MASSACHUSETTS

OVERVIEW OF EQUITY ACTIVITIES

NAIC meeting

July 26, 2022

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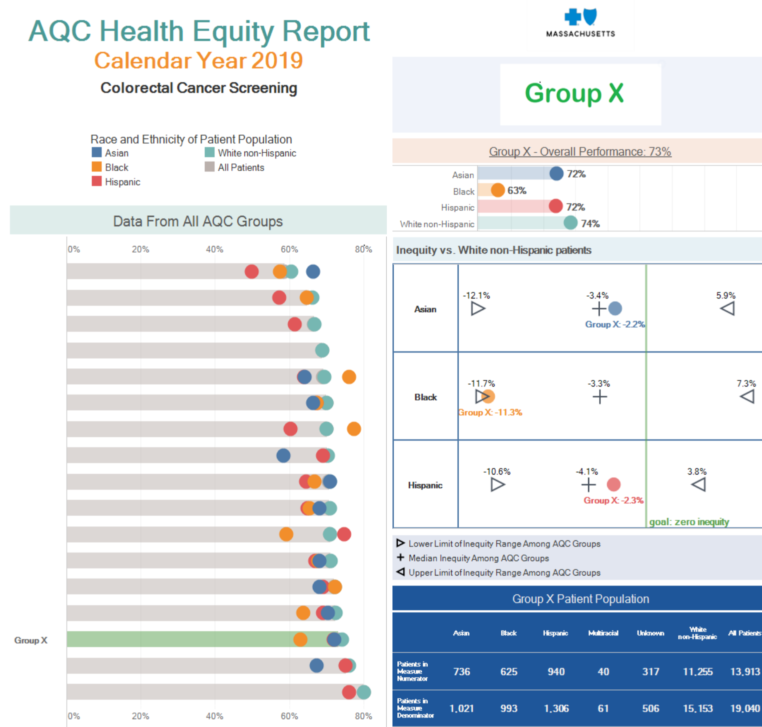
DATA ON RACE & ETHNICITY ARE CRITICAL TO MEASURING EQUITY AND DETECTING BIAS

For BCBSMA, these data enable equity audits of quality measures, algorithms, and other metrics



HEALTH EQUITY REPORT

A once-in-a-century pandemic has exposed nationwide racial inequities in health care.

At Blue Cross, we have a deep commitment to quality, affordable health care and that includes equity. So in 2021, we reviewed 2019 data for more than 1.3 million commercial Massachusetts members (the most recent complete data year). We found racial and ethnic inequities in the quality of care in the majority of measures below. These specific measures were chosen because they are widely used in health care to monitor performance on important dimensions of care and service.

In partnership with the clinicians in our network, we'll use this data to make meaningful change. We're publishing these results, which will be updated at least annually, to hold ourselves accountable. Our goal is eliminating racial disparities in the care our members receive.

LEARN MORE

CHRONIC CONDITIONS

	Asian	Black	Hispanic	White
Asthma Medication Ratio % of members with persistent asthma who received appropriate medication to prevent asthma attacks (ages 5 – 64)	76.20%	69.70%	68.60%	74.70%
Comprehensive Diabetes Care – BP control % of adult diabetic members with blood pressure controlled (ages 18-75)	84.30%	71.40%	76.60%	82.40%

Full report here

RACE AND ETHNICITY DATA COLLECTION: ALL ACTIVITIES

	2021	2022			
	Q4	Q1	Q2	Q3	Q4
SURVEYS VIA MAIL	Randomized 24 arm factorial design experiment to learn which approach maximizes response rate	**Large fielding of "winning" survey (March-April 2022):** First wave Q1 plus "coming soon" email test (March 2022) Email including link to web survey (May 2022) Second wave mailed survey (June-July 2022) Third wave Q3			
MYBLUE	MyBlue Version 1 went live December 2020			**MyBlue Version 2:** New survey version, will allow members to report race & ethnicity in more detailed categories (FHIR level 2)	
ACCOUNTS		1/1/2022 Open Enrollment Other file sharing			
PROVIDERS	BEGAN IN Q2 2021 Review methods used to collect race & ethnicity data. Determine provenance, data standards, and potential for data exchange. So far, only one provider's starting position is not to share. Working within Massachusetts toward vision and principles for data exchange, to avoid fragmented and conflicting databases on race & ethnicity.				

