

**Technical Assistance Webinar: Collecting and Using Stratified Data for
Quality Improvement in Medicaid And CHIP
Transcript
Thursday, July 11, 2019**

Hello, everyone. And thank you for attending today's Technical Assistance Webinar.

Before we begin, we'd like to go over a few housekeeping items. At the bottom of your audience console are multiple application widgets that you can use. You can expand each widget by clicking on the Maximize icon at the top right of the widget or by dragging the bottom right corner of the widget panel.

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Now I'd like to introduce Gigi Raney from the Center of Medicaid and CHIP Services. Gigi, you now have the floor.

Thank you, Brian.

And this is Gigi. I am with CMS in the Division of Quality and Health Outcomes, and we wanted to welcome you to today's webinar. We've been looking forward for a long time to have a webinar about stratification, and we were excited to be able to – to pull this together for us today.

So here's our Agenda for today. We're going to be focusing on collecting and using stratified data for quality improvement in Medicaid and CHIP. And we've invited our technical analytic support contractor Mathematica to join us to provide some background on collecting and using stratified Core Set data, as well as our colleagues from the Office of Minority Health, Shondelle, to share some information on collecting and using the data to reduce disparities.

As we know, it's really important, not only to us, but to you, to hear from states how they are doing things and how this will work in the real world. We invited two state presenters to share their experience with stratified data. So we are really excited to hear from Larry Humble and Eddy Myers and Kolynda Parker from Louisiana and Tom Curtis from Michigan. We're then going to come back to Mathematica for some info on using MACPro to report the stratified data, as well as some additional resources on this topic.

Next slide, please.

So, this kind of goes into the objectives slide. It pretty much says what I just said about focusing on the importance of collecting and using stratified data for quality improvement, and learning from our state speakers, and making sure that states have the resources that they would need to be able to actually

Technical Assistance Webinar: Collecting and Using Stratified Data for Quality Improvement in Medicaid And CHIP

stratify their data or be able to look at their data and see how they can improve it so that in the future they might be able to do this.

And now I'd like to turn it over to Alli Steiner with Mathematica.

All right. Thank you so much, Gigi. So, go to the next slide here.

And, again, my name is Alli Steiner. I work on the Technical Assistance Team for the Core Set project. And so just to get us warmed up today we're going to start with a poll to learn about states' experiences calculating and using stratified data. You should see some questions popping up on your screen in the event console.

And so, our first question is, "Does your state stratify Core Set measure rates by beneficiary characteristics such as race, ethnicity, geography." And, for this question, we're interested in knowing whether you calculate these rates regardless of whether or not you report them in MACPro.

So, take a moment to respond to that and then hit Submit.

Next slide, please.

All right. We'll just give a few more seconds. All right. And now I'll go to the result slide.

All right. So you can see about 38% of the people who responded say they do stratify Core Set measure rates. Twenty-seven percent said no. Some said they don't know. And then some said they're not – it's not applicable because they're not from a state agency.

All right.

And so, for the next question, for those who answered yes to the first question about stratifying Core Set measures, which stratification categories do you calculate? And for this one you can select more than one.

All right. So let's see the results.

All right. So it looks like race and/or ethnicity is the most commonly-reported stratification category. Sixty-two percent of respondents selected that. Then followed by the next-most-common category is sex. Followed by urban/rural location. And then primary language. And then followed by disability status. So – actually if you can scroll down a little bit more. Oh, and then we also have eligibility group which is at – is at 38%. And then a number of people said Other or not applicable.

All right. So then we'll go to the next polling question.

So we're – we're interested in knowing what are the barriers to calculating stratified rates. So, this next question asks, "Which of the following are the greatest barriers to calculating stratified rates?" And, again, you can answer more than one – you can select more than one option.

All right. Let's see the results.

Okay, interesting. So, it looks like data quality is the number one barrier that states encounter for calculating stratified rates, so it sounds like – and that's closely followed by data availability. So, having high-quality data and having available data to calculate these rates, those are the two most common selected barriers, so that's helpful information to know. And then followed by staff time and budget, because we obviously understand it's a lot of effort to calculate these rates. And then followed by leadership priorities. And then a smaller number of people responded Other.

And if you said that you experience other barriers, we'd be interested in learning more about that in the post-event evaluation that will pop up at the end of the webinar. And so this evaluation will also give you

Technical Assistance Webinar: Collecting and Using Stratified Data for Quality Improvement in Medicaid And CHIP

the opportunity to tell us what kinds of technical assistance would be helpful to help address some of these barriers.

So, that was really helpful just to give us some context about who's on the call and what you've done so far for stratifying Core Set data. And now we'll head to the next slide.

