State Health and Value Strategies (SHVS) assists states in their efforts to transform health and health care by providing targeted technical assistance to state officials and agencies. The program is a grantee of the Robert Wood Johnson Foundation, led by staff at Princeton University’s Woodrow Wilson School of Public and International Affairs. The program connects states with experts and peers to undertake health care transformation initiatives. By engaging state officials, the program provides lessons learned, highlights successful strategies, and brings together states with experts in the field. Learn more at [www.shvs.org](http://www.shvs.org).

**Questions?** Email Heather Howard at heatherh@Princeton.edu.

*Support for this webinar was provided by the Robert Wood Johnson Foundation. The views expressed here do not necessarily reflect the views of the Foundation.*
Welcome from State Health and Value Strategies (SHVS)

Dan Meuse
Deputy Director
State Health and Value Strategies
dmeuse@princeton.edu
Today’s Facilitator and Presenters

Michael Bailit
President
Bailit Health

Tom Curtis
Departmental Specialist
Office of Health Policy and Innovation
Michigan Department of Health & Human Services

Roshani Dahal
Senior Healthcare Analyst
Healthcare Research and Quality
Minnesota Department of Human Services
Housekeeping Details

All participant lines are muted. If at any time you would like to submit a question, please use the Q&A box at the bottom right of your screen.

After the webinar, the slides and a recording will be available at www.shvs.org.
**Agenda**

1. Health equity webinar series
2. Overview of state efforts to use measurement to advance health equity
3. State experiences and lessons in collecting data to advance health equity
   - Michigan’s experience
   - Minnesota’s experience
4. Conversation with the presenters
5. Wrap-up
Webinar Series Overview

• This series of five webinars is designed to assist state Medicaid agencies in improving health equity through their contracted Medicaid managed care organizations.

• The webinars are open to all interested state Medicaid agencies with any interested state agency partners (e.g., departments of public health).

• Webinars will be supplemented with virtual office hours: telephone calls for interested states with content experts on topics of state’s choosing.
State Efforts: Using Measurement to Advance Health Equity

- The 2016 Medicaid managed care rule includes quality of care provisions.¹ This rule specifically requires state Medicaid programs to:
  - Draft and implement a written strategy for “assessing and improving the quality of health care and services furnished” by managed care entities, and as part of its quality plan, “identify, evaluate, and reduce, to the extent practicable, health disparities based on age, race, ethnicity, sex, primary language, and disability status.”

Steps for Using Measurement in the Pursuit of Health Equity

• **Step 1**: Assess the landscape through stratification of existing quality measures

• **Step 2**: Monitor health disparities on an on-going basis and produce annual reports of health disparities

• **Step 3**: Identify a health disparity reduction target(s) and select an intervention(s)

• **Step 4**: Determine and implement a measurement approach

• **Step 5**: Assess performance and reassess program design
Step 1: Assess the landscape through stratification of existing quality measures

• Compare the relative performance rates of each subpopulation of interest (e.g., each racial and ethnic group) on the state’s standardized quality measures to the subpopulation with the highest quality score for a given measure.

• The availability of reliable demographic data is a prerequisite for this type of analysis.
  – The ACA requires states to collect demographic data on race, ethnicity, sex, primary language, and disability status for Medicaid and CHIP, but...
  – Some states report missing REL variables for up to 50% of their beneficiaries.
Step 1: Assess the landscape through stratification of existing quality measures

- If the state determines that any demographic data are sufficiently complete and reliable, they can then be used to compare the performance of different subgroups.
  - They can also potentially be used to compare performance of these subgroups across competing MCOs or in specific provider organizations (e.g., ACOs).

- This landscape analysis should be used to identify not only where disparities exist, but where they are most pronounced and where they may have the most deleterious impact.
Step 2: Monitor disparities on an ongoing basis and produce annual reports

• For several states, this entails ongoing monitoring of stratified performance measures.