RACE AND ETHNICITY DATA COLLECTION

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MyBlue results (as of 6/28/2022):

- 1,337,419 Unique views of the 'About Me' modal
- 353,979 members have provided their race and ethnicity
- 92,786 are non-White or Hispanic/Latino
- 2 member complaints

MyBlue race, ethnicity and language collection went live on 12/18/2020

Pilot mailed survey results:

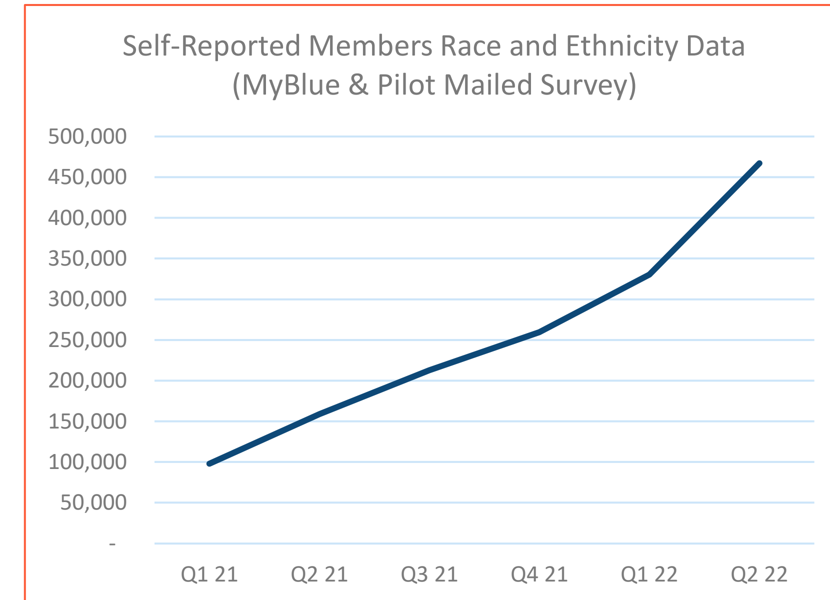
- 55,600 total surveys sent, 139,024 total members
- 9,294 member responses that provided race and ethnicity
- 1,398 member responses that are non-White or Hispanic/Latino
- 2 member complaints

Mailed Dec 9 – 13th 2021; Responses received by Jan 21, 2022

Wave 1 mailed survey results:

- 693,288 total surveys sent, 1,375,437 total members
- 103,721 member responses that provided race and ethnicity
- 15,354 member responses that are non-White or Hispanic/Latino
- 2 member complaints

Mailed March 18 – April 12th 2022; Responses received by June 3, 2022



~19% of BCBSMA current members have provided their race and ethnicity data
2022 Target: **35%**

PROVIDER ENGAGEMENT

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Adding equity to the Alternative Quality Contract (AQC) triad

DATA

PAYMENT

SUPPORT

Confidential **Equity Reports** to all AQC providers distributed September 2021, will be Updated at Least Annually

Pay for Equity Incentives added to AQC payment program beginning as soon as 2023

Equity Action Community with Institute for Healthcare Improvement (IHI) launched November 2021

Health **Equity Grants** to contracted provider organizations in 2022-2023 That Participate in the Equity Action Community via IHI

