Health Equity Regulatory Requirements

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Centers for Medicare and Medicaid Services

Agenda

- **Introductions**
  - HANYS AHEI team
  - AHEI faculty
- **Our partners**
- **Session 1:**
  - Health Equity Regulatory Requirements
- **Upcoming sessions**

HANYS AHEI team

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Theresa Green, PhD, MBA

Director, *Community Health Policy and Education, Center for Community Health and Prevention, University of Rochester Medical Center*

Our funder and partner

Our funder

Funding from the Mother Cabrini Health Foundation allows HANYS to expand its capacity to provide education, direct support, tools and data to our members in a strategic way. With this learning collaborative, we strive to effect lasting change in health equity at the local level by engaging providers and community stakeholders to address health disparities.

Our partner

DataGen develops custom analytics for participants to help them understand how and where communities are affected by health disparities so they can develop tailored interventions.

Presenter

Michelle Schreiber, MD

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Monitoring and Measuring Disparities in Health

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CMS Strategic Pillars

ADVANCE EQUITY

Advance health equity by addressing the health disparities that underlie our health system

EXPAND ACCESS

Build on the Affordable Care Act and expand access to quality, affordable health coverage and care

ENGAGE PARTNERS

Engage our partners and the communities we serve throughout the policymaking and implementation process

DRIVE INNOVATION

Drive Innovation to tackle our health system challenges and promote value-based, person-centered care

PROTECT PROGRAMS

Protect our programs' sustainability for future generations by serving as a responsible steward of public funds

FOSTER EXCELLENCE

Foster a positive and inclusive workplace and workforce, and promote excellence in all aspects of CMS's operations

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CMS National Quality Strategy Goals

The Eight Goals of the CMS National Quality Strategy are Organized into Four Priority Areas:

Equity

Advance health equity and whole-person care

Engagement

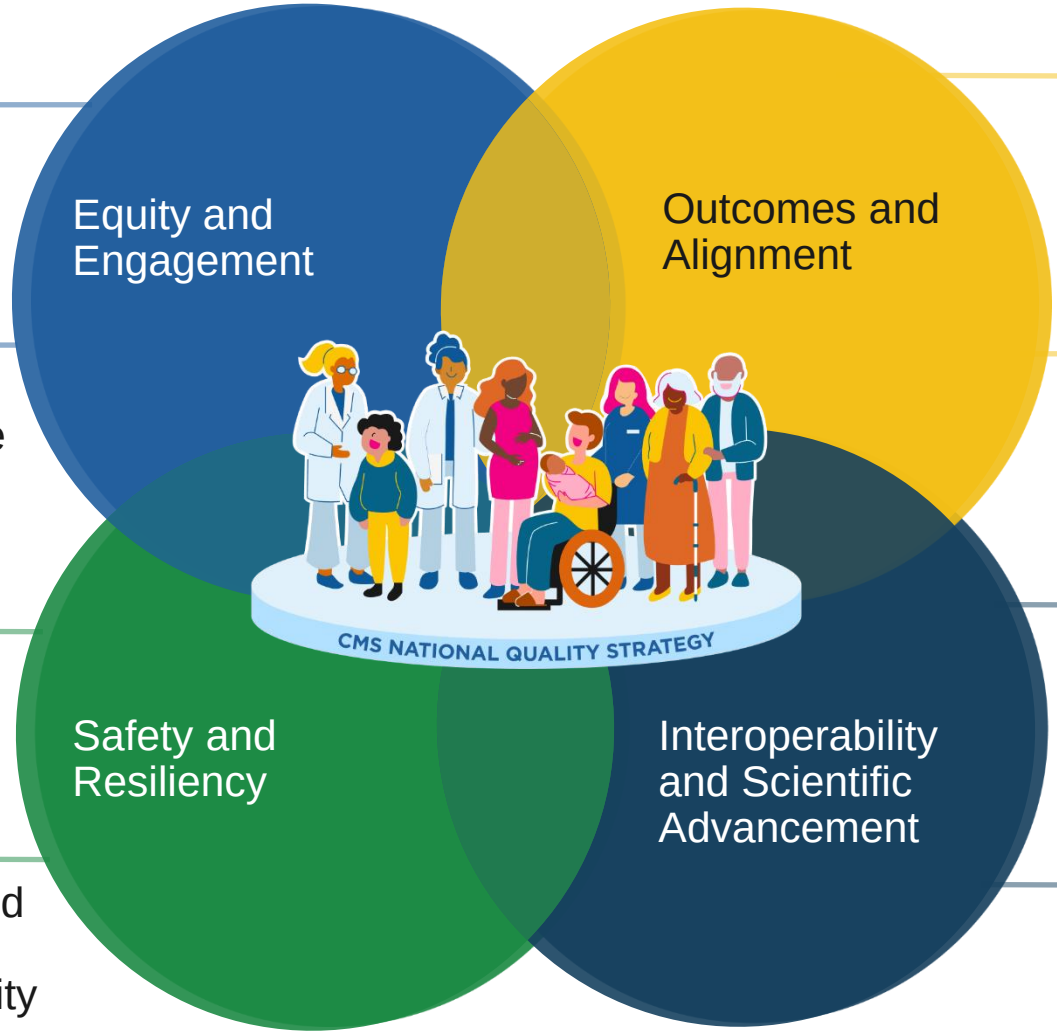
Engage individuals and communities to become partners in their care

