2021 CMS
QUALITY CONFERENCE

Healthcare Innovation During a Time of Disruption

Health Equity as a "New Normal": CMS Efforts to Address the Causes of Health Disparities

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Introduction and Speakers

- Tenly Pau Biggs, MSW, LMSW, CMS Office of Minority Health
- Jess Maksut, PhD, CMS Office of Minority Health
- Brandon Wilson, PhD, Center for Medicare and Medicaid Innovation

Social Determinants of Health Data Collection in PAC settings

Tenly Pau Biggs, MSW, LMSW

CMS Office of Minority Health

March 3, 2021

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IMPACT Act of 2014

IMPACT Act of 2014 mandated CMS to:

- submit standardized data in the four post-acute care settings:
  - Long Term Care Hospitals (LTCH)
  - Skilled Nursing Facilities (SNF)
  - Home Health Agencies (HHA)
  - Inpatient Rehabilitation Facilities (IRF)

  to improve Medicare beneficiary outcomes through shared-decision making, care coordination, and enhanced discharge planning.

IMPACT Act of 2014

CMS is mandated to:

- collect standardized data elements for use in the Post-Acute Care (PAC) Prospective Payment System
- assess appropriate adjustments to quality measures, resource measures, and other measures, and to assess and implement appropriate adjustments to payment

CMS OMH worked with CCSQ by proposing demographic and social determinants of health (SDOH) standards patient assessment data elements (SPADEs) to the four PAC settings.

Post-Acute Care Instruments

PAC Assessment Tools

Core set of screening, clinical, and functional status data elements assembled into item sets that are completed at regular intervals for all PAC patients. This information forms the foundation of a comprehensive assessment which, among other things, is used by providers to assess each patients needs and develop an individualized and holistic plan of care.

- Minimum Data Set (MDS) – Skilled Nursing Facilities
- LTCH Continuity Assessment Record and Evaluation (CARE) Data Set (LCDS) – Long Term Care Hospitals
- Outcomes and Assessment Information Set (OASIS) – Home Health Agencies
- IRF-Patient Assessment Instrument (IRF-PAI) – Inpatient Rehabilitation Facilities

Solicited Expert Feedback

- Convened a listening session with SDOH experts to solicit feedback on demographic and SDOH data elements CMS should prioritize.

Feedback

- CMS should explore standardizing data collection of demographic and SDOH data given health disparities and barriers to care coordination
- CMS should prioritize the following demographic and SDOH data elements:
  - Language Preference, Race, Ethnicity, Sexual Orientation, Gender Identity, Health Literacy, Social Isolation, Transportation Barriers, Food Insecurity, and Housing Insecurity

Solicited Public Feedback

- CMS proposed adding the following SPADE data elements:
  - Admission: Race, Ethnicity
  - Admission & Discharge: Language Preference, Health Literacy, Social Isolation, Transportation Barriers

Feedback

- Most stakeholders supported standardizing demographic and SDOH data elements
- Suggested these data elements should be asked only at admission
- Recommended CMS consider adding housing insecurity, food insecurity, sexual orientation, and gender identity
- Encouraged CMS explore expanding this initiative beyond PAC

Final Rule

- CMS adding the following SPADE data elements:
  - Admission: Race, Ethnicity, Language Preference
  - Admission & Discharge: Health Literacy, Social Isolation, Transportation Barriers
- Additions in the four patient assessments were codified in the FY/CY 2020 Quality Payment Program rules for each respective setting and the start dates for data collection is as follows:
  - Home Health Agencies — January 1, 2022
  - Long-Term Care Hospitals — October 1, 2023
  - Inpatient Rehabilitation Facilities — October 1, 2023
  - Skilled Nursing Facilities — October 1, 2024

Technical Assistance

- CMS OMH is collaborating with CCSQ to develop a guidance manual that provides definitions on key terminology and best practices for providers completing the patient assessment instruments.
- CMS OMH offers Health Equity Technical Assistance and resources to ensure successful implementation:
  - Guide to Developing a Language Access Plan
  - Improving Communication Access for Individuals who are Blind or have Low Vision
  - Improving Communication Access for Individuals who are Deaf or Hard of Hearing
  - Getting the Care You Need: A Guide for People with Disabilities

For these resources and more, please visit https://www.cms.gov/About-CMS/Agency-Information/OMH/resource-center/hcps-and-researchers/quality-improvements-and-interventions

Health Equity Technical Assistance Program

ACT

Implement targeted interventions to reduce health disparities.

PRIORITIZE

Identify disparities, plan initiatives, and set SMART aims.

IMPROVE

Evaluate and improve your plan to reduce disparities.

HealthEquityTA@cms.hhs.gov

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The Health Equity Summary Score

Jess Maksut, PhD

March 3, 2021

Office of Minority Health | Centers for Medicare and Medicaid Services

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Background and Rationale

Fundamental, upstream causes of health (i.e. causes of causes)[1,2] affect a multitude of health and health-related outcomes and health disparities.