So, over the next few slides we're going to talk about stratifying Core Set data and how it can help support your quality improvement efforts.

Next slide, please.

So, CMCS encourages states to stratify Child and Adult Core Set data by subpopulations. Aggregate state-level reporting is very important for measuring quality using the Core Set, but it can often mask differences between subpopulations or differences in different regions of your state. And so, information on variation in performance by beneficiary characteristics can be used to help tailor quality improvement efforts by beneficiary subgroups and help monitor progress in reducing disparities.

And so, currently in MACPro, states have the option to stratify each of the Core Set measures by race, ethnicity, sex, language, disability status, urban rural geography, and adult eligibility group, which is ACA expansion group.

Next slide, please.

This slide shows the status of state reporting of stratified data in MACPro for federal Fiscal Year 2017, which is the most recent publicly-available data. And as you can see, more states stratified Adult Core Set measures than Child Core Set measures. And the most frequent categories were race and ethnicity, which aligns with the poll that we did earlier in the webinar.

So of the 46 states that reported any Adult Core Set measures for FFY 2017, eight states reported one or more stratified rates.

And then for the Child Core Set, four out of the 50 states and D.C. reported stratified rates.

And so having stratified data for more states, more measures, and additional beneficiary characteristics could really help CMS and states plan and implement improvement activities that are targeted to subgroups with lower rates.

Next slide, please.

One of the first steps in using stratified data for quality improvement is to select – is to select measures that target reducing disparities. So this includes considering the prevalence and magnitude of the disparity, the evidence of the association between the measure and the outcome of interest, and the actionability of the measure for quality improvement.

The National Quality Forum Disparities Committee identified several Core Set measures as examples of disparities-sensitive measures including those focused on blood pressure control, hemoglobin A1c control, treatment for alcohol and other drug abuse or dependence, and low birth weight.

And, again, these are just a few examples of measures that you might consider for these efforts.

And then once you have calculated stratified data, you can use it for quality improvement in a few different ways.

First, you can publicly report stratified data to increase awareness and accountability.

Second, you can develop quality improvement projects focused on disparities that rely on stratified data.

And third, you can tie performance incentives to reducing disparities.

Technical Assistance Webinar: Collecting and Using Stratified Data for Quality Improvement in Medicaid And CHIP

Next slide, please.

This slide shows a roadmap for promoting health equity. As you can see, the first step is to identify disparities, which really drives home the importance of stratifying performance improvement data to help identify where those disparities are.

Next slide, please.

So now we'll pause briefly to see if anybody has a question before moving on. You can submit questions to the Chat box, or you can also press five star to raise your hand if you would like to speak out loud.

All right. Well, hearing that there are no questions, and there will be other opportunities later in the webinar as well, we're going to move on to the next slide, please, and I'm going to pass it over to Shondelle Wilson-Frederick who is at the CMS Office of Minority Health. So, Shondelle, you now have the floor.

Good afternoon for those of you who are on the west – east coast. And for those of you on the west coast, good morning. My name is Shondelle Wilson-Frederick, and I'm a statistician in the CMS Office of Minority Health. And I am very delighted to have this opportunity to share with you some of our recent findings from our five-year, now, stratified reporting program in the Office of Minority Health.

Next slide.

So here at CMS we apply a three-prong framework which we have branded the USA framework. The U stands for increasing understanding and awareness of disparities. S, developing and disseminating solutions. And A, implementing sustainable actions.

We use these three methods in order to ensure that the voices of the various populations that we represent, including racial ethnic minorities, people with disabilities, those who live in rural communities, and sexual and gender minorities, that their voices are expressed in the various programs and initiatives that not only our office leads but that are developed and disseminated by the agency.

The vision of our office is to ensure that all CMS beneficiaries have achieved their highest level of health. And that disparities in healthcare quality and access have been eliminated.

Next slide.

So, today most of the information I'm going to share is going to be based on the Medicare population. But, we can certainly envision, right, once our Medicare – the quality of our Medicaid data has improved, that these similar programs and projects could also be applied to Medicaid.

So let's just – let's go to the next slide.

Okay. So, in terms of understanding disparities. So, this is important because despite advances in – in health access and also in healthcare, even with increased spending, and we've seen improvements of quality, racial and ethnic minorities, they continue to fare worse and have worse health outcomes. So in order to better understand why there are disparities, it's important for us to collect data in a standardized and systematic way so that we can not only report on what we observe, but so that we can also monitor improvements.

So, by stratifying the data, it allows for us to identify disparities, but also target areas where we can make those improvements.

Next slide.