Safety

Achieve zero preventable harm

Resiliency

Enable a responsive and resilient health care system to improve quality



Outcomes

Improve quality and health outcomes across the care journey

Alignment

Align and coordinate across programs and care settings

Interoperability

Accelerate and support the transition to a digital and data-driven health care system

Scientific Advancement

Transform health care using science, analytics, and technology

Definition of Equity

- **Health equity** means the attainment of the highest level of health for all people, where everyone has a fair and just opportunity to attain their optimal health regardless of race, ethnicity, disability, sexual orientation, gender identity, socioeconomic status, geography, preferred language, or other factors that affect access to care and health outcomes.

- CMS is working to advance health equity by designing, implementing, and operationalizing policies and programs that support health for all the people served by our programs, eliminating avoidable differences in health outcomes experienced by people who are disadvantaged or underserved, and providing the care and support that our enrollees need to thrive.

Health Equity

CMS defines health equity as the attainment of the highest level of health for all people, where everyone has a fair and just opportunity to attain their optimal health.

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CMS Framework for Health Equity

- Operationalize health equity across all CMS programs: Medicare, Marketplace, Medicaid, and CHIP
- Is evidence-based and informed by decades of research and stakeholder input
- Review the framework: go.cms.gov/framework
- WH Executive Order 13985 – 2/16/23

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CMS Framework for Health Equity: 5 Priority Areas

Priority 1: Expand the Collection, Reporting, and Analysis of Standardized Data

Priority 2: Assess Causes of Disparities Within CMS Programs, and Address Inequities in Policies and Operations to Close Gaps

Priority 3: Build Capacity of Health Care Organizations and the Workforce to Reduce Health and Health Care Disparities

Priority 4: Advance Language Access, Health Literacy, and the Provision of Culturally Tailored Services

Priority 5: Increase All Forms of Accessibility to Health Care Services & Coverage

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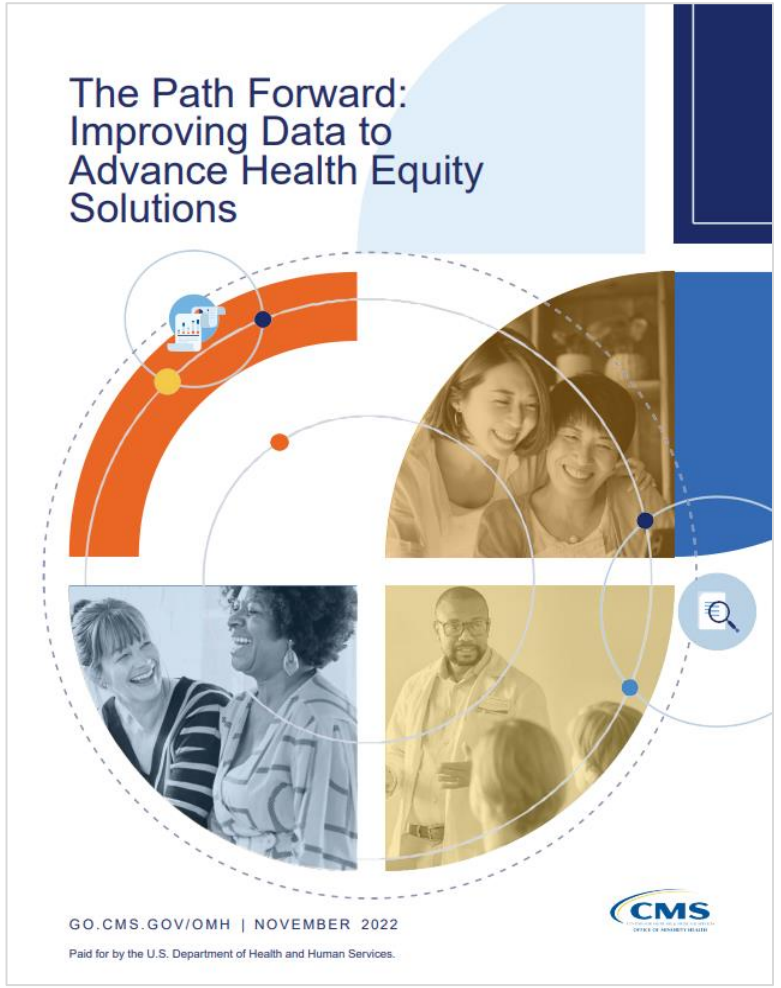
The Path Forward: Improving Data to Advance Health Equity Solutions