> **e.g.** exposure to disease; underlying health conditions and comorbidities; access to and engagement in quality health care[3-5]
>
> **e.g.** disparate patterns across sociodemographic strata or groups (e.g. race and ethnicity groups; gender groups; income level groups)[6,7]

The Health Equity Summary Score (**HESS**)[8] is a stratification/group differences **measurement tool** that was developed to:

- increase visibility of health care quality disparities for quality improvement (QI) and for disparity reduction.
- provide a mechanism for targeting incentives to achieve equity in quality of care across groups (e.g. racial and ethnic groups, those who are and are not dually eligible for Medicare and Medicaid/eligible for Low Income Subsidy [LIS]).

Proof-of-concept Exercise

The HESS methodology was developed by CMS OMH and then applied to data from Medicare Advantage (MA) contracts (i.e. health plans) as a proof-of-concept exercise.

While other potential grouping (i.e. stratification) variables were considered, ultimately the exercise was performed with the following grouping variables: **race and ethnicity** (i.e. Asian or Pacific Islander, Black or African American, Hispanic or Latino, and white) and **dual eligible/LIS status**.

- Any number of grouping or stratification variables with any number of strata can be used.
- Health quality indicators can span any domains of quality; the proof-of-concept exercise used indicators spanning patient experience and clinical quality domains.

OMH's a priori requirements for the methodology included (a) allowing for multiple grouping variables, not all of which will be measurable for all plans, (b) allowing for disaggregation by grouping variable for nuanced insights and QI, and (c) allowing for additional and different grouping variables to be used in the future.

Data Sources and Requirements

Analysis was restricted to plans with enrollment of 500 or more (~90% of plans), with at least one publicly reported MA summary rating, and at least one CAHPS or HEDIS star rating.

Each plan's score was based only on combinations of health care quality measures (e.g. getting needed care) and grouping variable unit (e.g. Black/AA group for which it met measurability requirements to ensure accurate measurement: sufficient sample size (*n*=100) and reliability (≥0.70).

PATIENT EXPERIENCE (MCAHPS)

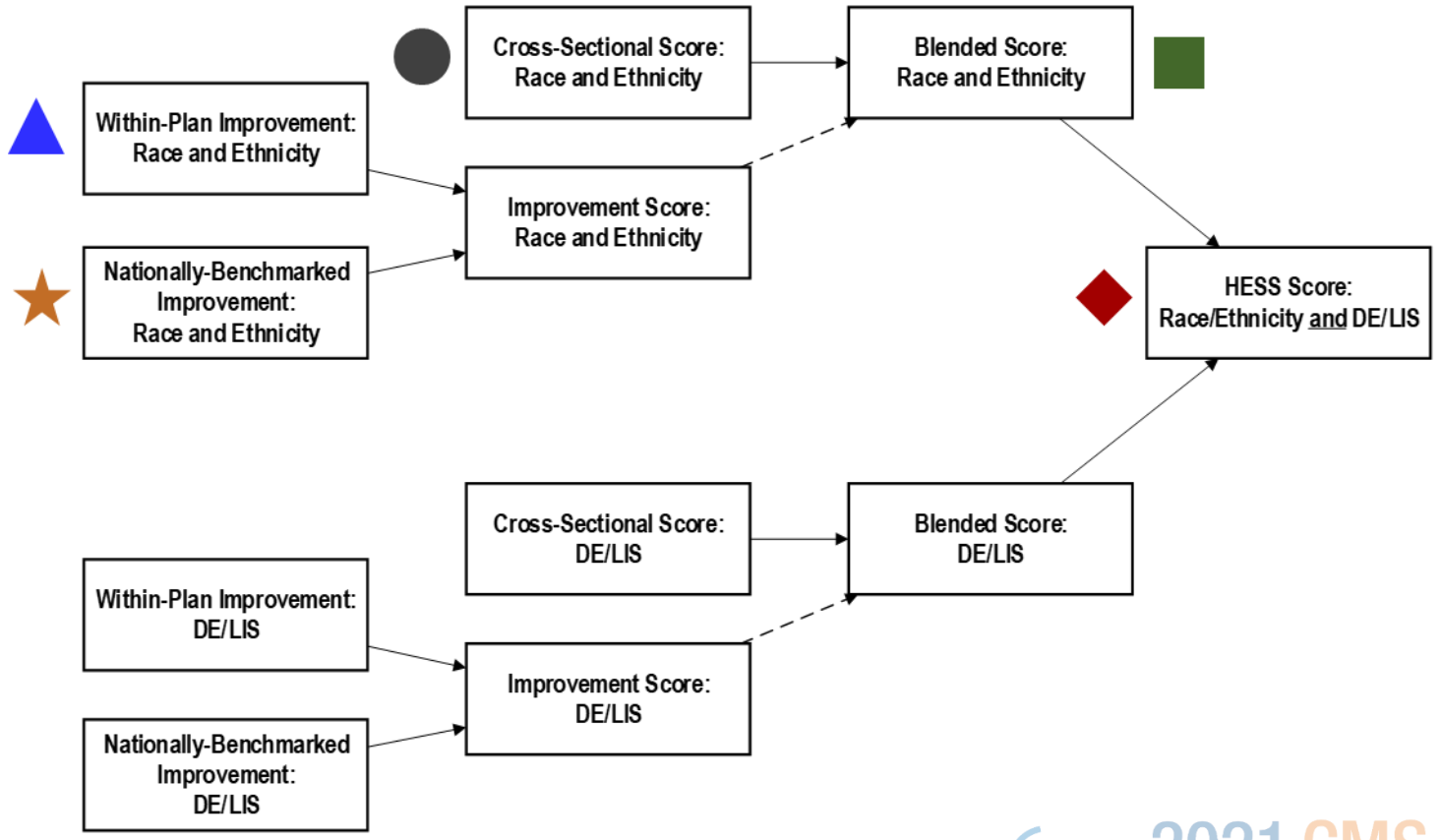
- Getting needed care
- Getting appointments and care quickly
- Customer service
- Doctors who communicate well
- Care coordination
- Getting needed prescription drugs
- Annual flu vaccine

