



Activities to Reduce Health Disparities under Massachusetts Health Care Reform

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Outline of the Talk



- ❑ Background
- ❑ Collection of Race, Ethnicity and Language by Health Plans in Massachusetts
- ❑ MassHealth Hospital Pay for Performance (P4P) Initiative
- ❑ The Massachusetts Council for the Elimination of Racial and Ethnic Disparities

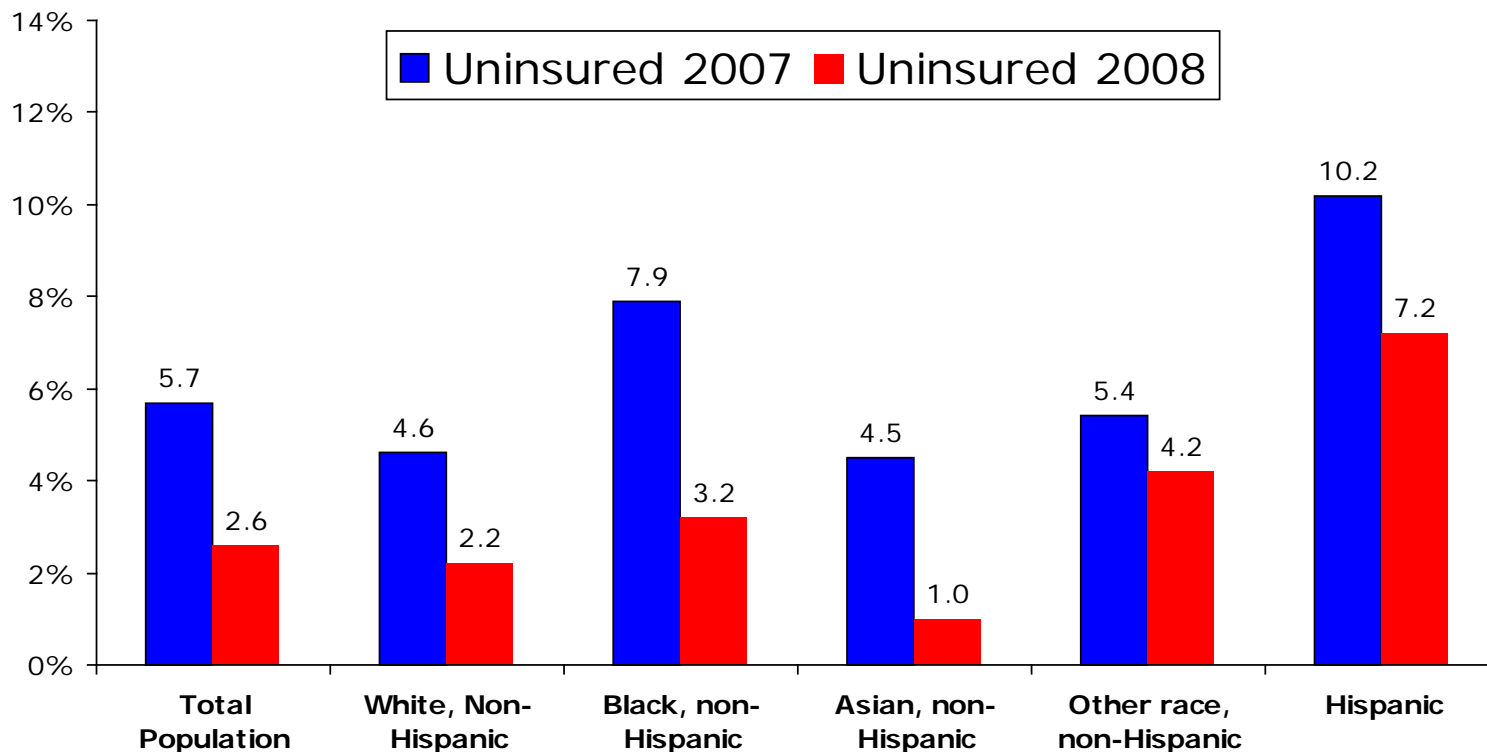
Will universal coverage lead to reductions in disparities?



