siren
Social Interventions Research & Evaluation Network

RACIAL HEALTH EQUITY IN SOCIAL CARE

2022 National Research Meeting

Challenges and strategies for evaluating racial equity in health initiatives

Day 1: Challenges and strategies for evaluating racial equity in health initiatives

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Agreements for a safe and brave meeting

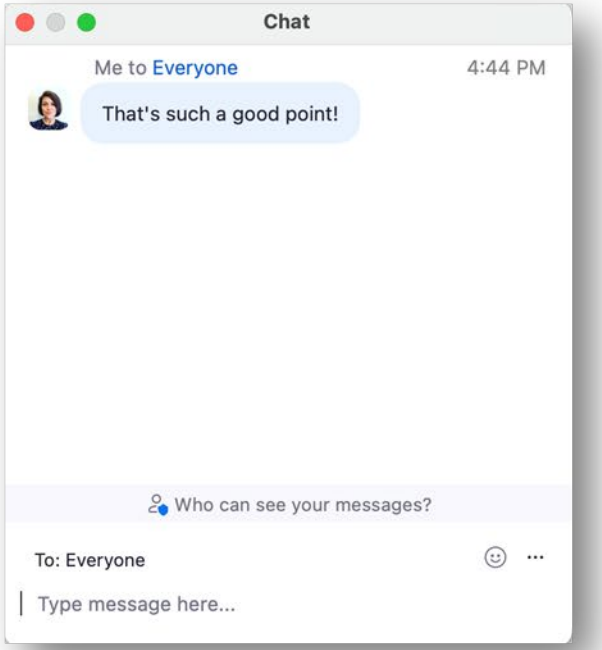
- Practice active, judgement-free, and empathetic listening
- Respect each other's differences and backgrounds
- Agree to disagree – but seek understanding. We are here to learn!
- Honor the difference between unsafe and uncomfortable
- Be curious about intentions but recognize that impact is more important than intentions
- Welcome being called in as a gift and an invitation to learn
- Be mindful of positionality and power dynamics
- Acknowledge judgments and assumptions (including our own – we all have biases)
- Use inclusive language and avoid using derogatory or stigmatizing language
- Release control, privilege, and notions of being right
- Accept that things may remain unresolved; we might not feel a sense of closure

Agreements adapted from Sharon Washington Consulting and those used in the AHRQ Health Equity Summit, as well as internal development

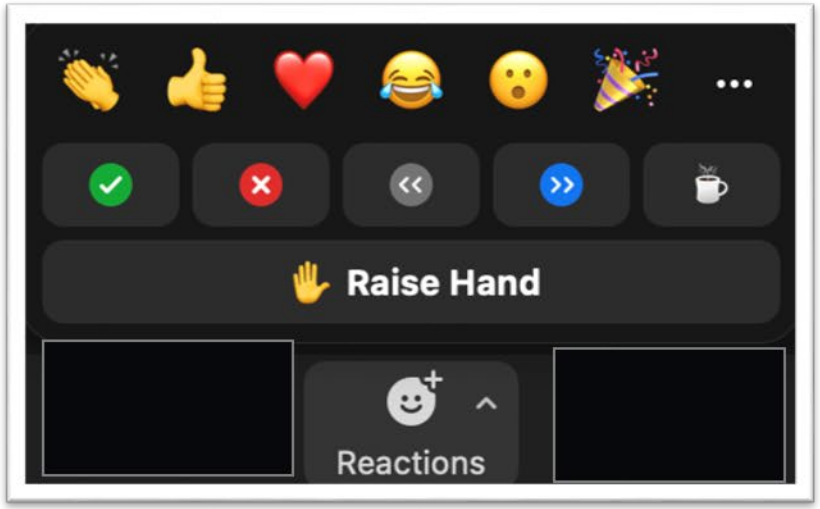
Reminder: This session is being recorded. Recordings and slides will be available after the meeting.