In November 2022, CMS OMH released a white paper, *The Path Forward: Improving Data to Advance Health Equity Solutions*, which outlines*:*

- The current state of health equity data collection across CMS programs
- Progress to date in improving CMS data collection
- Future actions to continue to improve health equity data

Health equity data is the combination of quantitative and qualitative elements that enable the examination of health differences and their causes between populations



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CMS OMH Initiatives to Improve Data Collection: Current State

Sociodemographic Data Type	Current State of Collection*			
	Marketplace®‡	Medicare Advantage***	Medicaid and CHIP†	Marketplace®‡
Sex				
Geography				
Language				
Disability Status				
Income				
Race/Ethnicity				
Sexual Orientation and Gender Identity				

- Collected aligned to 2011 HHS standards
- Collected with no major issues, no adopted standards
- Collected with standards and/or completeness issue(s)
- Not Collected

* The data elements included in this table are the same as those prioritized in Executive Order 13985 and the CMS Framework for Health Equity, and do not encompass all data elements that could be collected or improved.[1,3] This table does not reflect quality and completeness issues in all cases.

** Data received from SSA and collected via surveys detailed in the sections below.

*** Data collected from Medicare Part C/D enrollment form and various surveys detailed in the sections below, supplemented as needed with SSA data from Fee-for-Service Medicare.

† Data reported from states in the Transformed Medicaid Statistical Information System (T-MSIS).

‡ Data collected from the Marketplace programs using Healthcare.gov platform. Because CMS does not closely regulate data collection on State-Based Exchanges, this table shows data collected on the Federally-Facilitated Exchanges only.

Data Strategies

- No clear consensus on the data that should be collected
  - OMB and OMH are working on developing new standards
- Standardized data elements have been developed
  - Gravity Project
  - USCDI
- Use of imputation models
- Stratification of data important, but no clear consensus on how to stratify
  - Dual eligibility
  - Race, ethnicity
  - SDOH
  - Geographic methods – ADI, SVI, others
  - Other issues – social isolation, disability, Low Income Subsidy

CMS OMH Initiatives to Improve Data Collection: Progress to Date

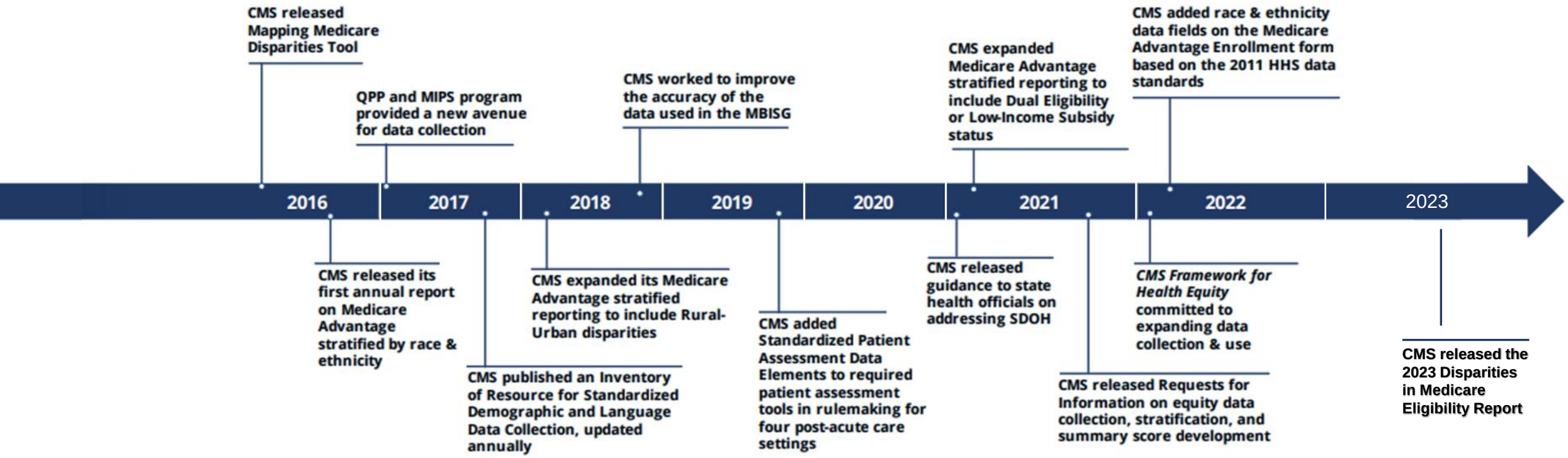


Figure 1: Illustrative Examples of CMS Progress to Date on Health Equity Data Improvement

CMS OMH Initiatives to Improve Data Collection: Vision for the Future

- Filling gaps in existing data
- Collecting new data elements
- Aligning data to standards
- Disaggregating data
- Continuing development of equity scores
- Releasing resources
- Addressing bias
- Acting on feedback

CMS National Quality Strategy: Advance Health Equity and Whole-Person Care

Address disparities, structural racism, and injustices that underlie our health system, both within and across settings, to eliminate gaps and ensure equitable access and care for all.