- ❑ Medicare coverage is associated with reductions in racial, ethnic, and socioeconomic health disparities in adults with diabetes and heart disease*
- ❑ “...*universal coverage [is] a possible means of reducing these types of health disparities in the general population.*”
 - Commonwealth Fund Press Release for this study

* J. Michael McWilliams, et al, 2009

Uninsurance Rates by Race/Ethnicity, All Ages



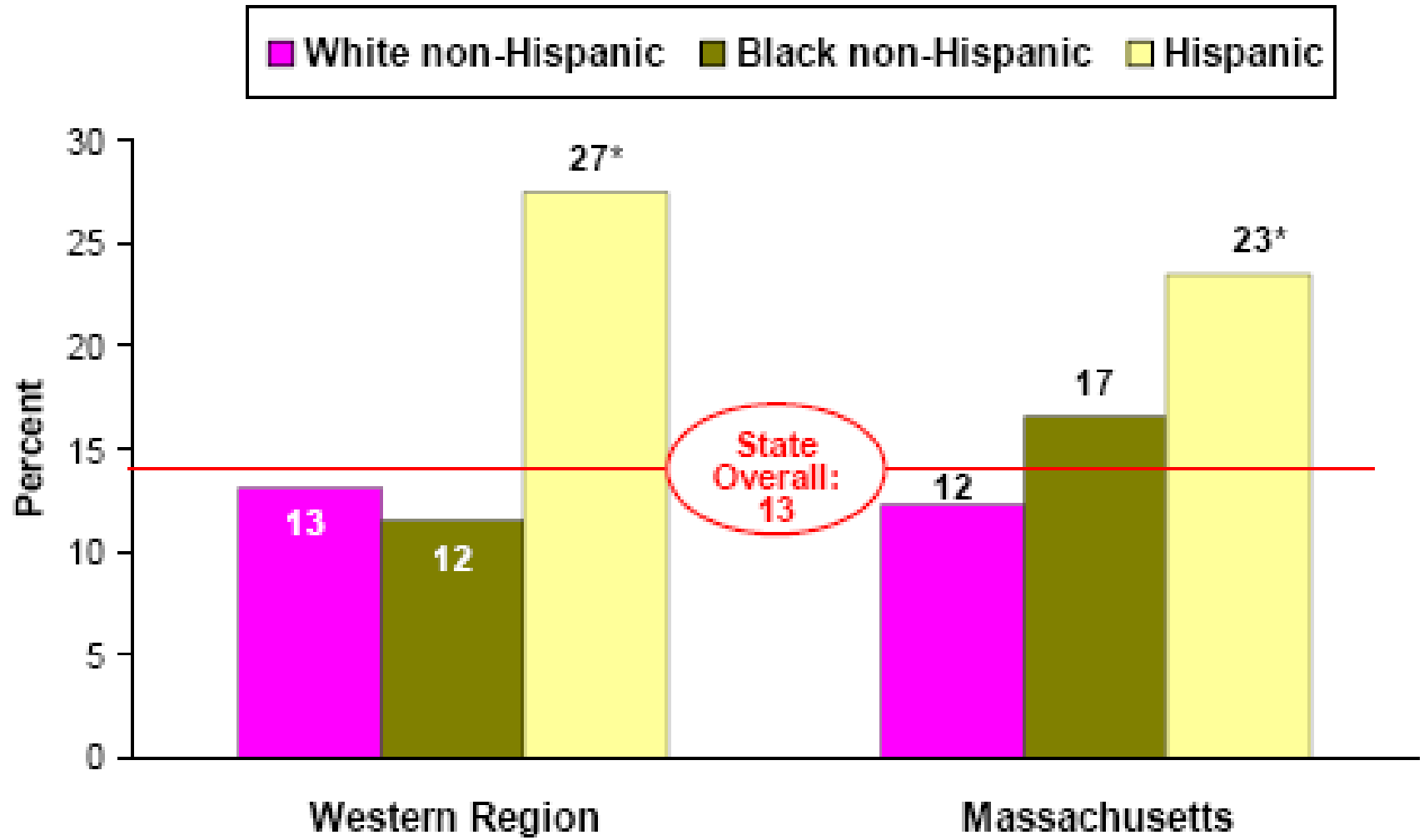
Sources: UMass CSR 2007; Urban Inst 2008; Note: Differences in methodology may be responsible for larger, or smaller, true difference.