3 Ways to Engage in the Room

1. Chat Window

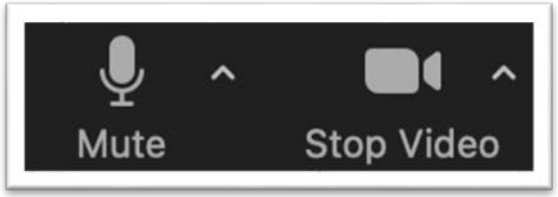


2. Emoji Reactions



3. Audio and Video

(We encourage you to keep your camera on during the session)



…and on Twitter!

#SIRENRacialEquity
@SIREN_UCSF

What have we learned so far about the effect of CMMI health care transformation efforts on health equity?

SIREN National Research Meeting

September 15, 2022

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What is the 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."

The Affordable Care Act

- 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

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The Biden-Harris Administration and CMS Leadership has identified advancing health equity as a key priority

- Historically, most Models have not been explicitly designed to address issues related to health equity, though some Models have addressed equity-related care barriers

- Evaluations are designed to assess the primary and secondary aims of health care Models (costs, quality, and beneficiary experience)
  - As practical and feasible, Model evaluations include subgroup analyses that aim to understand the Model's effects on underserved populations

- Underserved populations are those that are racial/ethnic minorities, beneficiaries with health-related social needs, and beneficiaries that have Medicaid or are low-income

We reviewed recently completed or currently in progress 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 across Models to understand what we have learned about how health care transformation efforts affect underserved populations & generate insights for future Model design

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As of September 2021, 17 Model evaluations include or plan to include a subgroup or stratified analyses of at least one beneficiary subgroup

Inclusion Criteria

If a Model meets one of the following criteria:

Model is designed to address the needs of underserved populations

Model evaluation includes or plans to include health equity related analyses

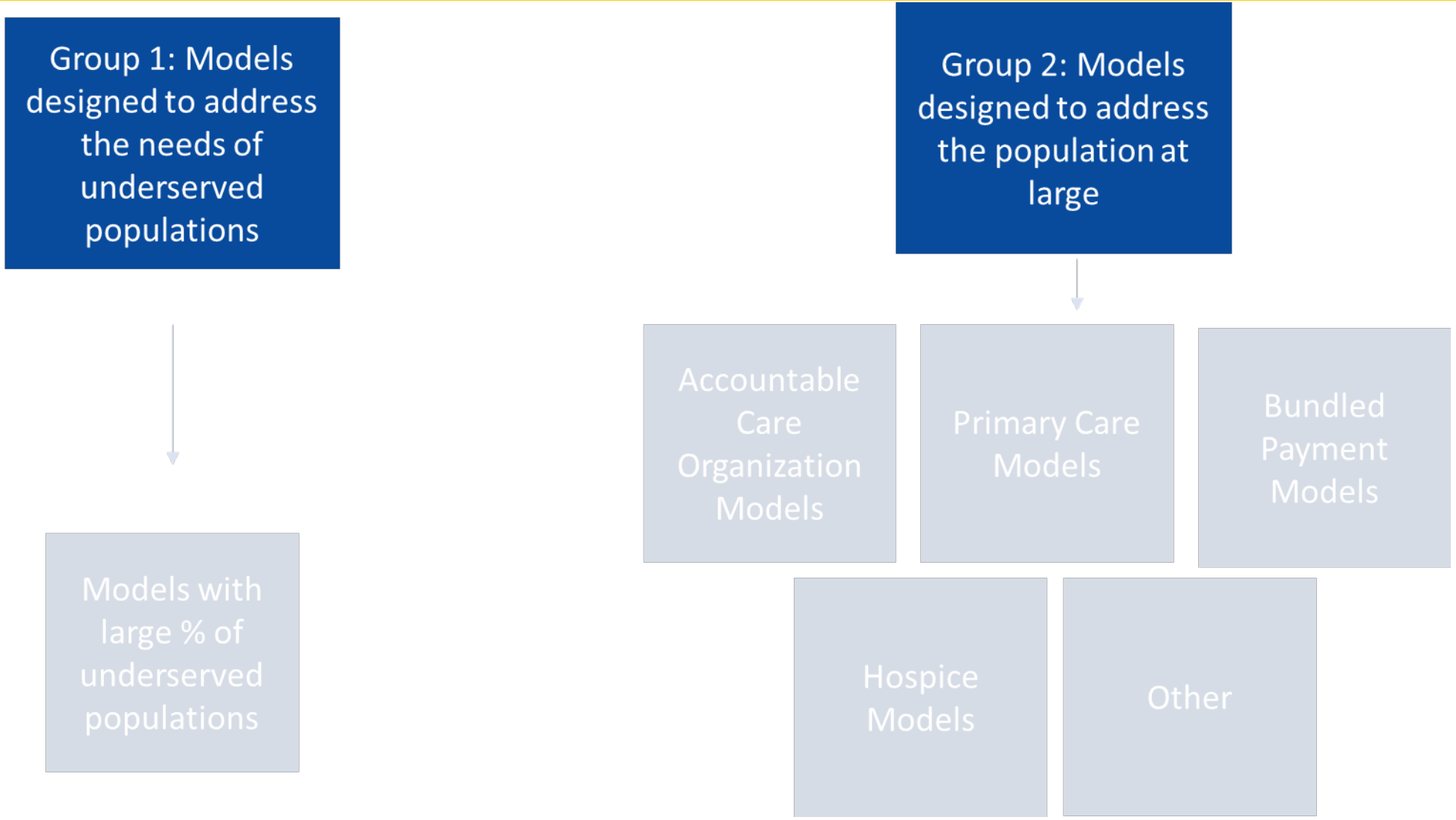
- race/ethnicity
- income/dual status
- health-related social needs