• The next slide provides a summary of activity in these states.
### Step 2: Monitor disparities on an ongoing basis and produce annual reports

<table>
<thead>
<tr>
<th>State</th>
<th>Subpopulations</th>
<th>Measures</th>
<th>Level of analysis</th>
</tr>
</thead>
<tbody>
<tr>
<td>California</td>
<td>Seniors and persons with disabilities</td>
<td>9 HEDIS measures</td>
<td>Statewide, and “reporting unit”</td>
</tr>
<tr>
<td>California</td>
<td>By age, gender, race/ethnicity, and primary language group</td>
<td>11 HEDIS and 1 state measure</td>
<td>Statewide, and county</td>
</tr>
<tr>
<td>Louisiana (pending)</td>
<td>By geography, ethnicity, race, and disability status</td>
<td>61 measures</td>
<td>MCO</td>
</tr>
<tr>
<td>Michigan</td>
<td>By race and ethnicity</td>
<td>13 measures</td>
<td>Statewide</td>
</tr>
<tr>
<td>Minnesota</td>
<td>By race and Hispanic ethnicity</td>
<td>5 HEDIS measures</td>
<td>Statewide</td>
</tr>
<tr>
<td>New York</td>
<td>By race/ethnicity, non-English speakers, members with a) SMI, and b) SUD,</td>
<td>70 measures</td>
<td>Statewide</td>
</tr>
<tr>
<td></td>
<td>members who received a) cash assistance, and b) SSI</td>
<td></td>
<td></td>
</tr>
<tr>
<td>North Carolina (pending)</td>
<td>By age, race, ethnicity, sex, primary language, and disability status, and</td>
<td>Up to 67, based on measure</td>
<td>PHPs, Statewide and EQRO</td>
</tr>
<tr>
<td></td>
<td>where possible, LTSS needs status and geography</td>
<td>population</td>
<td></td>
</tr>
</tbody>
</table>
State Efforts: Using Measurement to Advance Health Equity

• For more on this overview of state efforts, please see the SHVS brief: How States Can Use Measurement as a Foundation for Tackling Health Disparities in Medicaid Managed Care at www.shvs.org/resource/how-states-can-use-measurement-as-a-foundation-for-tackling-health-disparities-in-medicaid-managed-care/
Michigan Department of Health & Human Services

Quality Improvement and Program Development Section

July 9, 2019
Overview

• Approximately 2 million Medicaid managed care beneficiaries
• About 600,000 are part of the Medicaid expansion population
• Other than the Medicaid expansion folks, a majority of Medicaid managed care beneficiaries are children, parents of young children, and pregnant moms
• Another 250,000 are considered the fee-for-service (FFS) population; they are on Medicaid, but not in managed care
• FFS population tends to be mostly long-term care individuals
• 11 Medicaid Health Plans
  – As many as 500,000 members; as few as 3,400 members
### Managed Care Program Membership: Completeness of Race Data

<table>
<thead>
<tr>
<th></th>
<th>Unknown Race</th>
<th>Declined Response</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>HEDIS 2018 Medicaid</strong></td>
<td>11.88%</td>
<td>3.40%</td>
</tr>
<tr>
<td><strong>Weighted Average</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>HEDIS 2017 Medicaid</strong></td>
<td>12.44%</td>
<td>3.25%</td>
</tr>
<tr>
<td><strong>Weighted Average</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>HEDIS 2016 Medicaid</strong></td>
<td>12.23%</td>
<td>2.89%</td>
</tr>
<tr>
<td><strong>Weighted Average</strong></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
## Access to Preventive/Ambulatory Care - Total