Despite Health Care Reform, Health Disparities Still Exist



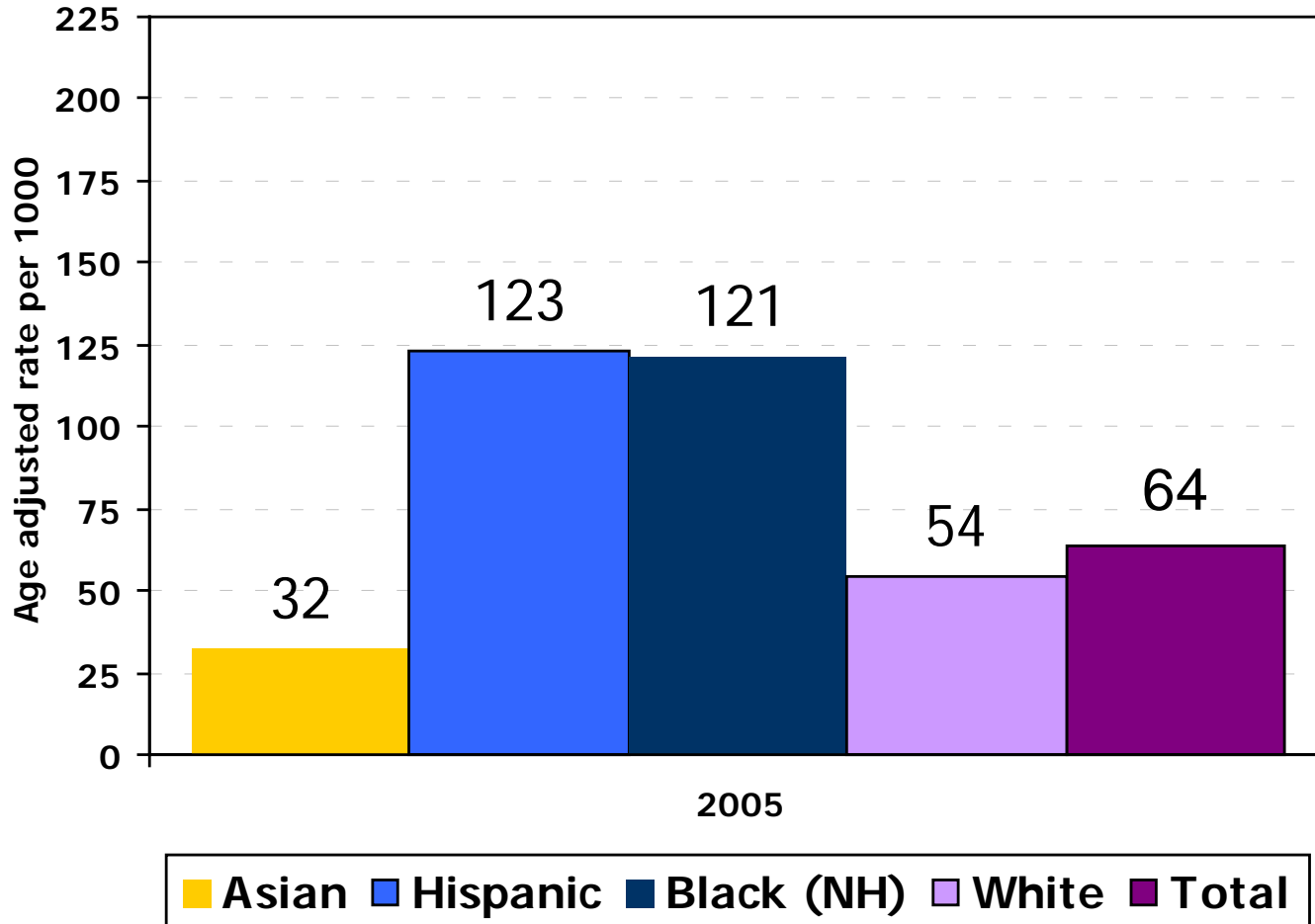
- ❑ Disparities are apparent in premature or excessive death rates for cancer, HIV, diabetes and asthma and in higher hospitalizations rates for many diseases and conditions
- ❑ Disparities also exist in access to services

Adults who Reported Fair or Poor Health by Race and Ethnicity Western Region and Massachusetts: 2005



* Statistically Significantly different from state (p ≤.05)

Prevalence of Diabetes in Massachusetts Varies Significantly by Race/Ethnicity



What Can States Do? Three Strategies



- Collect data (and make providers do the same)
- Incent reductions in disparities
- Report on progress (or lack thereof)



(1)