AND

Model evaluation date ranges from 2018 to current

It is included in our review

As of September 2021, 17 Model evaluations include or plan to include a subgroup or stratified analyses of at least one beneficiary subgroup



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17 Model evaluations include or plan to include a subgroup or stratified analyses of at least one beneficiary subgroup (as of Sept 2021)

Group 1: Models designed to address the needs of underserved populations

Models with large % of racial/ethnic minorities, Medicaid, and/or HRSNs

Group 2: Models designed to address the population at large

Accountable Care Organization Models

Primary Care Models

Bundled Payment Models

Hospice Models

Other

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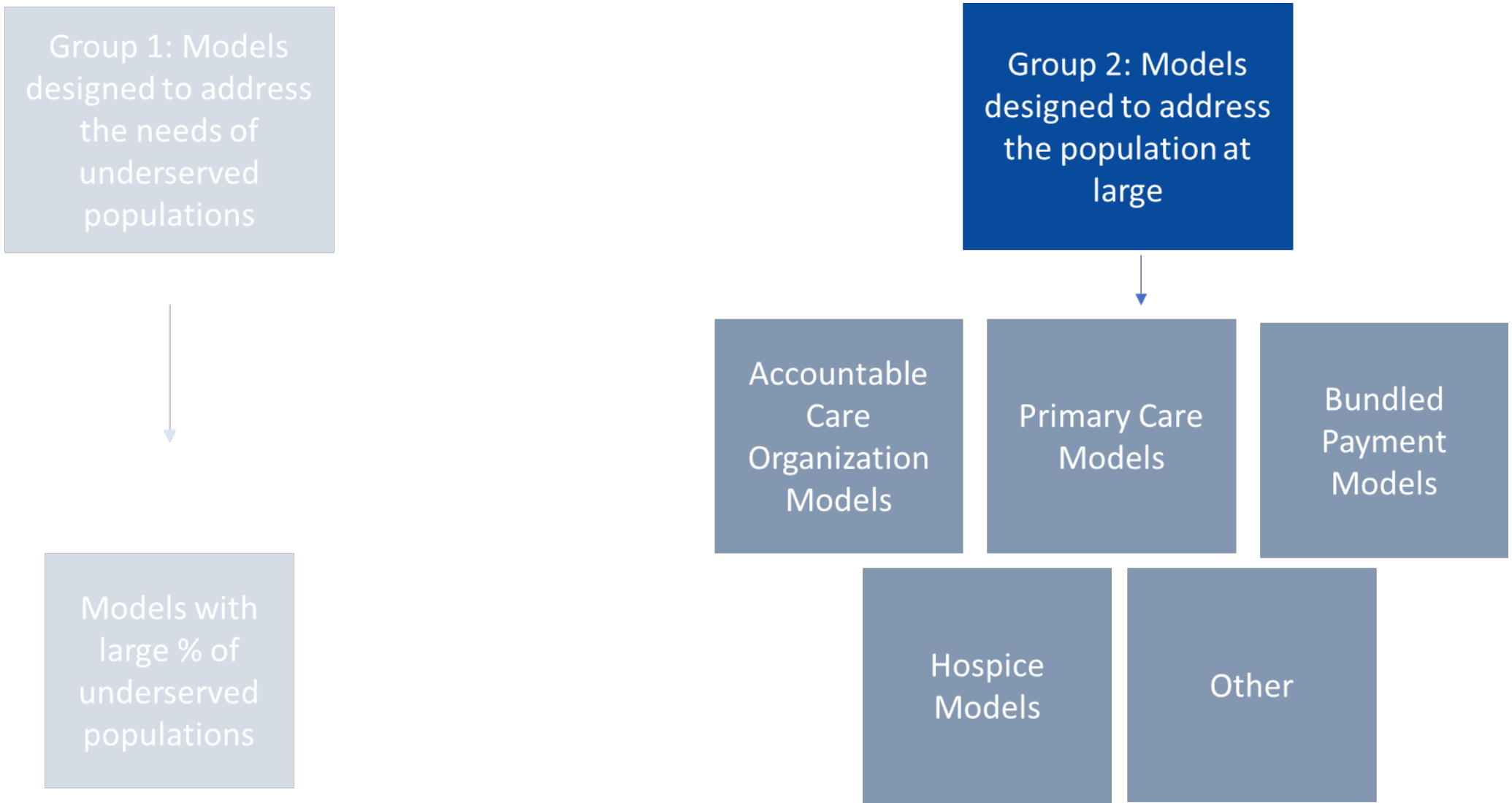
17 Model evaluations include or plan to include a subgroup or stratified analyses of at least one beneficiary subgroup (as of Sept 2021)