- Develop standardized approach to collection of patient reported data
- Develop standardized approach to stratification for appropriate measures
- Leverage quality and value-based programs to publicly report and incentivize closing equity gaps
- Support equity through performance metrics, regulations, oversight through survey and conditions of participation, and Quality Improvement assistance

CMS Quality Measurement Equity Action Steps

Highlights

- Implementation of Equity Measures in quality/VBP programs
- MA Stars – Proposal for rewarding excellent care for underserved populations (stratify by duals/low income, disability)
- MIPS – several proposed improvement activities to support equity
- Marketplace – Issuers must address health and health care disparities as a specific topic area within their Quality Improvement Strategy; issuers required to collect and report stratified data on select measures
- Stratification of Performance Metrics and Confidential Reporting
- Commitment to embed equity in all Value Based Purchasing as appropriate
- IPPS/SNF rules – Rewarding Excellent Care for Underserved Populations

CCSQ: Leveraging **Quality Measurement** to Identify and Close Equity Gaps
New Measures in the Hospital Inpatient Quality Reporting Program

Measure Name	First Data Collection Period	Data Submission Deadline
Hospital Commitment to Health Equity	CY 2023	First Submission Due: May 15th 2024 Collected Annually
Screening for Social Drivers of Health	Voluntary CY 23; Mandatory CY 24	First Voluntary Submission Due: May 15th 2024 Collected Annually
Screen Positive Rate for Social Drivers of Health	Voluntary CY 23; Mandatory CY 24	First Voluntary Submission Due: May 15th 2024 Collected Annually

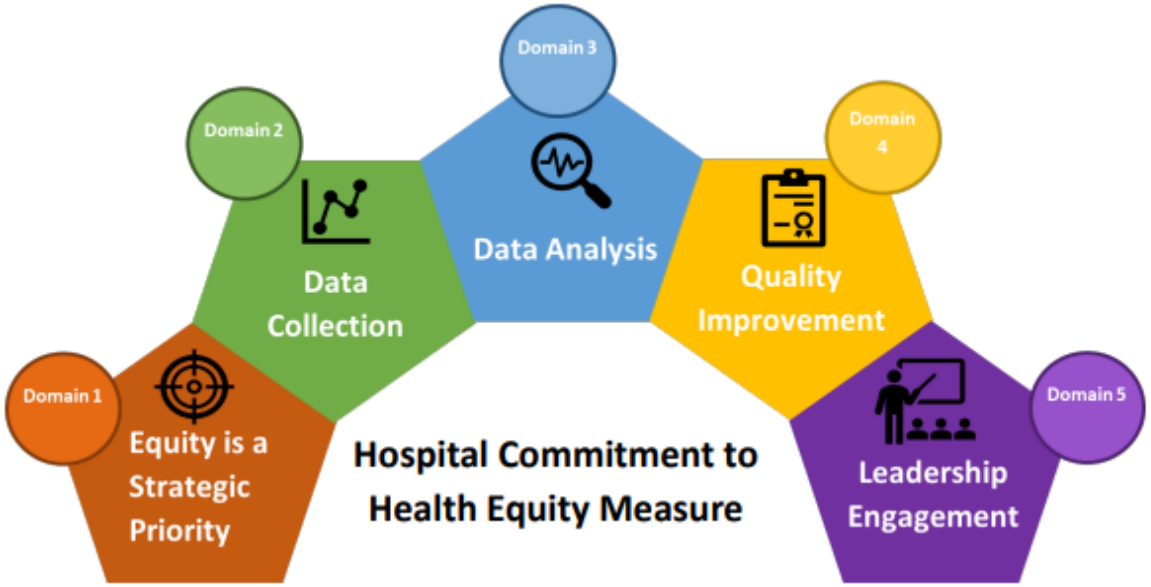
Measure #1: Hospital Commitment to Health Equity

- Structural measure that assesses hospital commitment to health equity using a suite of equity-focused organizational competencies aimed at achieving health equity

- Includes five attestation domains

- Numerator: the total number of domain attestations that the hospital is able to affirm

- Denominator: each domain will be represented as a point, for a total of 5 points (one per domain)



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Measure #2: Screening for Social Drivers of Health

- Assesses whether a hospital implements screening of all patients that are 18 years or older at time of admission for health-related social needs (HRSNs) including: food insecurity, housing instability, transportation needs, utility difficulties, and interpersonal safety.

- Requires that patients be screened for all five HRSNs.

- Numerator: the number of patients admitted to an inpatient hospital stay who are 18 years or older on the date of admission and are screened for all five HRSNs.

- Denominator: the number of patients who are admitted to a hospital inpatient stay and who are 18 years or older on the date of admission.

Measure #3: Screen Positive Rate for Social Drivers of Health

- Captures the magnitude of unmet social need, based upon HRSN screening, among patients admitted for an inpatient hospital stay and who are 18 years or older on the date of admission.

