their enrollment. Star ratings are presented on the consumer-facing Medicare Plan Finder, and plans that receive only one or two stars for three years in a row are identified with an additional warning symbol.[35]

However, despite the documented disparities both between and within MA plans, these differences in quality measure performance by race and ethnicity do not affect MA plan payments in any way, as was explicitly affirmed in CMS guidance.[36] And these disparities are not reflected in the star ratings that drive plan bonus payments and that consumers are advised to use in selecting a plan. Excluding disparities rankings from star ratings not only keeps CMS from paying plans based on equity performance, it prevents beneficiaries of color from knowing which plans perform better for their particular community.

CMS has taken a critical first step in attempting to stratify quality performance data by race and ethnicity at the contract level. However, to achieve meaningful reductions in disparities, there must be more direct financial and enrollment incentives to appropriately collect race and ethnicity data and to reduce disparities in quality measures.

Conclusion

To date, quality measurement initiatives have largely ignored the issue of health equity, missing a key opportunity to drive reductions in health disparities and risking inadvertent widening of disparities. State and federal policymakers should take advantage of system transformation efforts and their oversight of health plans to ensure that quality measures are stratified by race and ethnicity and that reducing disparities in these measures is directly incentivized.

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