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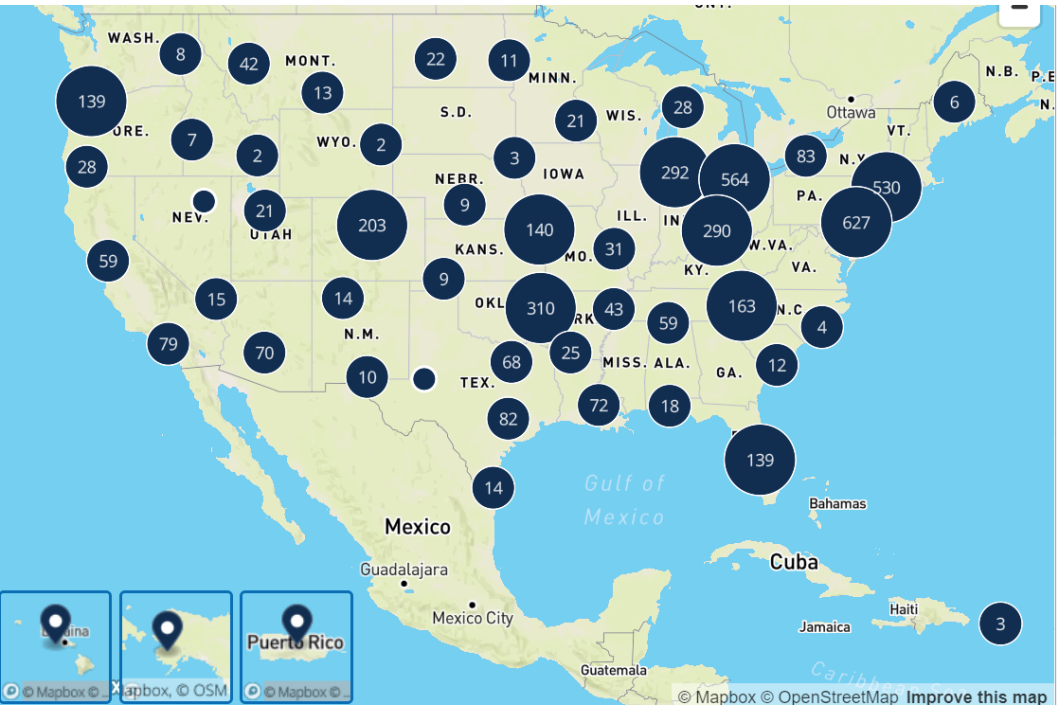
Understanding the Landscape