<table>
<thead>
<tr>
<th>Race</th>
<th>Numerator</th>
<th>Denominator</th>
<th>% of Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>AFRICAN AMERICAN / BLACK</td>
<td>165,065</td>
<td>217,660</td>
<td>28%</td>
</tr>
<tr>
<td>AMERICAN INDIAN / ALASKA NATIVE</td>
<td>7,000</td>
<td>8,748</td>
<td>1%</td>
</tr>
<tr>
<td>ASIAN AMERICAN</td>
<td>10,467</td>
<td>12,609</td>
<td>2%</td>
</tr>
<tr>
<td>HISPANIC</td>
<td>23,241</td>
<td>29,354</td>
<td>4%</td>
</tr>
<tr>
<td>NATIVE HAWAIIAN &amp; OTHER PACIFIC ISLANDER</td>
<td>540</td>
<td>664</td>
<td>0%</td>
</tr>
<tr>
<td>UNKNOWN</td>
<td>44,731</td>
<td>59,152</td>
<td>8%</td>
</tr>
<tr>
<td>WHITE</td>
<td>377,230</td>
<td>452,081</td>
<td>58%</td>
</tr>
</tbody>
</table>
## Health Effectiveness Data and Information Set (HEDIS) Measures

<table>
<thead>
<tr>
<th>Measures</th>
<th>Abbreviation</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Women – Adult Care and Pregnancy Care</strong></td>
<td></td>
</tr>
<tr>
<td>Breast Cancer Screening</td>
<td>BCS</td>
</tr>
<tr>
<td>Cervical Cancer Screening</td>
<td>CCS</td>
</tr>
<tr>
<td>Chlamydia Screening in Women - Total</td>
<td>CHL</td>
</tr>
<tr>
<td>Post-Partum Care</td>
<td>PPC</td>
</tr>
<tr>
<td><strong>Child and Adolescent Care</strong></td>
<td></td>
</tr>
<tr>
<td>Childhood Immunizations - Combination 3</td>
<td>CIS</td>
</tr>
<tr>
<td>Immunizations for Adolescent - Combination 1</td>
<td>IMA</td>
</tr>
<tr>
<td>Lead Screening in Children</td>
<td>LSC</td>
</tr>
<tr>
<td>Well Child Visits 3-6 Years</td>
<td>W34</td>
</tr>
<tr>
<td><strong>Access to Care</strong></td>
<td></td>
</tr>
<tr>
<td>Children and Adolescents’ Access to PCP (25 Months-6 Years)</td>
<td>CAP</td>
</tr>
<tr>
<td>Adults' Access to Preventive/Ambulatory Health Services (20-44)</td>
<td>AAP</td>
</tr>
<tr>
<td><strong>Living with Illness</strong></td>
<td></td>
</tr>
<tr>
<td>Comprehensive Diabetes Care - HbA1c Testing</td>
<td>CDC1</td>
</tr>
<tr>
<td>Comprehensive Diabetes Care - Eye Exams</td>
<td>CDC2</td>
</tr>
<tr>
<td>Comprehensive Diabetes Care - Med. Attention for Nephropathy</td>
<td>CDC3</td>
</tr>
</tbody>
</table>
**Index of Disparity**: Population Disparity describes how much disparity exists in the entire population for one indicator by combining the disparity experienced by all subgroups into one measure. For each indicator, population disparity was estimated with an Index of Disparity (ID), which describes average subpopulation variation around the total population rate.

**Pairwise disparities** were measured between the non-white population of interest and the reference population.
Index of Disparity by Indicator, Michigan Medicaid All Managed Care Plans
Post-Partum Care, By Race/Ethnicity

Michigan Medicaid All Managed Care Plans
HEDIS 2017

<table>
<thead>
<tr>
<th>Race/Ethnicity</th>
<th>Percentage</th>
<th>CI (±)</th>
</tr>
</thead>
<tbody>
<tr>
<td>AI/AN</td>
<td>57.82%</td>
<td>± 8.0%</td>
</tr>
<tr>
<td>Asian/NH/OPI</td>
<td>71.92%</td>
<td>± 5.2%</td>
</tr>
<tr>
<td>African American</td>
<td>54.14%</td>
<td>± 1.0%</td>
</tr>
<tr>
<td>Hispanic</td>
<td>62.76%</td>
<td>± 2.2%</td>
</tr>
<tr>
<td>White</td>
<td>63.31%</td>
<td>± 0.71%</td>
</tr>
<tr>
<td>All Plan</td>
<td>60.62%</td>
<td>± 0.5%</td>
</tr>
</tbody>
</table>
## Rate Differences: White, African American and Hispanic