Collection of Race, Ethnicity and Language by Health Plans in Massachusetts

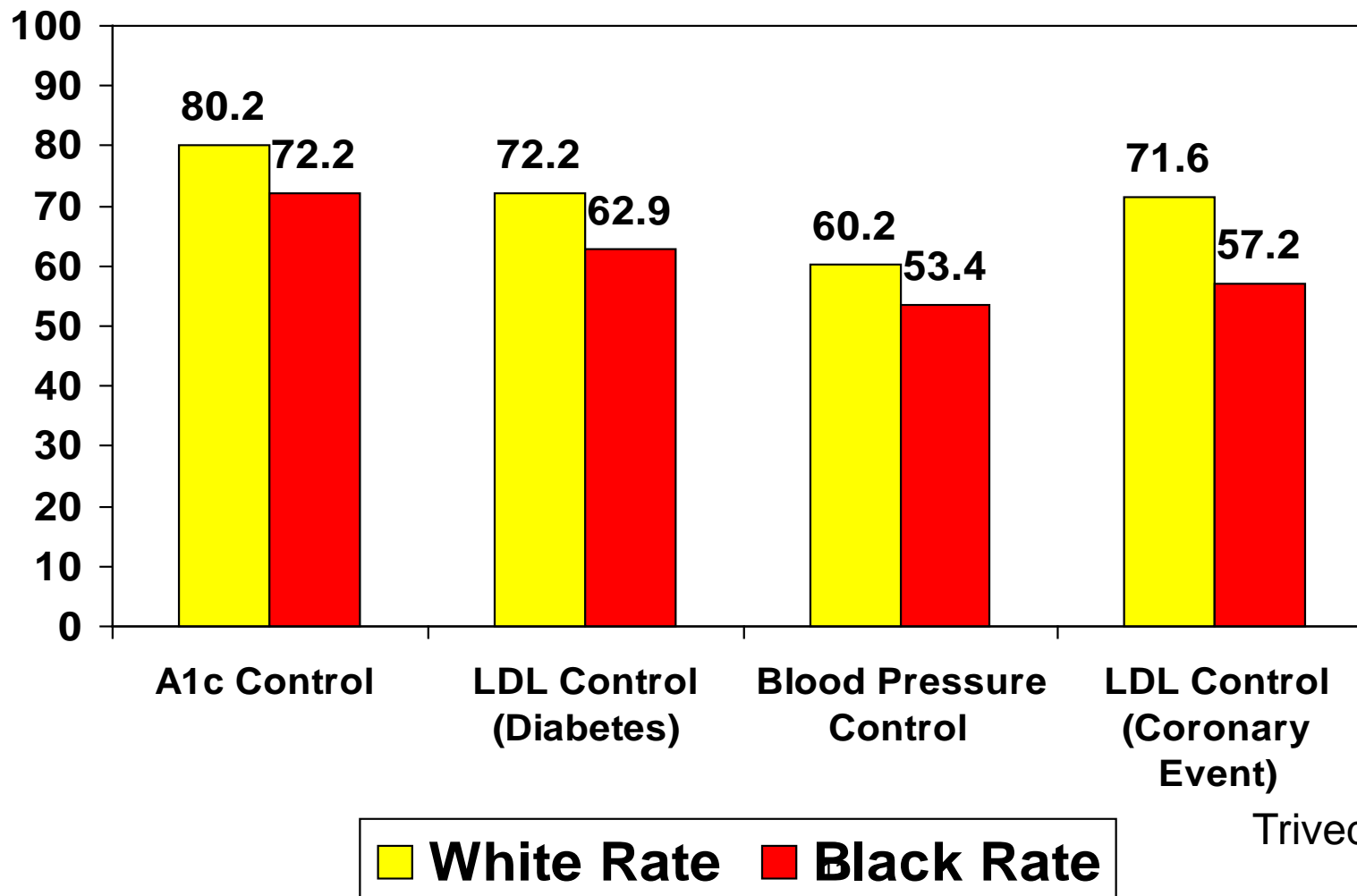
Massachusetts already requires collection of R/E from hospitals



The Division of Health Care Finance and Policy requires Race and Ethnicity reporting by Hospital Inpatient Discharge Data...

...But insurance companies have data that hospitals do not...