Historically, Model designs have not specifically focused on equity and have 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 does not prioritize enrolling substantial numbers of underserved beneficiaries limits our ability to identify effects on these populations

Budgetary constraints often limit the ability to conduct extensive subgroup analyses

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Understanding the Landscape

Most Models enroll Black beneficiaries in generally similar proportions as the proportions observed in the Medicare population, but there are exceptions

- About 10% of the Medicare population is Black. CPC+, for example, includes about 9% Black beneficiaries
- Hospice models have lower enrollment of racial/ethnic minorities
- We cannot disentangle ‘other’ so unclear if this holds across races
- Data quality and completeness for race/ethnicity data is a work in progress

Group 1 Models are expected to reach larger proportions of underserved populations

- All Models screen for social needs, but we do not receive screening data for all Models
- Food insecurity is the most common need (AHC)

Group 1: Models designed to address the needs of underserved populations

- Accountable Health Communities
- Financial Alignment Initiative
- Integrated Care for Kids
- Strong Start
- Maternal Opioid Model

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Models designed for underserved populations

AHC
FAI
MOM
InCK
Strong Start

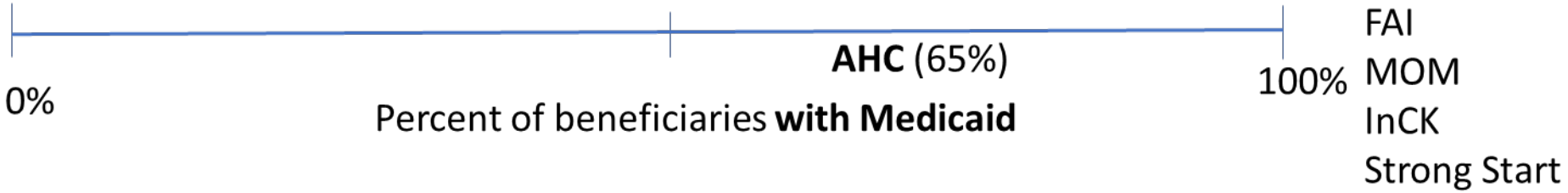
These Models enroll or are expected to enroll a high proportion of underserved beneficiaries

AHC	Beneficiaries eligible for enrollment include about 27% Blacks, 32% Hispanic, and 10% other race
FAI	Racial demographic varies widely, depending on state. Blacks range from 6 – 48%, Asians range from 2 – 8%, Hispanics range from 1 – 21%
InCK	4/7 awardees are serving populations that are majority Black and Hispanic
Strong Start	A wide range of demographic groups represented; 40% of pregnant beneficiaries identified as Black and 30% as Hispanic
MOM	Early in implementation period

Models designed for underserved populations

AHC
FAI
MOM
InCK
Strong Start

All Models in Group 1 screen for health-related social needs and aim to connect beneficiaries with resources to meet needs



HRSN screening has identified a range of unmet needs

- AHC: Food insecurity is the most reported need (69% on average across all sites)
- We do not receive screening data for all Models

Health needs appear to be related to social needs, rates of which are higher for some underserved beneficiaries

Availability of community resources present challenges across Models

Models designed for underserved populations

AHC
FAI
MOM
InCK
Strong Start

FAI Model evaluations report only on descriptive use of services by race/ethnicity because low sample sizes in racial/ethnic subgroups preclude impact analyses

Descriptive utilization analyses show that Black beneficiaries in most states have higher inpatient admissions and ED visits than other racial and ethnic groups

- Does not control for confounders

Models designed for underserved populations

AHC
FAI
MOM
InCK
Strong Start

- Only 23% of infants whose births are covered by Medicaid are Black, but almost 40% of pregnant beneficiaries enrolled in Strong Start identified as Black and 30% identified as Hispanic
- Strong Start Participants receiving prenatal care in Freestanding Birth Centers and Group Prenatal Care had better outcomes at lower cost relative to participants in typical care settings
- For MOM, pre-implementation case studies provide some insights related to equity
  - Most pregnant people accessing OUD services are white, even in diverse areas
  - Barriers include long travel times and transportation problems, limited access to telehealth, lack of childcare, and other social needs