- Numerator: the number of patients admitted for an inpatient hospital stay who are 18 years or older on the date of admission, who were screened for a HRSN, and who *screen positive* for having a need in one or more of the previous five HRSNs (calculated separately).

- Denominator: the number of patients admitted for an inpatient hospital stay who are 18 years or older on the date of admission and are screened for all five HRSNs during their hospital inpatient stay.

Equity Metrics Across Programs

- IQR- HCHE, SDOH – mandatory in 2024
- HVBP – Rewarding excellence for underserved pops
- HOQR, ASC, REH – Under consideration FCHE and SDOH
- Cancer, IPF – FCHE mandatory 2024; SDOH mandatory 2025
- ESRD – FCHE 2024; SDOH 2025
- Post Acute Care – data collected through assessment instruments
- MIPS – SDOH voluntary 2023; Connection to community service provider voluntary 2024
- MA Quality Bonus Program – Bonus points for excellent care for underserved populations

FCHE – Facility Commitment to Equity

SDOH – Social Drivers of Health screening and Percent Positivity

Stratification of Metrics

- CMS has started providing confidential feedback information on select measures for equity
  - Readmission
  - Evaluating mortality
  - Spreading across all programs
- How to stratify?
  - Race, ethnicity
  - Duals
  - Low Income Subsidy
  - Disability
  - ADI or other geographic dependent variables
  - SDOH variables

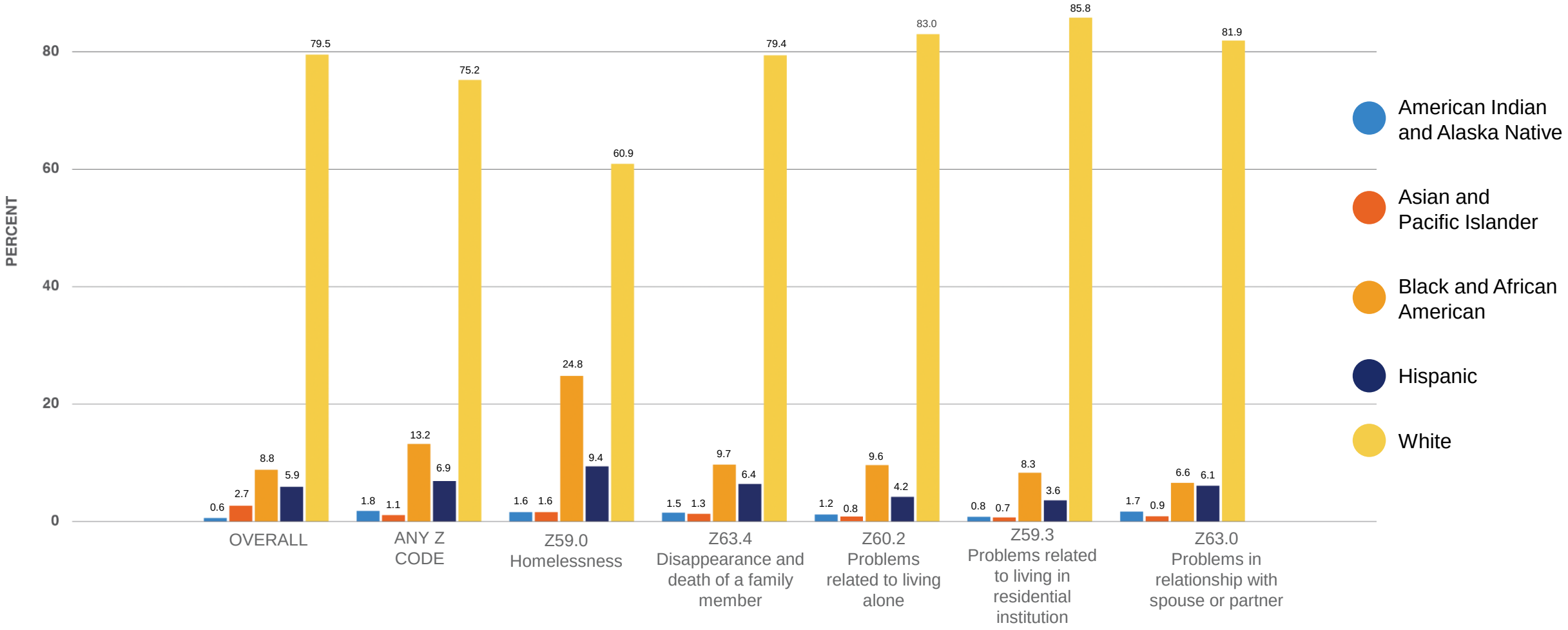
Rewarding Excellence for Underserved Populations (REUP)