So, in 2019, April 2019, we released our fifth national stratified report, and the red arrow there highlights directing you to a thumbnail on our website where you can access all of these reports. And in November

Technical Assistance Webinar: Collecting and Using Stratified Data for Quality Improvement in Medicaid And CHIP

2018, we released our first rural health report that stratified by rural and urban geography by race ethnicity.

For the national report on quality measures, we stratified by race ethnicity, gender, and we also examined quality measures stratified by race within gender groups.

So, over the years of producing these stratified reports, we continue to get positive feedback from health plans as well as from various other stakeholders, and so that's one of the reasons why we continue producing them.

Next slide.

So, this next slide here shows a screenshot of our 2019 report titled Racial, Ethnic and Gender Disparities in Health Care and Medicare Advantage. This report is comprised of two sources of data. The first reports on patient experience measures, and those data are derived from the 2016 and '17 Medicare Consumers Assessment of Health Care Providers and Systems. The acronym is CAHPS.

The second data source is also a long one, and this reports on clinical care measures, and it's called the HealthCare Effectiveness Data and Information Set, also known as HEDIS. So this report compares quality of care for women and men and looks at racial and ethnic differences in quality of care among women and men separately.

In addition to the national report, we also co-release data stratified by racial and ethnic groups at the contract level, so at the health plan level, for both the clinical care measures and the patient experience measures.

Next slide.

So these are just some findings from the 2019 report. Hispanic women and men received worse clinical care than white women and men on 33% of measures reported. And reported worse experience with care on 29% of those measures.

For the majority of the clinical care measures examined, Asian and Pacific-islander beneficiaries received care that was either similar to or better than the care received by white beneficiaries.

Compared to white beneficiaries, American Indian or Alaska Native beneficiaries reported worse experience on getting appointments and care quickly. And similar experience on six other measures.

Black women received worse clinical care than white women on 42% of the measures and reported worse experiences with care on 29% of the measures.

One thing I wanted to mention is that one of the early slides, on slide 16, several of the measures that were shown as examples by the National Quality Forum were actually able to report on using these data sources. Namely, blood pressure control as well as treatment for alcohol and other drug abuse or dependence. But that wouldn't be possible, again, if race and ethnicity were not reported in a systematic way. And if we did not develop a standardized way in order to present the information.

Next slide.

So, this next slide here shows a screenshot – actually the next two slides show a screenshot – of the contract-level reporting. So this is even more granular than the national reports because in the national reports we're presenting an aggregate, so an overall average of all contracts that were able to report information. So by – so by showing the information at a more granular level, health plans, so you can think of states, could then go in and see how their state compares to other states based on a given quality measure. So the example here shows colorectal cancer screenings stratified by race and ethnicity. And that second gray row shows the average of all the contracts that were able to report on this measure by race and ethnicity. API is the acronym we use for Asian and Pacific-Islanders or Pacific Islanders.

Technical Assistance Webinar: Collecting and Using Stratified Data for Quality Improvement in Medicaid And CHIP

And then the column to your left shows the H contract. And so, if you know the contract, for instance, for this example, if you know that Kaiser Foundation is contract 80524, we have our information set up in Excel where you can just filter or do a search for that specific contract.

But you can see when you compare to the average for all reported contracts that Kaiser fares pretty well across all racial and ethnic groups. And so that's one of the benefits of us showing the data in this more granular format.

And then for the next slide, we show patient experience measures similarly shown in a comparable format where that second row of gray information shows the average of all reported contracts, again stratified by race-ethnicity. And the quality measure that we're showing here is for – oh, I failed to include that. But this is for ability to get scheduled appointments quickly.

And, again, we can see, since this is stratified by state, that the state of California seems to compare, equally compare, to what we see for an average for all reported states.

Next slide.

So as I mentioned in the introduction, we released our first rural-urban disparities report in Medicare in 2018. And it used similar data to our race and ethnicity report.

Next slide.

So key takeaways from the 2018 rural-urban report include that both – oh, one key difference of this report than our race and ethnicity report is that the rural-urban report includes both Medicare Advantage and Fee-for-Service. Those are two different types of Medicare. The race and ethnicity report only included Medicare Advantage.

So, in the rural-urban report, we see that both MA and Fee-for-Service beneficiaries living in rural areas had worse flu vaccination rates than MA and Fee-for-Service urban beneficiaries. MA beneficiaries living in rural areas received worse clinical care than MA beneficiaries living in urban areas for 54% of the measures, so more than half of the measures.

Rural-urban patient experiences among MA beneficiaries enrolled by race ethnicity included that rural-urban whites reported similar experiences with care. Rural blacks reported experiences with care that were often worse than urban blacks. And that rural Hispanics reported better experiences with getting needed care and doctor communications than urban Hispanics.