CLINICAL QUALITY (HEDIS)

- Adult BMI assessment
- Breast cancer screening
- Colorectal cancer screening
- Diabetes: blood sugar controlled
- Diabetes: kidney disease monitoring
- Diabetes: retinal eye exam
- Controlling high blood pressure

Construction of the HESS

- ▲ Within-plan improvement: examining standardized (i.e. z-score) differences between leading (group with highest score) and lagging groups during each time period
- ★ Nationally benchmarked improvement: absolute improvement over time
- ● Cross-sectional score: difference between leading and lagging groups during most recent time period only
- ■ Each grouping variable's blended score combines cross-sectional and improvement scores (and gives more weight to improvement when cross-sectional performance is low).
- ◆ The final, overall HESS score combines blended results (and allows analysis of multiple grouping variables simultaneously).



Performance of the HESS

A moderate, positive correlation was observed between plans' overall HESS and MA summary ratings (i.e. *r* = 0.66).

- A very high correlation (~1) would indicate redundancy with existing measures.
- A very low correlation (~-1) would call into question the validity of the measure.

Scores demonstrated moderately high stability over time.

- Very high stability would indicate that plans were unable to make changes in their performance.
- Very low stability might indicate poor reliability.

The HESS can identify plans that provide equitable care across race/ethnicity and dual/LIS status strata.

- High scoring plans typically had sizable enrollment of persons of color (38-42%) and dual eligible/LIS beneficiaries (29-38%).

Listening Sessions and Dashboard

In Listening Sessions (07/2020) many plans expressed that the HESS would be a good tool to use for needs evaluation.

69% of Listening Sessions participants reported that they were actively engaged in health equity work within their organizations, and more than half said they felt they could act on information provided by the HESS.

Plans expressed eagerness to understand the drivers of the disparities in order to develop more targeted interventions.

CMS OMH is working on designing a dashboard to provide confidential HESS data to MA contracts in the future.

Scores on this metric could potentially be incorporated into the Medicare Plan Finder and the MA Quality Star Ratings Program.

This approach could easily be extended to other grouping variables and measures.

Key Takeaways

CMS OMH has developed a succinct, summary measure of health care quality equity that can be used to encourage high-quality, equitable care delivery for all individuals.

Our proof of concept exercise was performed using race and ethnicity groups and dual eligible/LIS status groups with HEDIS and CAHPS measures of health care quality (patient experience and clinical quality domains) from MA plans.

The approach was feasible for almost all plans (~90%) and moderately correlated with MA plans' summary ratings.

The HESS can identify plans that do well at providing equitable health care across groups, as well as plans that may possibly require equity-focused technical assistance and other related supports.

The HESS was designed such that it can easily be extended to additional settings (e.g. hospital setting) as well as to different measures (either grouping [e.g. gender] or health quality variables [e.g. other clinical quality variables, such as STI screenings]).

References

1 Link BG, Phelan J. Social conditions as fundamental causes of disease. Journal of Health and Social Behavior. 1995 Jan 1:80-94.

2 Marmot M. Social determinants of health inequalities. Lancet. 2005;365(9464):1099-1104. doi:10.1016/S0140-6736(05)71146-6

3 Houlihan J, Leffler S. Assessing and Addressing Social Determinants of Health: A Key Competency for Succeeding in Value-Based Care. Prim Care. 2019;46(4):561-574. doi:10.1016/j.pop.2019.07.013

4 Ford CL, Airhihenbuwa CO. The public health critical race methodology: Praxis for antiracism research. Soc Sci Med. 2010;71(8):1390-1398. doi:10.1016/j.socscimed.2010.07.030

5 Krieger N. Proximal, distal, and the politics of causation: What's level got to do with it?. Am J Public Health. 2008;98(2):221-230. doi:10.2105/AJPH.2007.111278