Models designed for underserved populations

AHC
FAI
MOM
InCK
Strong Start

Based on pre-implementation case studies for InCK, several care related barriers have been identified, including:

- Access for rural families
- Differential treatment of children by race
- Inappropriate/inadequate treatment of children with disabilities
- Care barriers related to income, such as inadequate transportation resources

Currently, only descriptive analyses available for race across Group 1 Models

- InCK will have some forthcoming impact estimates
- AHC may do some race-based impact analyses, depending on sample size and data availability

Group 2: Models designed for the population at large

ACO Models

ACO Models are groups of providers that accept joint responsibility for health care cost, utilization, and quality outcomes

NGACO

NGACOs have a higher percentage of white beneficiaries (83%) relative to Blacks (6.3%), Hispanics (4.4%) and Asian (3.6%) beneficiaries

- Lower proportions than are in the eligible populations in NGACO markets

NGACO also enrolls a lower percentage of dually eligible beneficiaries with disabilities (11.2%) compared to FFS Medicare beneficiaries (14.5%) in the NGACO market areas

CEC

Enrollment data shows that 39.4%-41.3% (waves 1 and 2) of beneficiaries are black, 15% are Hispanic

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ACO Models

NGACO
CEC

Impact analyses show no consistent patterns in health care cost and utilization outcomes across race and dual status

Differences in cost by subgroups

- NGACO: Reduction in Medicare spending for white and non-dual beneficiaries only
- CEC: The CEC evaluation observed the greatest reduction in Total Medicare A&B spending and readmissions for full duals

Some differences in utilization by race/ethnicity and dual status within CEC

- No adverse effects observed

Group 2: Models designed for the population at large

Bundled Payment Models

Bundled Payment Models incentivize greater coordination by providing a single target price for an episode of care

CJR	Requires mandatory participation; enrollment data shows 6.4% are Black and 5.9% are Hispanic
OCM	Enrollment data show that 9% are Black, 4.8% are Hispanic
BPCI	Demographic data is not available

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Bundled Payment Models

CJR
OCM
BPCI

Overall, investigations demonstrate very few differences between subgroups and those differences that are significant do not indicate consistent patterns

Health equity research is being expanded in CJR, OCM, and BPCI-A

Group 2: Models designed for the population at large

Primary Care Models

Primary Care Models aim to advance and strengthen quality and efficiency of primary care

IAH	Given the eligibility criteria, the Demonstration includes about 40% beneficiaries with Medicare and Medicaid (dually eligible)
CPC+	Most patients served by CPC+ are White, with about 9% Black, and 7% other races

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Primary Care Models

IAH
CPC+

Beneficiaries with Medicare and Medicaid in IAH received more care outside of institutional settings with no impact on total Medicare and Medicaid spending

- Race subgroup analyses were not performed

CPC+ did not find any differences in key outcomes for patient subgroups based on race and dual status

Results from study comparing CPC+ applicant practice characteristics with non-CPC+ applicant practice characteristics suggest the presence of selection bias

Group 2: Models designed for the population at large

Models involving Hospice

Hospice Models aim to increase access to supportive services in hospice care, reduce spending, and improve quality of care

MCCM

About 8% of beneficiaries enrolled in MCCM are Black, 6% are “other” race/ethnicity, and 12% are dually eligible beneficiaries

- Disparities in hospice uptake are well documented

Hospice component of VBID

Among those eligible for the original VBID Model, 3.7% of beneficiaries were Black, 1.6% were Hispanic, and 11% were dually-eligible for Medicare and Medicaid

Hospice Models

MCCM
VBID

Most of the patients who enroll in hospice are white and not dually eligible

In MCCM, racial minority and dually eligible beneficiaries had less favorable outcomes compared to white and Medicare MCCM enrollees on 5 out of 6 quality outcome measures

The new version of VBID (CY2021 and beyond) aims to increase minority enrollment and include efforts to address social needs

Other Models that encourage appropriate hospice use include OCM and CEC

- Tried to increase hospice uptake but there were no significant changes
- Many providers reported feeling uncomfortable with bringing up the topic of hospice with patients
- Inequities in uptake were also unchanged

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What’s the story?