So, since we have information on geography, we're able to use that to now look at another dimension of health disparities that otherwise wouldn't be available if we weren't collecting this information in a standardized way.

Next slide.

So, finally, we're able to take this information, understanding disparities, developing solutions, and then – and now develop solutions. So the next series of slides are going to go over some materials that our office has led the development of to help states – to help health plans in order to improve data collection. And also just advance equity among Medicare and Medicaid beneficiaries.

Next slide.

So this slide shows different infographics highlighting the six priority areas of our CMS Equity Plan for Improving Medicare. This plan was released several years ago, and it remains to be not only a foundation for our agency and how we address health disparities, but also it is the blueprint for all the work that we do in the CMS Office of Minority Health.

I'd like to highlight priority one which focuses on increasing understanding and awareness of the value of collecting and analyzing standardized patient data. It also focuses on developing solutions and tools for

Technical Assistance Webinar: Collecting and Using Stratified Data for Quality Improvement in Medicaid And CHIP

stakeholders to collect and analyze local data and pinpoint needs and health disparities in their community.

All six of these priorities include not only Medicare beneficiaries but those who are dually-eligible for Medicaid. Our office does quite a bit of work in collaborating with our Duals office, and we wanted to make sure that this equity plan for Medicare encompassed that population as well.

Next slide.

So one of the first products of the equity plan was the Mapping Medicare Disparities tool. The main source of data for the MMD tool comes from the 2012 through 2017 CMS administrative claims data for Medicare beneficiaries enrolled in the Fee-for-Service Medicare program. We also include information on beneficiaries who are dually eligible for both Medicare and Medicaid.

With the MMD tool, it's possible to perform geographic comparisons at the state, county level, rural versus urban, as well as the national level. And so the next slide actually shows a screenshot from an analyses I ran on the Dual population. And this figure shows that, based on the Arizona statewide prevalence of pneumococcal vaccination in 2017, that eight percent of whites versus 11% of American Indian or Alaska Native dual beneficiaries were vaccinated. Therefore, a higher percentage of AIANs than white duals were vaccinated in the state of Arizona in 2017.

So this could be used by state health plans to perhaps do more targeted interventions for specific populations in their state. A state can then go in – so I could have also gone into Arizona and looked at the county level to see which counties may fare better than other counties to even have more targeted interventions or just more targeted focus or programs in order to improve vaccination rates in those respective counties.

But one thing I do want to highlight on this screenshot is underneath the text at the top of the map you see like three blue squares. One of them says Trend View. Another State Profile View. And the third National Profile View. And so, on the next slide I show examples of the Trend View and the State Profile View. For the Trend View, you're able to see data points for each year from 2012 to 2017 based on the Medicare Fee-for-Service administrative data. So you can actually monitor and track disparities with this tool and monitor improvements.

And then on the right side you see information at the state level. So for – this is statewide in Arizona over multiple years. And this data comes from the American Community Survey which is led by the U.S. Census Bureau.

So all of this information is embedded into the Mapping Medicare Disparities tool. There's no need for you to go to the Census Bureau to get the data. We already have it embedded in the tool for you to use.

Next slide.

So now after developing solutions, we can actually implement action. And here is actually where we've done quite a bit of work in developing tools for our stakeholders to use. Also tools that we shared across the agency.

The next slide highlights CMS-proposed rules that we've been involved in with other parts of the agency around collecting data on social determinants of health. And examples of those measures that we proposed in these three bulleted items that you see on the slide are actually shown on the next slide.

And so there are seven items that we have proposed to be collected by post-acute care on the post-acute surveys in all post-acute care settings. Race-ethnicity. Preferred language. Interpreter services. Health literacy. Transportation. As well as social isolation.

On the next slide we show one of the products that we've developed as part of our building an organizational response to health disparities initiatives. This was actually one of the first products from that initiative, and it's a compendium of resources for standardized demographic and language data

Technical Assistance Webinar: Collecting and Using Stratified Data for Quality Improvement in Medicaid And CHIP

collection. This compendium is a very useful resource. It includes information on the minimum required HHS standards for collecting race-ethnicity, sex, and disability information. We also include guidelines for collecting data on disability. And we frequently keep it updated, so it's not one of these items that we post to our website and it just stays there and the information isn't current. We keep it current. We update it a couple of times a year. And it includes active hyperlinks so that you don't have to search for the information. It's kind of like a one shot – one-stop shop of information on collecting these various disparities demographic information.

The next slide highlights a very valuable resource. So we – our office – the Office of Minority Health – we actually offer technical assistance to health plans, to states, to other stakeholders on collecting real data, race-ethnicity, language, disability data. And so if any of you are interested in how you could strengthen your data collection, improve the capacity of your team to collect this information, I encourage you to reach out to us at the HealthEquityTA email box that's shown at the bottom of the slide. We can help you with developing disparities impact statements in order to get the support of your organization to collect this information. As well as direct you to various tools and resources so you don't have to reinvent the wheel to develop different assessments in order to collect this information.