Clinical Performance on HEDIS Outcome Measures, by Race



Trivedi, JAMA, 2006

R/E/L data collection by health plans is inconsistent



- ❑ Most health plans do not routinely capture information on race/ethnicity of their members and do not assess quality of care stratified by race and ethnicity

Nerenz, et al. 2002

The HCQCC



- ❑ The Massachusetts Health Care Quality and Cost Council (HCQCC) was charged with directing health plans to collect and report race/ethnicity data for the all-payer claims database
 - per regulations promulgated in 129 CMR 2.00
“Uniform Reporting System For Health Care Claims Data Sets”
- ❑ The question is: “How and how much?”

Thank God! A panel of experts!



"Thank God! A panel of experts!"

HCQCC R/E/L Regulatory Motions (all unanimously accepted)



1. Requires health plans to submit self-reported R/E data
2. Includes preferred spoken language **and** written language
3. Specified thresholds beginning July 1, 2010.

Proposed Thresholds for Reporting Race, Ethnicity, and/or Language



| Date | Threshold (assuming no transfer of information from hospitals) | Threshold (with transfer of information from hospitals, DHCFP, or sponsors) |
|---------------------|---|--|
| July 1, 2009 | 0% | 0% |
| July 1, 2010 | 2% | 2% |
| July 1, 2011 | 3% | 5% |
| July 1, 2012 | 5% | 10% |

Meanwhile, while we wait for good R/E/L data to be reported...



What is indirect estimation?

- ❑ Indirect Estimation methodologies use an individual's name and address to estimate the probability that the person is white, the probability that the person is black, Hispanic, Asian, and so on.
- ❑ It does **NOT** assign a specific category to any individual.
- ❑ Approximately 90% of enrolled individuals have enough information to estimate their race-ethnicity.



(2)

MassHealth Hospital Pay for Performance (P4P) to Reduce Disparities

Pay-for-Performance, defined



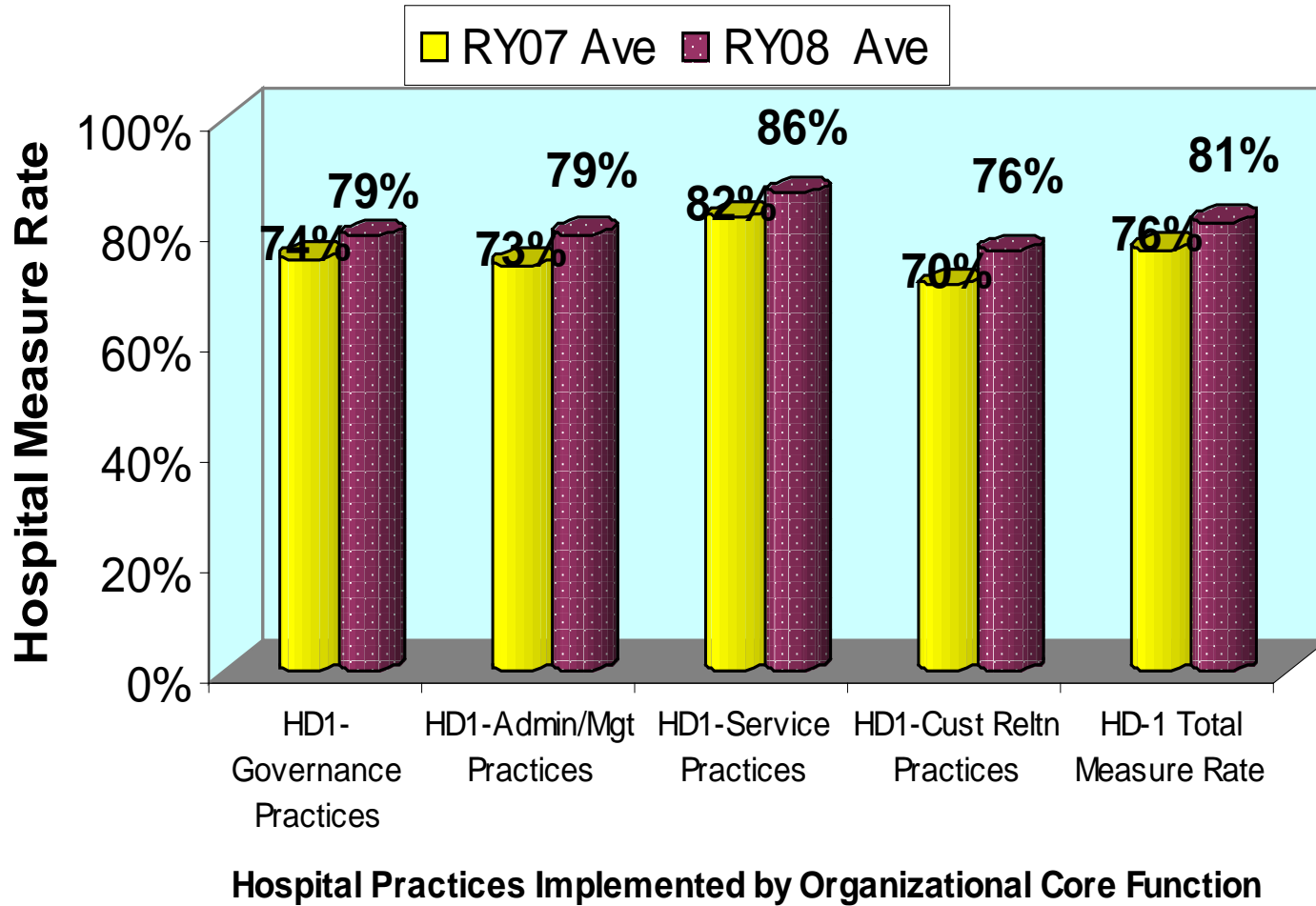
Pay-for-Performance (of P4P) is the practice of rewarding providers to meet quality goals and to improve outcomes of care, rather than paying for the volume of services they provide.