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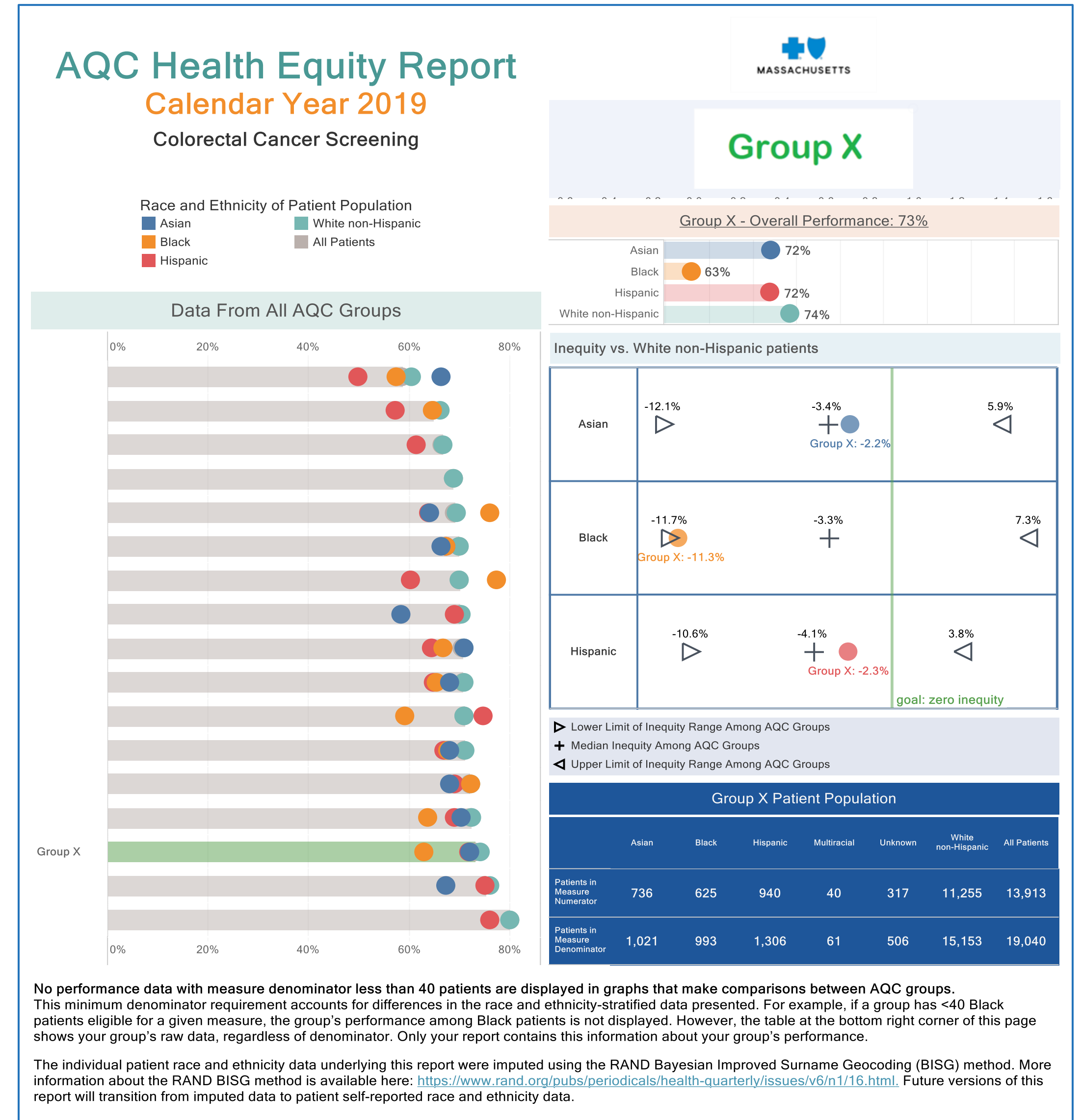
Equity Audits For Providers

We computed each Alternative Quality Contract provider group's internal inequities based on 2019 contracted performance measures

- We shared confidential health equity reports with each Alternative Quality Contract group in September 2021
- Reports include an organization's performance on HEDIS quality measures with blinded comparisons to other provider organizations across the state
- A report mock-up is pictured to the right