- **The CMS Strategy to Promote Equity in Quality and Value Programs**
- Douglas B. Jacobs, MD, MPH[1]; Michelle Schreiber, MD[1]; Meena Seshamani, MD, PhD[1]
- *JAMA Health Forum.* 2023;4(10):e233557. doi:10.1001/jamahealthforum.2023.3557. Oct 20, 2023
- Incentives/upside only additional points/dollars for excellence in care for underserved populations – HVBP, SNFVBP, MA QRP, ACO

CLAS

- National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care
- 15 standards in 4 categories
  - Principle Standard – Provide effective, equitable, understandable and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy and other communication needs
  - Governance, Leadership and Workforce standards
  - Communication and Language Assistance standards
  - Engagement, Continuous Improvement and Accountability Standards

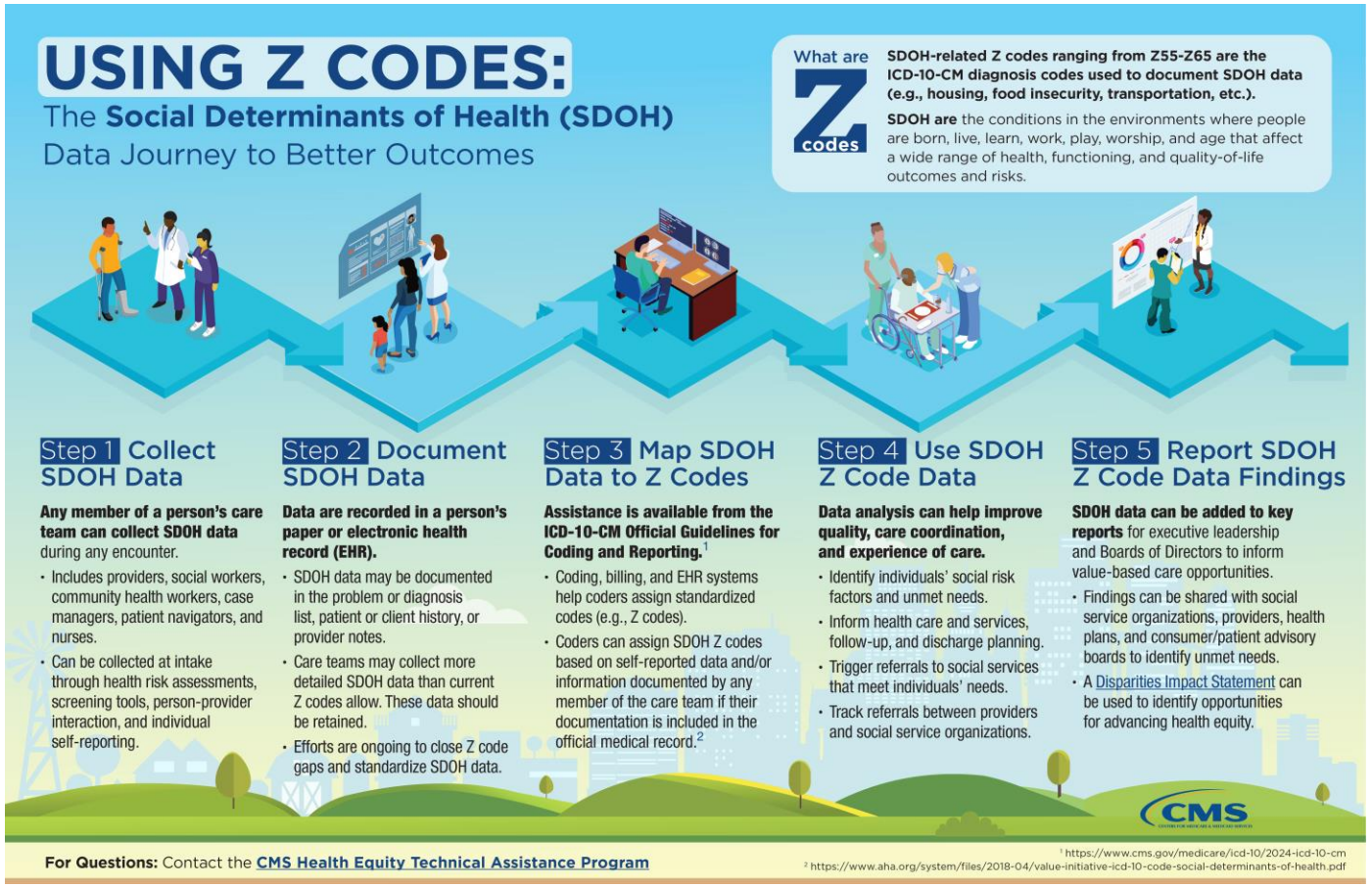
Proportion of Medicare FFS Beneficiaries with Z Code Claims across Race and Ethnicity Groups, Any Z Code and Top Five Most Utilized Z Codes, 2019



BENEFICIARIES WITH Z CODES BY RACE AND ETHNICITY GROUP

Source: Centers for Medicaid & Medicare Services. Utilization of Z Codes for Social Determinants of Health among Medicare Fee-for-Service Beneficiaries, 2019. CMS.gov. Last modified Sept. 2021. https://www.cms.gov/files/document/z-codes-data-highlight.pdf

Z Codes Journey Map Infographic



A step-by-step infographic for health care administrators, health care team members, and coding professionals to understand the best practice and importance of gathering and tracking SDOH data.