Health Disparities Measurement & Incentive Strategy



| Strategy | RFA08 (Yr.1) HD-1 Structural Measure | RFA09 (Yr. 2) HD-2 Clinical Measures |
|--------------------------------------|--|--|
| Overall Approach | <ul style="list-style-type: none"> <input type="checkbox"/> Reward Hospitals to improve organizational factors that reduce racial/ethnic health disparities. | <ul style="list-style-type: none"> <input type="checkbox"/> Reward Hospitals to report data by Race/Ethnicity & reduce disparities in clinical quality measures |
| Performance Measure | <ul style="list-style-type: none"> <input type="checkbox"/> Require Hospitals to implement CLAS standards regardless of patient R/E/L mix served. | Clinical Quality Measures: <ul style="list-style-type: none"> <input type="checkbox"/> Maternity/Newborn indicators <input type="checkbox"/> Pediatric Asthma indicators <input type="checkbox"/> Pneumonia indicators <input type="checkbox"/> Surgical Infxn Prevention indicators |
| Performance Assessment Method | <ul style="list-style-type: none"> <input type="checkbox"/> CLAS Validation Rate <input type="checkbox"/> CLAS Best Practice Rating <input type="checkbox"/> CLAS Measure Score | <ul style="list-style-type: none"> ▪Data Validation Rate (RY09) ▪Clinical Disparity Measure Score (RY2010) |
| Bonus Payment Approach | <ul style="list-style-type: none"> <input type="checkbox"/> Earn payments for meeting performance thresholds on organizational factors (implementing CLAS). | <ul style="list-style-type: none"> <input type="checkbox"/> Earn payments for meeting performance thresholds on clinical disparities measures |

R Y08 CLAS Measure Rate Results



P4P Challenges



- Implementation problems with the CLAS measure: Does the measure used for implementing CLAS standards for high stakes purposes need to be different than the one used previously just for reporting?
- Should clinical measures be based on Medicaid patients only, or all patients?
- Do Massachusetts hospitals have sufficient numbers of minority cases for stratification purposes? Are there large enough disparities?
- How to address the “between” problem?



(3)

The Massachusetts
Council for the
Elimination of Racial and
Ethnic Disparities

Council's Statutory Responsibilities



❑ Mandate:

- To develop recommendations for reducing and eliminating racial and ethnic disparities in health care access and outcomes within the Commonwealth

❑ Leadership

- Rep. Rushing and Sen. Fargo, Co-Chairs
- Secretary of EOHHS Judyanne Bigby, MD is a member