6 Braveman PA, Kumanyika S, Fielding J, et al. Health disparities and health equity: The issue is justice. Am J Public Health. 2011;101 Suppl 1(Suppl 1):S149-S155. doi:10.2105/AJPH.2010.300062

7 Braveman P. What are health disparities and health equity? We need to be clear. Public Health Rep. 2014;129 Suppl 2(Suppl 2):5-8. doi:10.1177/00333549141291S203

8 Agniel D, Martino SC, Burkhart Q, et al. Incentivizing Excellent Care to At-Risk Groups with a Health Equity Summary Score. J Gen Intern Med. Published online November 11, 2019. doi:10.1007/s11606-019-05473-x

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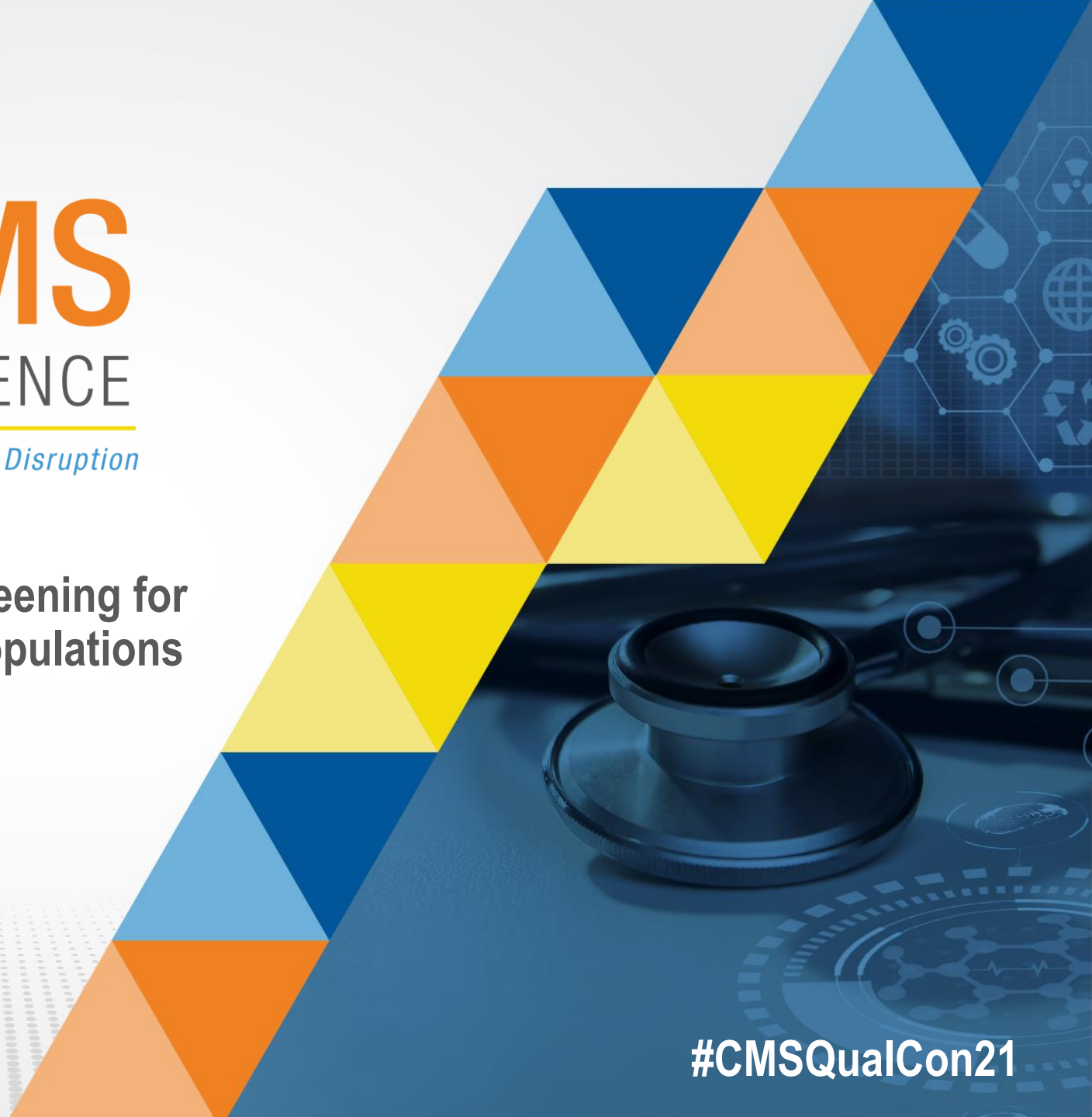
Accountable Health Communities Model: Screening for Health-Related Social Needs in Vulnerable Populations