Historically, Models were not designed to target health equity, but this is changing

Group 1 Models enroll higher proportions of racial minorities and beneficiaries with Medicaid; these Models aim to implement universal screening for health-related social needs

- Programs that conduct screening generally aim to make community connections and develop referral networks, but communities usually do not have adequate resources
- Models focused on care coordination and referrals may have difficulties affecting outcomes without corresponding attention to building infrastructure to meet identified needs

Among some Models that enroll a higher proportion of underserved populations, subgroup analyses are planned but this depends on sample size

Some Models show promising potential for improving care and outcomes in underserved subpopulations, but there are limitations

Model evaluations with impact analyses for underserved populations show no consistent pattern of positive or negative effects on health care cost and utilization, and we find no systematic evidence of adverse impacts on quality

- We cannot draw definitive conclusions and results should be interpreted with caution
- Small sample sizes limit our ability to detect and interpret findings for subgroup analyses
- Race and ethnicity data is incomplete in both Medicare and Medicaid

Limitations of secondary data curtail our ability to assess impacts on some of the most underserved populations

- Claims data does not distinguish within racial categories
- Imputation can help, but not fix the problem

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Some Models show promising potential for improving care and outcomes in underserved subpopulations, but there are limitations

Beneficiary experience is key to understanding the effect of the Model on quality of care

- Models examine beneficiary experience, most commonly through patient surveys, so underserved beneficiaries are included in overall Model analyses
- Subgroup analyses is limited due to sample size
- Confounding between area level factors and demographic characteristics

Evaluations with qualitative information provide a glimpse into the challenges faced by low income, rural, and racial minority populations

- Most information from Group 1 Models, but these are early in implementation so we cannot draw conclusions

What are we doing?

Carefully considering key features from the start of Model design to help increase Model reach and increase enrollment of underserved populations

- Risk stratification
- Eligibility criteria
- Incentives

Collecting data directly from care sites to obtain more accurate and nuanced information about patients and their backgrounds

- Considerations related to burden

What are we doing?

Identifying external data sources with administrative data to help bridge the gaps

- Linking claims with other resources to identify people living in health care or food deserts and people living in areas with high environmental contamination

Qualitative data can help identify critical subgroups and garner perspectives on data quality and paths for change

All of these strategies working **in concert may** help to identify priority populations, inequities they may experience, and potential paths to more equitable outcomes

Thank you

- Federal Evaluation Leads at CMMI
- Renee Mentnech
- Noemi Rudolph
- Dora Hughes

Discussion Questions

- Examples of appropriate/successful uses of social/non-health care interventions, those that address health related social needs, that could be worthwhile for CMMI in the future?
- What opportunities exist outside of government for similar interventions/evaluations?
- We know across health care sectors there are many similar demonstrations, research, etc. in this area. We'd be curious to know what are some of the challenges and limitations you have faced, with respect to either collecting certain SDOH related data, sufficient sample sizes, etc.?
- Ideas for future models that can incorporate health equity?

Innovation Center Models

Group 1 - Models designed to address the needs of underserved beneficiaries

Model Name		Model Goal	Model Website
Accountable Health Communities	AHC	The Accountable Health Communities Model addressed a critical gap between clinical care and community services in the current health care delivery system by testing whether systematically identifying and addressing the health-related social needs of Medicare and Medicaid beneficiaries' through screening, referral, and community navigation services will impact health care costs and reduce health care utilization.	https://innovation.cms.gov/innovation-models/ahcm
Financial Alignment Initiative	FAI	The Financial Alignment Initiative is designed to provide individuals dually enrolled for Medicare and Medicaid with a better care experience and to better align the financial incentives of the Medicare and Medicaid programs. Through the Initiative, CMS partners with states to test two new models for their effectiveness in accomplishing these goals.	https://innovation.cms.gov/innovation-models/financial-alignment
Strong Start for Mothers and Newborns Initiative	Strong Start	The Strong Start for Mothers and Newborns initiative, an effort by the Department of Health and Human Services, aimed to reduce preterm births and improve outcomes for newborns and pregnant women.	https://innovation.cms.gov/innovation-models/strong-start
Maternal Opioid Misuse Model	MOM	The model addresses fragmentation in the care of pregnant and postpartum Medicaid beneficiaries with opioid use disorder (OUD) through state-driven transformation of the delivery system surrounding this vulnerable population.	https://innovation.cms.gov/innovation-models/maternal-opioid-misuse-model
Integrated Care for Kids	InCK	The Integrated Care for Kids (InCK) Model is a child-centered local service delivery and state payment model that aims to reduce expenditures and improve the quality of care for children under 21 years of age covered by Medicaid through prevention, early identification, and treatment of behavioral and physical health needs.	https://innovation.cms.gov/innovation-models/integrated-care-for-kids-model