<table>
<thead>
<tr>
<th>Measure</th>
<th>2017 White Rate</th>
<th>2017 African American Rate</th>
<th>Rate Difference</th>
<th>2017 Hispanic Rate</th>
<th>Rate Difference</th>
</tr>
</thead>
<tbody>
<tr>
<td>Breast Cancer Screening</td>
<td>63.23%</td>
<td>60.66%</td>
<td>-2.56%</td>
<td>65.79%</td>
<td>2.57%</td>
</tr>
<tr>
<td>Cervical Cancer Screening</td>
<td>58.60%</td>
<td>63.07%</td>
<td>4.47%</td>
<td>62.27%</td>
<td>3.67%</td>
</tr>
<tr>
<td>Chlamydia Screening in Women - Tot</td>
<td>58.54%</td>
<td>75.73%</td>
<td>17.19%</td>
<td>65.37%</td>
<td>6.83%</td>
</tr>
<tr>
<td>Post-Partum Care</td>
<td>63.31%</td>
<td>54.14%</td>
<td>-9.17%</td>
<td>62.76%</td>
<td>-0.56%</td>
</tr>
<tr>
<td>Childhood Immunizations - Combo 3</td>
<td>73.26%</td>
<td>64.60%</td>
<td>-8.65%</td>
<td>79.35%</td>
<td>6.09%</td>
</tr>
<tr>
<td>Immunizations for Adolescents - Combination 1</td>
<td>85.64%</td>
<td>83.86%</td>
<td>-1.78%</td>
<td>91.15%</td>
<td>5.50%</td>
</tr>
<tr>
<td>Lead Screening in Children</td>
<td>80.69%</td>
<td>77.92%</td>
<td>-2.77%</td>
<td>87.66%</td>
<td>6.97%</td>
</tr>
<tr>
<td>Well Child Visits 3-6 Years</td>
<td>74.35%</td>
<td>69.23%</td>
<td>-5.12%</td>
<td>76.07%</td>
<td>1.72%</td>
</tr>
<tr>
<td>Children and Adolescents' Access To PCP (25 Months-6 Years)</td>
<td>91.77%</td>
<td>83.30%</td>
<td>-8.48%</td>
<td>90.88%</td>
<td>-0.89%</td>
</tr>
<tr>
<td>Adults' Access to Preventive/Ambulatory Health Services (20-44 Years)</td>
<td>84.58%</td>
<td>76.69%</td>
<td>-7.89%</td>
<td>81.73%</td>
<td>-2.85%</td>
</tr>
<tr>
<td>Comprehensive Diabetes Care - HbA1c Testing</td>
<td>86.92%</td>
<td>80.93%</td>
<td>-5.99%</td>
<td>86.20%</td>
<td>-0.72%</td>
</tr>
<tr>
<td>Comprehensive Diabetes Care - Eye Exams</td>
<td>55.56%</td>
<td>49.17%</td>
<td>-6.39%</td>
<td>53.73%</td>
<td>-1.83%</td>
</tr>
<tr>
<td>Comprehensive Diabetes Care - Medical Attention for Nephropathy</td>
<td>89.94%</td>
<td>90.26%</td>
<td>0.32%</td>
<td>89.20%</td>
<td>-0.74%</td>
</tr>
</tbody>
</table>
Post-Partum Care by Race, Ethnicity

Figure 17. Post-Partum Care by Race/Ethnicity 2012-2017
Using our Data Warehouse

- HEDIS and other measures rules engine extracting encounter data on a quarterly basis
- Applying attribution and continuous enrollment criteria to measurement rates
- Stratifying by region, race/ethnicity, gender, age group, benefit plan, etc.