Brandon G. Wilson, DrPH, MHA

AHC Project Officer



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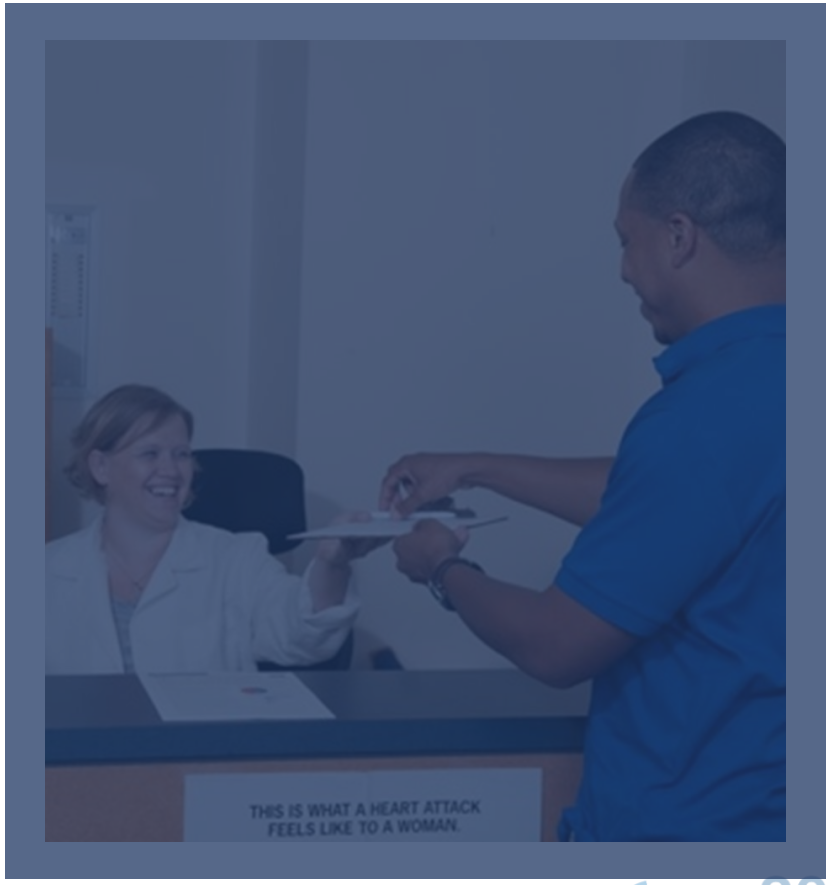
Why the AHC Model

- Many of the largest drivers of healthcare costs fall outside the clinical care environment
- Social and economic determinants, health behaviors, and the physical environment significantly drive utilization and costs
- There is emerging evidence that addressing Health-Related Social Needs (HRSN) through enhanced clinical-community linkages can improve health outcomes and impact costs
- The AHC Model seeks to address current gaps between healthcare delivery and community services

Key Innovations

- **Systematic screening** of all Medicare and Medicaid beneficiaries to identify unmet health-related
- Tests the **effectiveness of referrals and community services navigation** on total cost of care using a rigorous mixed method evaluative approach
- **Partner alignment** at the community level and implementation of a community-wide quality improvement approach to address beneficiary needs



Rigorous Evaluation Design

One Model, Two Interventions

The AHC Model uses two tracks to test two interventions to help Medicare and Medicaid beneficiaries with HRSNs resolve those needs:

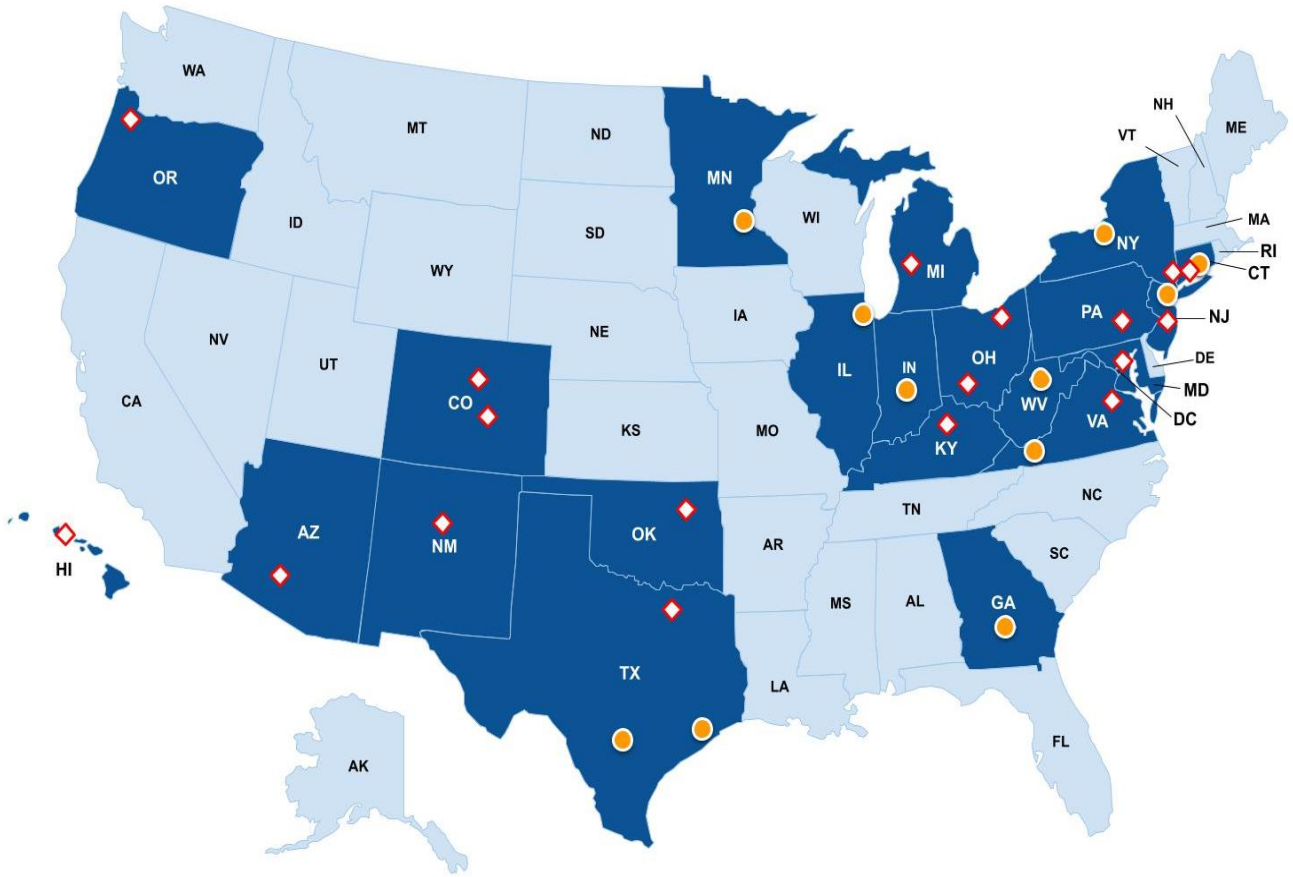
The Assistance Track tests universal screening to identify Medicare and Medicaid beneficiaries with HRSNs and provision of navigation assistance to connect navigation-eligible beneficiaries with the community services they need.