And then we can go to the next slide, which I think is the final slide, that just includes my contact information, the website for the Office of Minority Health, as well as the email box to receive health equity technical assistance.

Thank you, so much, Shondelle. I didn't see any questions.

Great, so we can go to the next slide. We're going to have another opportunity for questions. And I just wanted to remind everybody that the slides are available in the Resources widget, so all of those really great resources that Shondelle just pointed out, you can access the links to them in the slides.

And so, we do have a couple of questions that have come in through the Chat box. The first question it says, "Is it true that CMS will release a guidance on core measure criteria for the required 2024 Adult and Child Measures mission? For example, if hybrid measures are required, if stratified measures are required, which core measures should be submitted? Thank you." So, I think I'll turn it over to the CMCS colleagues to answer that question.

Thank you. And this is Gigi speaking. Yes, CMCS is in the process of developing a rule which we will be putting out for comment probably in the next year or two to address any questions or concerns that might be raised about the mandatory reporting. For those that aren't familiar with the change, currently reporting of the Adult and Child Core Sets is voluntary for states. And we know that – we definitely appreciate all of the hard work that states have put in to reporting the measures on this voluntary basis. And we'll still actually really appreciate it when it's mandatory as well. But with the Balanced Budget Act of 2018 and the Support Act of 2018, reporting of both the Child Core Set measures and the behavioral health measures on the Adult Core Set becomes mandatory starting in 2024. So, we are working on that rule right now. We'll be putting out guidance and definitely be open to comments for that.

We – we know that states are very curious about what is this going to mean. So far what we have clarified is that mandatory means all measures are expected to be reported, and that we – we will be working with states so that they can report the measures on the entire population of Medicaid and CHIP beneficiaries in their states. So, all of the beneficiaries on all of the measures that are on the Core Sets.

So, thank you very much for the question.

All right. Thank you, Gigi.

And we have one more question, and I think it would be best directed at Shondelle. The question is, "I believe you mentioned Medicare or Medicaid. Can we use these tools for a CHIP population?"

Sure. So the tool – I'm – I'm guessing that you're talking about the compendium that I referenced in terms of the different resources on collecting race-ethnicity, disability, or language information? Is that what's

Technical Assistance Webinar: Collecting and Using Stratified Data for Quality Improvement in Medicaid And CHIP

being referenced in terms of tools? Or in terms of just stratifying quality measures by race and ethnicity and gender?

I – it was a Chat message, so I believe it was the former, the tools that you shared during the presentation.

Yes, yes. They could be used for collecting information on children, yes, most definitely. And if they want to follow up with me with a more specific question, they can. Whoever asked the question.

All right.

And I think one of the things that Shondelle highlighted in her presentation was that all of these materials have been developed and reports that they've run in Medicare are things that we look forward to being able to do with Medicaid as well once we have that data available. But we know that there is – there is some commonality across states with the different disparities that people see across race, ethnicity, and gender in these measures. So, just because we see it happening in the Medicare population doesn't mean that that's not – the same thing isn't happening in your Medicaid population.

Right. Right. And you can – I mean, to do like a quick data run, I encourage you to use the Mapping Medicare Disparities tool and run an analysis just focused on the Dual population. That may also provide some insight on what may be going on in Medicaid.

All right. Thank you. Well, we don't have any questions. Again, we'll have two more opportunities for questions, so I think we'll keep moving. If you could go to the next slide, please.

So, we're really excited to have representatives from two states here with us today. We're going to hear from Larry Humble and Eddy Myers from Louisiana, and we'll hear from Tom Curtis from Michigan. And so we thought it was really important to bring the state perspective into the presentation and learn about what they've done, and what challenges they've experienced, and what best practices they've – they've encountered along the way. So, we'll go to the next slide, and then we'll pass it over to Larry and Eddie to start us off.

Thank you, Alli, and greetings from Louisiana. My name is Larry Humble. Eddy Myers and I are with the Office of Outcomes Research at the University of Louisiana at Monroe. We are business associates of Louisiana Medicaid and support the work of the Quality and Innovation Section through an interagency contract. We appreciate the opportunity to provide our perspective related to our team's experience on the CMS core measures. Eddy will provide details of our work with Louisiana Medicaid on stratified reporting of the core measures. Additionally, we will provide insight on stratified reporting of a Louisiana-defined maternal child quality measure. Stratified reporting of this measure has been key to the success of performance improvement initiatives resulting in increased access with 17P.