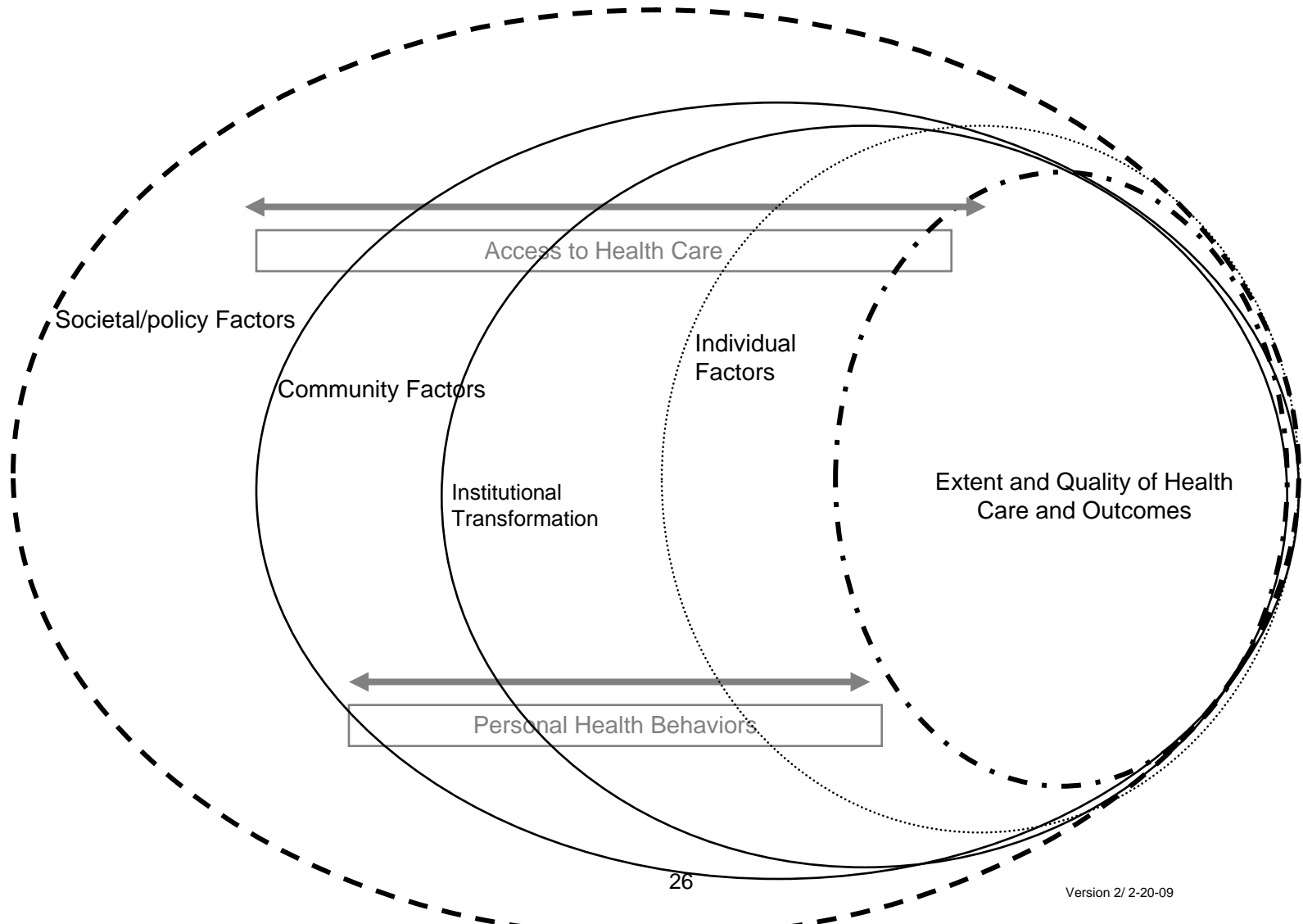
Why a Disparities Report Card?



“...report cards provide transparent public information and a clear incentive for improved performance.”