The Alignment Track tests universal screening, referral, and navigation COMBINED WITH engaging key stakeholders in community-level continuous quality improvement to align community service capacity with the community's service needs.

The AHC Model focuses on five core HRSNs:

- Housing instability
- Food insecurity
- Transportation problems
- Utility difficulties
- Interpersonal violence

AHC Implementation Locations



Assistance Track
Bridge Organization

Alignment Track
Bridge Organization

AHC Model Structure

Bridge organizations lead a consortium of CDSs, CSPs, and the state Medicaid agency to implement the AHC Model.

AHC HRSN Screening

Bridge organizations will:

- Screen in at least one of each of the following types of clinical delivery sites: a hospital (including the Emergency Department and Labor and Delivery unit); a primary care provider or practice; and a provider of behavioral health services.
- Use the screening questions provided by CMS to screen for core health-related social needs
- Choose an appropriate method to administer the screening tool
- Make the tool available to all beneficiaries regardless of language, literacy level, or disability status

AHC HRSN Referral

- Bridge organizations must maintain a community resource inventory
- If a beneficiary screens positive for a health-related social need, the bridge organization must provide the beneficiary with a tailored community referral summary (CRS)
- The tailored CRS must include contact information and hours of operation for each community service provider that may be able to address their needs

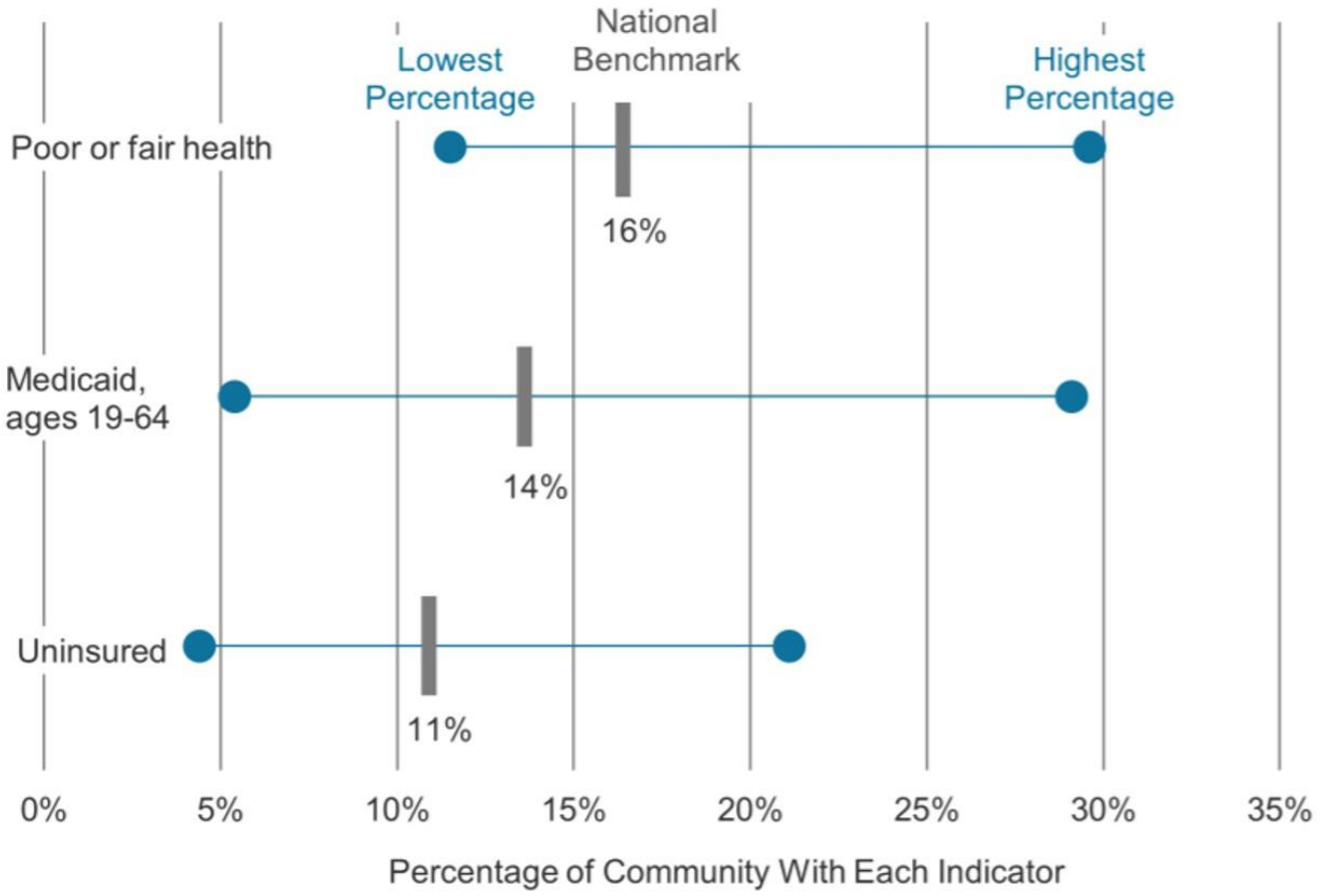
Health Resource Equity Statements

Minority and Underserved Populations

- Racial and Ethnic Minorities
- Linguistics, Immigration, and Cultural Considerations
- Poverty, Homelessness, and Justice-Involved Populations
- Geographically Focused – Rural Areas of Concern
- Chronic Conditions – Behavioral Health, Obesity, Diabetes
- Dually Eligible Beneficiaries

Range of Health Care Indicators in Communities Served by Bridge Organizations

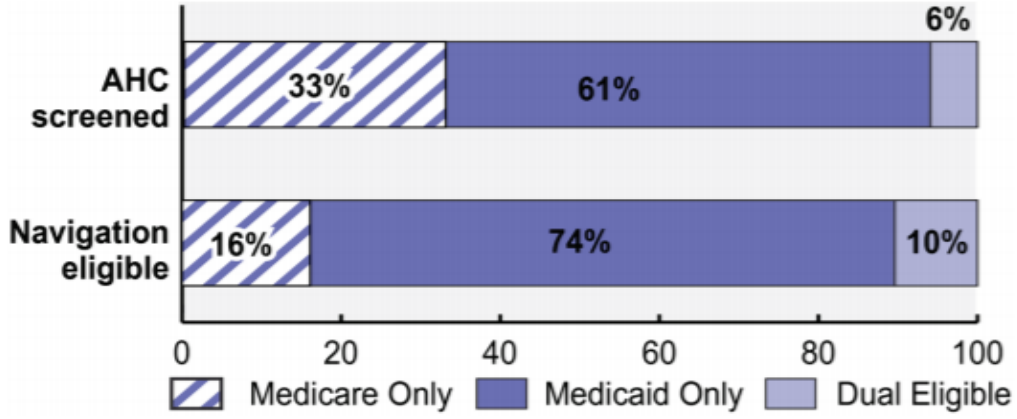
AHC communities vary widely on key health indicators.



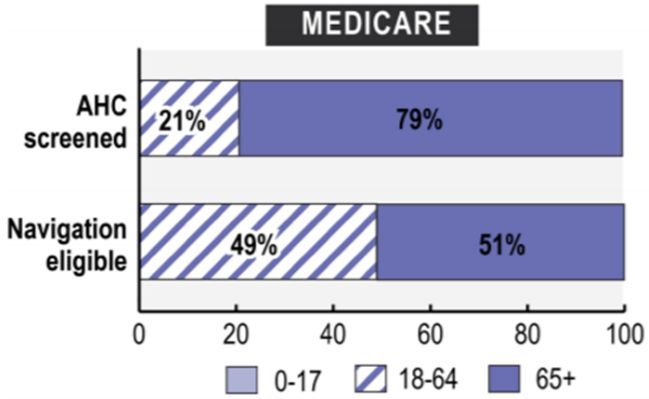
Vulnerable Populations: Insurance Type and Age at Screening