Thank you, again, for the opportunity, and Eddy.

Good afternoon. This is Eddy Myers here at the University of Louisiana at Monroe. And just a little background about Louisiana's motivation for reporting stratified core set data.

Initially we began reporting stratified data for three measures for the CMS Adult Quality Grant in 2014. And we originally stratified data by race, ethnicity, gender, and geography with urban and rural breakdowns. And after that initial year, the Louisiana Department of Health Quality leadership was interested in expanding that and – and asked us to, you know, each year try to increase the number of measures that we calculated and reported, you know, based on stratifications as much as feasible. So, we currently stratify a majority of the administrative measures that we report. And we stratify them by gender, race, ethnicity, disability, and geography. And, again, that's broken out as urban versus rural.

And a little bit about how we use stratified data for quality improvement. The state is able to review the stratified data and consider whether further analysis or act – action is warranted. And two examples of how Louisiana uses stratified data are with the HEDIS ambulatory ED visits measure. And with – the

Technical Assistance Webinar: Collecting and Using Stratified Data for Quality Improvement in Medicaid And CHIP

other one is what Larry alluded to, there's a state-specific 17P initiation of progesterone measure. And so those are the two areas that – that there's been recent focus on, looking at stratified data.

And so, first about the ambulatory ED visits measure data, we stratify it by urban-rural, by region, parish, zip code, age group, etc. And, you know, some of these breakdowns are beyond what is normally done for the Adult, or CHIPRA, in this case, Core Set reporting. But we were looking at breakdowns that the state was interested in as part of an effort to identify potential issues and solutions relating to emergency department utilization.

And then for the state-specific 17P initiation of progesterone for pre-term birth prevention measure, the state has reviewed data stratified by age group, race, ethnicity, geography, rural-urban, and region. And when looking at the region analysis, the state requested a drill down to the provider level to be used to create a outlier report for provider outreach and education.

And so that's just a little bit about how Louisiana has used stratified data for quality improvement.

And moving on, we'll look at some of the successes and challenges in calculating and reporting stratified data.

And so first successes. We've been able to successfully collect data needed for stratifications from our eligibility files and Louisiana Medicaid's data warehouse. And we created a standardized Excel template for collecting the data. And we utilize a standardized programming code that links the denominator and numerator files for each measure to the state's eligibility data to stratify the final results for each measure. And so that helps make the process more efficient is, you know, we have a – kind of an Excel template that we put the results in, so for each measure, the stratifications, you know, look the same and so you're able to – we're able to use those. Those are the – that's what we use to key the data in to MACPro from. And then also having kind of a standardized set of – of programming code helps to make it efficient for doing the stratifications for each measure because once we, you know, have that established, we can apply it to new measures.

And then looking at some of the challenges we face, there's certain stratifications that aren't available in our data. For example, primary spoken language is not in the data warehouse. And then also for race, we do have some members that, you know, have a race value of Other, or Unknown, or Undeclared. So, you know, that does not align with MACPro stratification values. And then in our data we don't have a separate ethnicity field, so the way we handle that is we use the race field values for Hispanic versus all other values – race values to stratify by ethnicity.

And then also urban-rural classification is based on the member's parish in Louisiana, which, you know, relates to counties, you know, in other states. And that can change over time as the member moves. So we use the parish as of the anchor month of whichever measure we are stratifying or, you know, if the measure didn't specify an anchor month, we use the last month of eligibility according to the measure criteria to determine whether a person is urban or rural. But, you know, just something to keep in mind is that determination is at a point in time, and that may not truly match up with where a person was when they received, you know, a particular service. So, those are just some challenges or – or just things to consider when calculating the stratified rate.

And then also looking at reporting stratified rates in MACPro. We don't report measures that have small denominator populations or very small numerators. Some examples are chart review measures or the prevention quality indicator measures such as diabetes, short-term complications, or congestive heart failure because we – we don't do stratifications on those because the resulting subpopulations, you know, may be too small, and therefore the results wouldn't necessarily be able to be reliably interpreted.

And then probably the biggest challenge that, you know, we've encountered with reporting stratifications is just the amount of – of labor and time in entering the data. Because, you know, when you break out these measures by these various stratifications, you end up with a lot of data. And especially when you have measures that have multiple numerators like, for example, childhood immunization status has 19 different numerators, you know, you end up with a lot of data to be keyed in. And so, you know, a

Technical Assistance Webinar: Collecting and Using Stratified Data for Quality Improvement in Medicaid And CHIP

suggestion we would have there is, on measures like that, you know, it may be most beneficial to at least initially, you know, report stratified data at, you know, maybe the combination two, or three, or whichever is of most interest to the state, you know. Just stratify at a higher level there than trying to attempt to do it by every single, you know, individual numerator.