Trivedi, et al, on creating State Minority Report Cards,

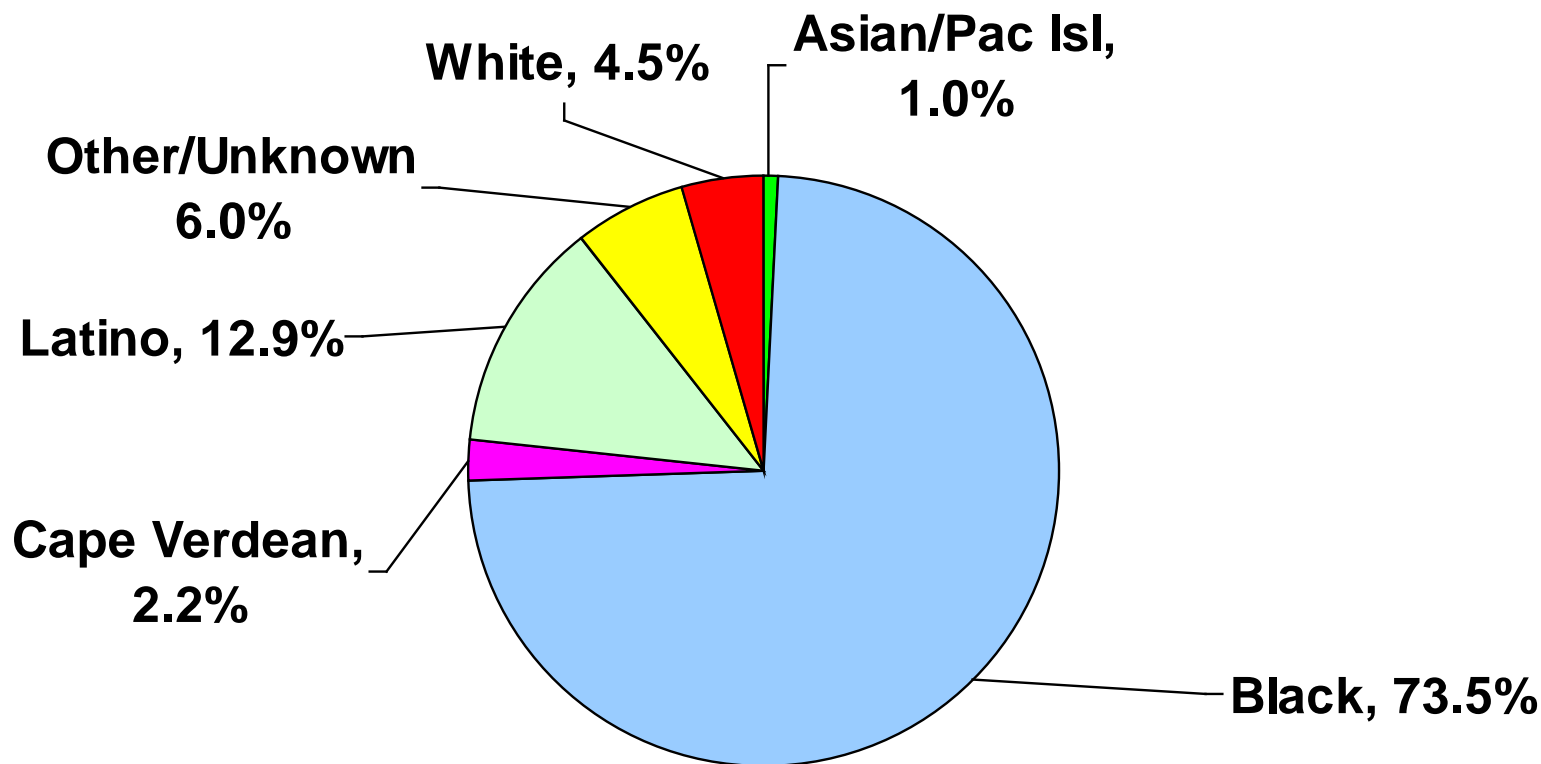
Framework for Addressing Health Disparities



Nonfatal Gunshot Injuries by Race/Ethnicity Boston, 2003-2005 Combined



***Black Bostonians are 24% of total population
and 74% of victims of gunshots***



“Disparities Report Card for Massachusetts -- Outline



- ❑ Health Status Indicators
- ❑ Health utilization, access, and quality indicators
- ❑ Personal health practices/ Individual factors
- ❑ Social determinants
 - Basic Needs and Social Well-Being
 - Community attributes
- ❑ Laws and Social Policies affecting health that may disproportionately affect racial-ethnic minorities

SUMMARY



- ❑ The effect of Massachusetts HCR on disparities is still unknown
- ❑ The QCC is poised to make Massachusetts the first state in the nation to stratify HEDIS-type quality measures by race-ethnicity
- ❑ MassHealth is implementing financial incentives to reduce racial-ethnic disparities in hospitals
- ❑ The Massachusetts Health Disparities Council is creating a Disparities Report Card



Questions???

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