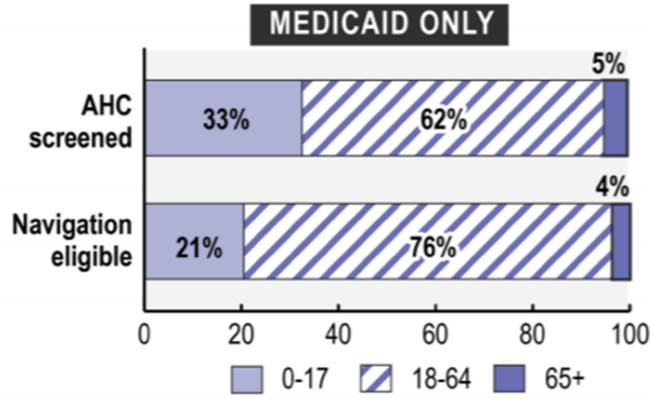
Insurance Type

The majority of AHC beneficiaries are Medicaid-only enrollees.



Age at Screening

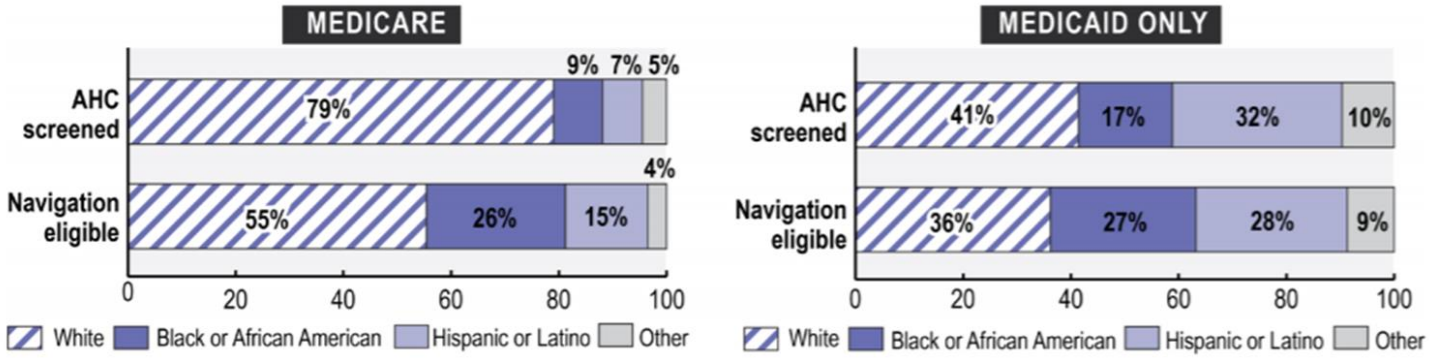




Vulnerable Populations: Race/Ethnicity and Less than a HS Education by Insurance Type

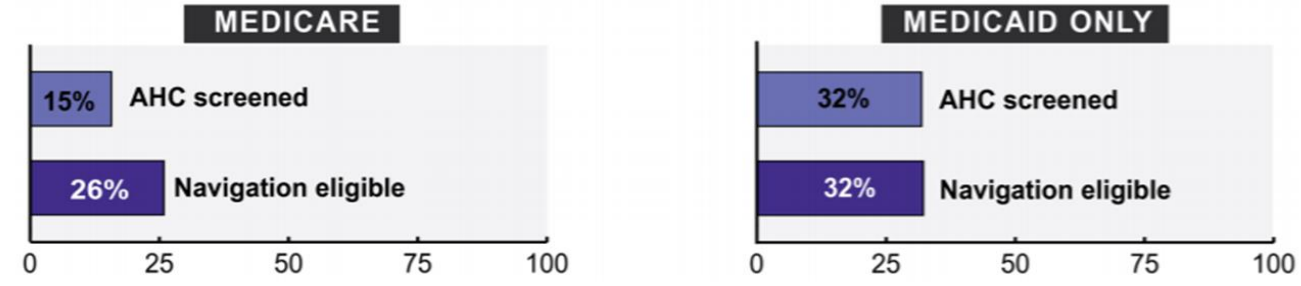
Race/Ethnicity

Compared to AHC-screened beneficiaries, both Medicare and Medicaid-only navigation-eligible beneficiaries were more likely to be minorities.



Less than HS Education

Navigation-eligible Medicare beneficiaries were more likely than AHC-screened beneficiaries to have less than a high school education—a difference that does not hold for Medicaid-only beneficiaries.



Key Findings

- The AHC Model has been successful at identifying vulnerable populations within the broader communities served by the bridge organizations.
- Lower income beneficiaries who are racial and ethnic minorities and have less than a high school degree or equivalent were more likely to report HRSNs and two or more ED visits in the 12 months before screening
- Food and housing were the most prevalent needs among this population
- Although less prevalent, those with transportation needs were more likely to meet the high ED use requirement for navigation.

Questions?

Want to Know More?

AHC Website:
https://innovation.cms.gov/initiatives/ahcm

If you can't find what you're looking for:

AccountableHealthCommunities@cms.hhs.gov

Q&A