And – and so, I guess a suggestion we would have there, you know, that might help that is if there were some way developed that the states could upload the stratifications as – in a, you know, like as an Excel attachment or, you know, some other type of form that could be simply attached and uploaded, that could make it, you know, a lot easier from a data entry standpoint and could make it more feasible for states to report more measures.

And then, finally, just the best practices that we've – would like to highlight is they could recommend establishing a standardized template for collecting the stratified data results for each measure. And we also recommend utilizing standardized programming code to stratify the numerator and denominator populations for each measure.

So, so that – that's kind of what we would like to cover, and – and we turn it back over – over to you.

Great. Well, thank you so much. And we already have a few questions for you, but I think we will hear from Michigan, and then we will take questions from everyone at the end and that way we can have both Louisiana and Michigan respond to the questions. So, thank you. That was very interesting. We'll turn it over to Tom now.

Great. Thank you, Alli. My name is Tom Curtis. I'm the Manager of the Quality Improvement Program Development Section in the Managed Care Plan Division in Michigan. And part of what our area does is oversees the quality performance for our 11 Medicaid health plans here in Michigan. Roughly two million beneficiaries.

Our stratification efforts – I guess I'll start the story – was back in about 2010 when the Department really recognized that there is a difference in how quality of care is provided and received based on race-ethnicity in our state for our Medicaid population. And we, at that time, did not have the data warehouse capabilities to really start looking at it from that perspective. So – so our stratification really started in collaboration with our Medicaid health plans, asking them to stratify their HEDIS-audited data by race-ethnicity and reporting those numerator-denominator stratifications to us. We started with, I think, 13 HEDIS measures. And began doing two calculations with the data that the health plans were providing us.

One of them is the Index of Disparities calculation. And this was comparing every subpopulation, racial-ethnic subpopulation, to the overall health plan rate and sort of absolute valuing all of those differences into a single index, if you will.

The second calculation that we conducted on these data were a pair-wise comparison. And we focused on the African-American and the Hispanic and comparing each one of those racial-ethnic groups to the white reference population. And we still do those pair-wise and the Index of Disparities calculations. And the reason we focus on the white reference population is because we are looking at systemic differences, systemic injustices, that different populations experience in relation to the white population here in Michigan in the Medicaid program.

We have been publishing that report since 2011, I believe, or 2012. And we're hoping that maybe Gigi or Alli or Brian can help us send out the link to all of our reports after this webinar to give everybody a sense of how all of these quality measure rate performances stratified by race-ethnicity have trended over time.

What – one thing that came out of that project was using the outcomes, because this is Medicaid health plan HEDIS-audited data, using the outcomes of these calculations to really look at how to leverage some of our incentives to pursue reductions in inequities based on race and quality measurement.

Technical Assistance Webinar: Collecting and Using Stratified Data for Quality Improvement in Medicaid And CHIP

So the first sort of foray into that was a chlamydia screening project. What we found was women in our Medicaid program were receiving chlamydia screening services at a disproportionate rate. And in this case, the African-American women around 15 percentage points higher than white women in Medicaid.

So we really – we required all of our health plans, I think in 2014, starting in 2014, to reduce the – the racial disparity for that measure in their – in their population.

Sort of parallel to the Medicaid Health Equity Report and this P-for-P program that I just described, we received a – an Adult Medicaid Quality Grant back, I think, in 2012. And this funding – from CMS. This funding was used to develop the capacity here in the Department to begin querying our Medicaid data warehouse, to begin stratifying by race-ethnicity, and focusing in, actually, on some of the CMS Core Set measures. So we did get some assistance from CMS in developing this capacity and really starting to look at the data in our warehouse which allowed us to also start comparing what we were getting out of our warehouse with what we were seeing in the Medicaid health plans' HEDIS-audited rates.

Moving on to about 2012, we developed the capacity using the symmetry HEDIS rules engine. We developed the capacity to begin querying our own warehouse using HEDIS-specified measurements, on a quarterly basis, about 400 measures every quarter. Actually this includes HEDIS, Core Set, PQIs, a large number of measures, every quarter are ran out of our warehouse using our encounter data and are automatically stratified by region and by race-ethnicity, and reported to the Department. And by health plan.