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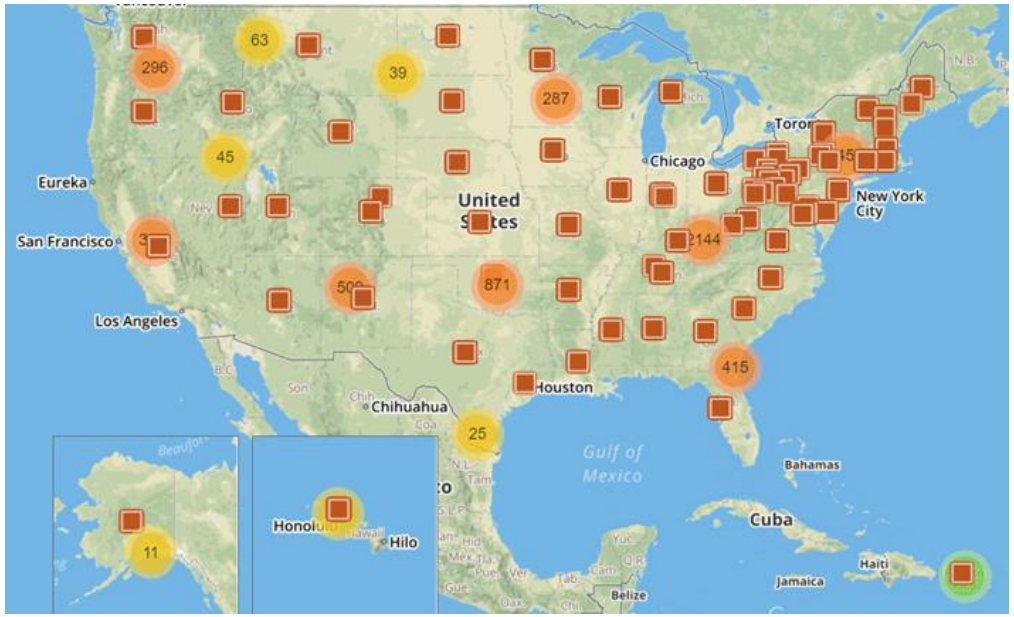
CMS Innovation Center

"The purpose of the [Center] is to **test innovative payment and service delivery Models** to reduce program expenditures…while preserving or enhancing the quality of care furnished to individuals under such titles."

- Launched over fifty health care payment and care delivery reform Models
- Aims to test and evaluate health care transformation initiatives, called Models, and scale those who meet criteria for success
- Fee for service care delivery system → value-based care system

Identify and Design → **Implement, Test and Evaluate** → **Scale**

Understanding the Landscape



- Historically, Model designs had not specifically focused on equity and had not prioritized equity in award decisions
  - The location of Model participants impacts who is served
  - Most Models do not reach a sizeable proportion of underserved populations
- Model design that did not prioritize enrolling substantial numbers of underserved beneficiaries limited ability to identify effects on these populations

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CMMI engaged in evaluations that include equity-related analyses on three domains

Reach: Who do our Models reach? Which underserved groups are represented? Who have we not reached?

Impact: What were the main outcomes for cost, utilization, and quality for underserved groups?