Innovation Center Models

Group 2 - Models designed to address the population at large

Accountable Care Organizations (ACOs)

Model Name		Model Goal	Model Website
Next Generation Accountable Care Organizations	NGACO	Next Generation ACO Model offered an exciting opportunity in accountable care—one that set predictable financial targets, enabled providers and beneficiaries greater opportunities to coordinate care, and aimed to attain the highest quality standards of care.	https://innovation.cms.gov/innovation-models/next-generation-aco-model
Comprehensive End-Stage Renal Disease Care	CEC	The Comprehensive ESRD Care (CEC) Model was designed to identify, test, and evaluate new ways to improve care for Medicare beneficiaries with End-Stage Renal Disease (ESRD).	https://innovation.cms.gov/innovation-models/comprehensive-esrd-care

Innovation Center Models

Group 2 - Models designed to address the population at large

Bundled Payment Models

Model Name		Model Goal	Model Website
Bundled Payments for Care Improvement Initiative	BPCI	The Bundled Payments for Care Improvement (BPCI) initiative was comprised of four broadly defined models of care, which linked payments for the multiple services beneficiaries received during an episode of care.	https://innovation.cms.gov/innovation-models/bundled-payments
Comprehensive Care for Joint Replacement	CJR	The Comprehensive Care for Joint Replacement (CJR) Model is designed to improve care for Medicare patients undergoing hip and knee replacements (also called lower extremity joint replacements or LEJR) performed in the inpatient or outpatient setting and for total ankle replacements performed in the inpatient setting.	https://innovation.cms.gov/innovation-models/cjr
Oncology Care Model	OCM	The Oncology Care Model aimed to provide higher quality, more highly coordinated oncology care at the same or lower cost to Medicare.	https://innovation.cms.gov/innovation-models/oncology-care

Innovation Center Models

Group 2 - Models designed to address the population at large

Primary Care Models

Model Name		Model Goal	Model Website
The Independence at Home demonstration	IAH	Under the Independence at Home Demonstration, the CMS Innovation Center works with medical practices to test the effectiveness of delivering comprehensive primary care services at home and if doing so improves care for Medicare beneficiaries with multiple chronic conditions.	https://innovation.cms.gov/innovation-models/independence-at-home
Comprehensive Primary Care Plus	CPC+	Comprehensive Primary Care Plus (CPC+) was a national advanced primary care medical home model that aimed to strengthen primary care through regionally-based multi-payer payment reform and care delivery transformation.	https://innovation.cms.gov/innovation-models/comprehensive-primary-care-plus

Innovation Center Models

Group 2 - Models designed to address the population at large

Hospice Models

Model Name		Model Goal	Model Website
Medicare Care Choices Model	MCCM	Through the Medicare Care Choices Model (MCCM), the Centers for Medicare & Medicaid Services (CMS) tested a new option for Medicare beneficiaries to receive supported care services from selected hospice providers, while continuing to receive services provided by other Medicare providers, including care for their terminal condition.	https://innovation.cms.gov/innovation-models/medicare-care-choices
Hospice component of the Medicare Advantage Value-Based Insurance Design	VBID	The hospice component of the VBID Model tests the impact of care delivery and quality of care when participating Medicare Advantage (MA) plans are financially responsible for all Parts A and B benefits.	https://innovation.cms.gov/innovation-models/vbid