	Asian	Black	Hispanic	Multiracial	Unknown	White non-Hispanic	All Patients
Patients in Measure Numerator	736	625	940	40	317	11,255	13,913
Patients in Measure Denominator	1,021	993	1,306	61	506	15,153	19,040

No performance data with measure denominator less than 40 patients are displayed in graphs that make comparisons between AQC groups. This minimum denominator requirement accounts for differences in the race and ethnicity-stratified data presented. For example, if a group has <40 Black patients eligible for a given measure, the group's performance among Black patients is not displayed. However, the table at the bottom right corner of this page shows your group's raw data, regardless of denominator. Only your report contains this information about your group's performance.

The individual patient race and ethnicity data underlying this report were imputed using the RAND Bayesian Improved Surname Geocoding (BISG) method. More information about the RAND BISG method is available here: https://www.rand.org/pubs/periodicals/health-quarterly/issues/v6/n1/16.html. Future versions of this report will transition from imputed data to patient self-reported race and ethnicity data.

PROVIDER EQUITY SUPPORT GRANT

Preparing our providers for P4E

- $25 million granted to Institute for Healthcare Improvement (IHI), for distribution to providers participating in the Equity Action Community in 2022 and 2023
- Purposes:
  - Defray costs of participating in Equity Action Community
  - Support development of core capabilities (e.g., data, equity performance tracking)
  - Begin targeted improvement efforts on equity performance measures
- Distribution & monitoring will be up to IHI
  - Goal: Produce maximum measurable improvements in BCBSMA's statewide equity report

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BLUE CROSS BLUE SHIELD OF MASSACHUSETTS CONTRIBUTES $25 MILLION TO HELP LOCAL HEALTH CARE ORGANIZATIONS ADDRESS INEQUITIES IN PATIENT CARE

BOSTON — December 2, 2021 — Blue Cross Blue Shield of Massachusetts (Blue Cross) today announced it will contribute $25 million to support local health care organizations in their efforts to improve the equity of care their patients receive. The company announced in September its plans to incorporate equity measures — differences in the quality of care across racial and ethnic groups — into its contracts and payment programs with clinicians who care for Blue Cross members starting in 2023. As part of that work, Blue Cross will distribute $25 million in funding to the Institute for Healthcare Improvement (IHI) to assist physician practices and hospitals in their equity improvement efforts and help them prepare for the rollout of financial incentives linked to improvements in inequities in care.

PRESS RELEASE

DESIGN PRINCIPLES FOR PAY-FOR-EQUITY IN ALTERNATIVE QUALITY CONTRACT

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1. Incentivize and enable improvement in measures of the equity of care.
2. Apply BCBSMA's longstanding standards for validity and reliability for high-stakes measurement to pay-for-equity (P4E).
3. Do not pay for equity improvements resulting from performance declines.
4. Emphasize collaboration over competition between provider groups.
5. Maximize the likelihood of positive spillover effects for patients who are not BCBSMA members.
6. Do not penalize providers who serve more diverse patient populations.
7. Apply greater financial incentives when inequities are larger in magnitude and affect larger populations.
8. Incentivize providers to collect & share more complete and accurate race & ethnicity data.
9. Maximize understandability and behavioral impact of P4E design.
10. Make incentives durable over time, to reward improvements that take time to achieve.
11. Future-proof P4E methodological chassis:
    a. Robustness to changes over time in provider group structure and patient population served.
    b. Generalizability to any number of member categories or dimensions of equity (e.g., beyond race & ethnicity).
12. Harmonize BCBSMA's P4E design with other payers' P4E designs.

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We are formulating our strategy re equity & provider directories

Guiding questions:

1. *Which changes to provider directories might improve the equity of care our members receive?*
2. *How might these changes interact with BCBSMA's other equity strategies, and strategies used by other payers?*
3. *How might we assess the effects of these directory changes?*

THANK YOU

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