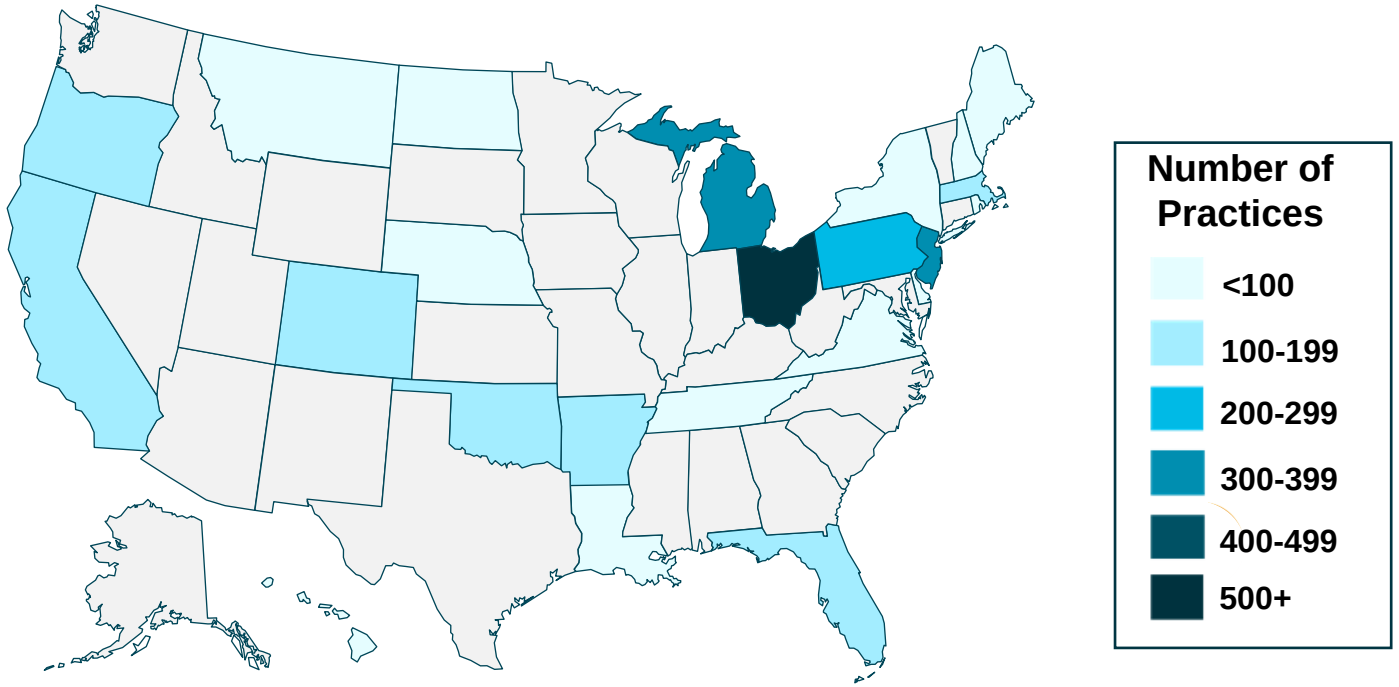
Experiences: What are the experiences of underserved beneficiaries participating in our Models?

Goal: Synthesize findings within and across Models to understand what we have learned about how health care transformation efforts affect underserved populations & generate insights for future Model design

Primary Care First: 2,949 Practices in 26 Regions

Primary Care First Goals

- To **reduce Medicare spending** by preventing avoidable inpatient hospital admissions.
- To **improve quality of care and access to care** for all patients, particularly those with complex chronic conditions.



PCF

Person-Centered Innovation – An Update on the Implementation of the CMS Innovation Center's Strategy

November 2022

Strategic Objective 2: Advance Health Equity

Health equity is integral to the Innovation Center's vision of improving health care quality. As it pursues a broad range of strategies to advance equity over the next decade, the Innovation Center has developed five health equity metrics that will allow it to track its progress (see Table 3).

Table 3. Health Equity Metrics

Aim: Embed health equity in every aspect of Innovation Center models and increase focus on underserved populations.

Impact on Beneficiaries: By embedding health equity into all Innovation Center models, underserved beneficiaries will have increased access to accountable, high-quality, and person-centered care. Model tests will then allow for robust evaluation and confidence in generalizing results to all populations served by CMS programs.

Metric 1: Percent of all models that will collect and report demographic and, where feasible, social needs data and health equity plans to CMS	• **2022 Baseline**	• 37%
	• **2025 Target**	• 85%
	• **2030 Target**	• 100%
Metric 2: Percent of facilities participating in Innovation Center models identified as safety net facilities***	• **2022 Baseline***	• 3.9%
	• **2025 Target**	• 7.0%
	• **2030 Target**	• 12.0%
Metric 3: Percent of primary care providers participating in Innovation Center models identified as safety net providers***	• **2022 Baseline***	• 23.9%
	• **2025 Target**	• 24.9%
	• **2030 Target**	• 26.5%
Metric 4: Rate of potentially preventable admissions for overall conditions per 100,000 Medicare beneficiaries served by an Innovation Center model	• **2022 Baseline****	• 4,989
	• **2025 Target**	• 4,614
	• **2030 Target**	• 3,989
Metric 5: Disparity in the rate of potentially preventable admissions for overall conditions per 100,000 Medicare beneficiaries served by Innovation Center models across race and ethnicity groups	• **2022 Baseline****	• 6,097
	• **2025 Target**	• 5,722
	• **2030 Target**	• 5,097

* Note this baseline is an average of 2017, 2018, and 2019 data (see supplemental document).
**Note this baseline is an average of 2017, 2018, and 2019 data (see supplemental document).
***See supplemental document for definitions of safety net facilities and providers.

Upcoming sessions

Tuesday, April 9 | 11 a.m. to noon.

We Ask Because We Care

Learn how to use the We Ask Because We Care framework to collect patient demographic data with accuracy and respect.

Sessions will be held on the following Tuesdays from 11 a.m. to noon:

- April 16 | SOGI data best practices
- April 23 | Collecting and reporting SDoH data
- April 30 | Establishing referral processes with SDoH data
- May 7 | Using data to identify disparities (1/2)
- May 14 | Using data to identify disparities (2/2)
- May 21 | Community partnerships
- May 28 | Patient and family engagement

Register here.

ADVANCING HEALTHCARE
EXCELLENCE AND INCLUSION

Questions?

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