Validating Data with Health Plans

- Pulling member-level data that make up numerator/denominator for measures
- Working with all health plans to pull from their systems, compare results at the member-level, and report any identified discrepancies
Targeting QI Needs and Incentive Programs

• Identifying high-priority measures by health plan, by region, and by race/ethnicity that demonstrate significant geographic and/or racial disparity in access to and quality of care

• Using capitation withhold and quality-based auto-assignment programs to reward performance in reducing racial disparities and improving regionally-defined performance rates

• Moving toward population health defined measurement targets (race/ethnicity, by region—agnostic of individual health plan performance) requiring regional health plan collaboration and partnership with communities to address geographic performance
Race/Ethnicity Data Collection From Applicants

County-entered application

- Fixed choice drop down menu/check boxes
- Free-text response option (up to 75 characters)

Health Care Exchange application

NOTE: ‘Unable to determine’ category is assigned by the data warehouse.
Distribution of (Optional) Self-Reported Race/Ethnicity Among Minnesota Health Care Program (MHCP) Recipients

### CY2015

- **Unknown**: 44.5%
- **Black**: 52.6%
- **Asian/Pacific Islander**: 14.2%
- **Hispanic**: 5.7%
- **Native American**: 4.4%
- **White**: 3.7%

### CY2018

- **Unknown**: 44.5%
- **Black**: 16.2%
- **Asian/Pacific Islander**: 6.3%
- **Hispanic**: 6.4%
- **Native American**: 3.7%
- **White**: 52.6%

- Optional race reporting can produce higher rates of non-response.
- Non-random non-response will cause biased estimates.
How is Minnesota using Race, Ethnicity, and Language data to understand and address healthcare disparities?

Purpose: To explore healthcare ‘gaps’ that exist between various non-white racial-ethnic populations and the majority white population enrolled in Minnesota Health Care Programs.

<table>
<thead>
<tr>
<th>Service</th>
<th>Abbreviation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Services</td>
<td>ASM</td>
</tr>
<tr>
<td></td>
<td>ADV</td>
</tr>
<tr>
<td>Asthma</td>
<td>ASM</td>
</tr>
<tr>
<td></td>
<td>AWC</td>
</tr>
<tr>
<td>Practitioners</td>
<td>CAP</td>
</tr>
<tr>
<td></td>
<td>CDC</td>
</tr>
<tr>
<td></td>
<td>CHL</td>
</tr>
<tr>
<td></td>
<td>CIS</td>
</tr>
<tr>
<td></td>
<td>COL</td>
</tr>
<tr>
<td>Drug Dependence Treatment</td>
<td>IET</td>
</tr>
<tr>
<td></td>
<td>PPC</td>
</tr>
<tr>
<td>Of Life</td>
<td>W34</td>
</tr>
<tr>
<td></td>
<td>W15</td>
</tr>
<tr>
<td>Respiratory Infection</td>
<td>URI</td>
</tr>
</tbody>
</table>
Preventive Health

• Breast Cancer Screening*
• Colorectal Cancer Screening
• Childhood Immunization Status (Combo 10)*

Chronic Conditions

• Optimal Diabetes Care
• Optimal Vascular Care
• Optimal Asthma Control – Adults
• Optimal Asthma Control – Children
• Controlling High Blood Pressure*

Depression

• Adult Depression Remission at Six Months
• Adolescent Mental Health and/or Depression Screening

Managed care components of Minnesota’s Medical Assistance and MinnesotaCare programs.

- Two separate data sources
  1. Medical Groups and Clinics
  2. Health Plans

- Two types of quality measures
  - Direct Data Submission (DDS) measures use data from clinics.
  - Healthcare Effectiveness Data and Information Set (HEDIS) measures use data from health plans.

MHCP results are compared to Other Purchasers, which include commercial (employer-based and individual health insurance coverage) and Medicare managed care data.
Race and Hispanic Ethnicity Analyses

For the seven DDS measures, the race and ethnicity data is submitted by medical groups through MNCM’s DDS process.

The Race/Ethnicity/Language (REL) Data Handbook

Developed by MN Community Measurement in collaboration with medical groups and community members, the Handbook establishes a standard set of data elements for collecting race, ethnicity and language data from medical groups and clinics that participate in MNCM’s Direct Data Submission. Besides presenting the data elements to be collected, the Handbook outlines the case for collecting these data, tips on how to establish a successful data collection system, and ideas for how to use the data to improve quality.


For the three HEDIS measures, the race and ethnicity data for MHCP is submitted by health plans. Health plans receive this information through the state public program enrollment process.
Example: HEDIS measure
MHCP vs. Other AND By Race and Ethnicity

**FIGURE 24: Trend in Controlling High Blood Pressure**
(2015–2018 report years)

- 2015: 70%
- 2016: 78%
- 2017: 74%
- 2018: 77%

**FIGURE 25: Controlling High Blood Pressure MHCP Rates by Race and Hispanic Ethnicity**
(2018 report year)

- American Indian/Alaskan Native (N = 351):
  - MHCP: 72%
- Black/African American (N = 3,343):
  - MHCP: 72%
- Asian (N = 784):
  - MHCP: 74%
- White (N = 5,411):
  - MHCP: 73%
- Multi-Racial (N = 44):
  - MHCP: 11%
- Unknown race (N = 1,340):
  - MHCP: 73%
- Hispanic (N = 249):
  - MHCP: 74%
- Not Hispanic (N = 3,353):
  - MHCP: 74%
- Unknown ethnicity (N = 13):
  - MHCP: 78%
Minnesota Health Care Disparities by Race, Hispanic Ethnicity, Language and Country of Origin

Preventive Health
• Colorectal Cancer Screening

Chronic Conditions
• Optimal Diabetes Care
• Optimal Vascular Care
• Optimal Asthma Control – Adults
• Optimal Asthma Control – Children

Depression
• Adolescent Mental Health and/or Depression Screening
• Depression Follow-Up – 12 months
• Depression Response – 12 months
• Depression Remission – 12 months

Features statewide and medical group performance rates stratified by race, Hispanic ethnicity, preferred language, and country of origin.
How is Minnesota improving health equity?
Data-Informed Actions

• Influence Performance Improvement Projects for MCO health plans
    • Improving Antidepressant Medication Adherence
    • Improving Follow-up After Hospitalization for Mental Illness

• Inform Integrated Health Partnerships (IHPs)
  • Measures selected for the IHP contracts with providers are the measures that show disparities between commercial and Medicaid populations

• Use performance of commercial payers to help identify benchmarks for the Medicaid program and address disparities

• Use Tableau dashboard visualizations to identify and monitor patterns in health care disparities and inform policy discussions
Thank you!

Contact Information:

Roshani Dahal: roshani.dahal@state.mn.us

Mark Foresman: mark.foresman@state.mn.us
Discussion

The slides and a recording of the webinar will be available at www.shvs.org after the webinar
Discussion

• Michael Bailit will pose several questions to panelists.

• We will then open up the discussion for your questions entered in the webinar Q&A box.

• The slides and a recording of the webinar will be available at www.shvs.org after the webinar.
Next Two Health Equity Series Webinars

• **August 27**: Evidence-based Strategies for Reducing Health Disparities
  - **Presenter**: Marshall Chin, UChicago, and Co-Director, RWJF’s Advancing Health Equity program

• **September 24**: Using MCO Contract and Performance Requirements to Advance Health Equity
  - **Presenter**: Mary Beth Dyer, Bailit Health
Wrap-Up

• Should you wish to identify health equity-related topics that you would like addressed in future webinars, and/or during virtual office hours calls with other states or other content experts, please email Margaret (mtrinity@Bailit-health.com).

• As a reminder, our next webinar, Evidence-based Strategies for Reducing Health Disparities, is scheduled for August 27 (2:30pm EDT). We will be joined by the University of Chicago’s Marshall Chin, who leads RWJF’s Advancing Health Equity program.
Thank You

Michael Bailit
President
Bailit Health
mbailit@bailit-health.com

Dan Meuse
Deputy Director
State Health and Value Strategies
dmeuse@princeton.edu
609-258-7389
www.shvs.org