We have, about the last 18 to 20 months, been using these rates generated out of our warehouse and actually pulling member-level data for some of the key measures, and working collaboratively with all of our 11 Medicaid health plans to validate the rates that we pull out of our system with the rates that they pull out of their systems. This has been a very important effort that I hope some – some of the folks on the webinar understand what this has allowed us to do. We – it's resulted in us making some – some tweaks to our own system because we need to try to match one system with 11 different systems. But it's also identified some issues on some of the health plan sides as it relates to maybe their queries that they were running, etc. But once we identified the discrepancies and – and came within about a percentage point or less, depending on the measure, with what we pull out of the system and what they pull out, this has allowed us to really look at stratified quality improvement needs and – and add measures pulled out of our warehouse and performance rates pulled out of our warehouse to our capitation with both programs, and even our quality-based auto assignment algorithm. So we can now look at health plan performance, for example, by region and influence auto assignments scores based on how they perform in those specific regions.

I think the last thing I wanted to say here is this has really started to come together in one of our most recent projects focused on low birth weight. So we did start reporting the low birth weight measure as part of Core Set reporting. We've also been generating – started to generate the low birth weight outcomes out of our data warehouse. And we've started to look at regional differences in low birthweight outcomes. And even differences by race-ethnicity in the different regions. And what we have found is there are roughly five regions in our state where the rate for African-American women and babies in the Medicaid population is about 14% for low birth weight outcomes. In those same regions, white women and babies, the rate is about seven percent. So we have been working with our health plans and essentially requiring designating specific health plans to work in specific regions, and to work together, to address the regional disparity that the Medicaid population is experiencing.

So this is a shift for – for us in – in trying to move a bit away from health plan-specific performance rates and rewarding improvement in health plan specific rates and asking them all to work together to – to move the needle at a regional level, at a – at a geographic or a population-based level.

So we have just started that project. Probably a lot more to report later on with that, but wanted to give everybody a sense of how we're – how we're trying to use stratification to identify racial disparities to incentivize health plans to improve on – to reduce racial disparities in their own population. And even looking for ways to incentivize health plans to work together to reduce racial disparities and address social determinants at a broader population health level.

Technical Assistance Webinar: Collecting and Using Stratified Data for Quality Improvement in Medicaid And CHIP

All right. Thank you very much, Tom. That was very interesting. Really liked that last example of what you're doing with the low birth weight measure.

So one of the first questions that we received was actually about disseminating the materials that both you and the Louisiana team had mentioned. So, if there are materials that – the materials – the reports that you mentioned in your presentations that you would be able to send to the Mathematica team, we can absolutely work on a way to make those available for others to see.

So we had one question. I think we can open it up to both states. So, somebody asked regarding data quality for stratifications: "Did the state have any issues with data quality accuracy, and if so, how did – how did you improve it?" So maybe we'll start with Louisiana for that question and then open it up to Michigan.

We – we don't have any major challenges there because the data that we use in the Medicaid data warehouse, it has already gone through a, you know, data cleaning process, and there, you know, there are rules and criteria for the data, you know, how the data is entered and populated by the fiscal intermediary. And they collect the data from, you know, from the plans, and from Fee-for-Service Medicaid, and, you know, make sure that it is standardized. And so the data is – is actually fairly clean. Now, you know, there are some caveats to that, like, as I mentioned, with, you know, race, you know, is – it's not always populated. You know, we have, you know, some members show up with a value of, you know, like not populated or not declared. But, you know, that's not – that's definitely, you know, a minority of the cases there. So, you know, in general, we don't experience too many issues in our system with data quality.

And so just one follow-up question to that. Is the race data – is that collected by self-report?

It is collected through the, you know, Medicaid eligibility process, and so I would assume that it's probably, you know, self-reported at the time of enrollment in Medicaid.

Okay. And then how about Michigan? Do you have anything to say related to data quality and accuracy?

I guess I'll add that our race-ethnicity is also collected at time of enrollment. It is an optional field. But we are seeing year-over-year about 85% completion on that optional question. So, we do have a high – high percentage of folks who answer – tell us what race they are.

The other thing I'll note here is the validation effort with our health plans has really – so, the encounter data in our warehouse has already been adjudicated and cleaned and processed. And we also identify query – any querying issues or coding issues when we do the validation process with our health plans. And the other thing we find is when we pull these measures, and even when we stratify by race-ethnicity, typically the number of folks are – are enough to assure us that the performance race – the rate stratified by subpopulations of race – are likely representative of the quality of care that subpopulations in those races are experiencing so that the denominators are significantly high so we can be assured that even if not everybody was answering the optional question, we still have enough folks that we're measuring to – to be certain that that is a representative of quality of care that folks in – in – as a member of that race are receiving.

Okay. Thank you. And we received another question. It's pretty similar, so I'll just read it and then you can let us know if you have any additional comments. But it says, "In my state, race and ethnicity come from our eligibility system. They are mandatory fields. Our concern is that processing applications the fields are coded incorrectly, especially from paper and electronic applications if the applicant doesn't answer or the worker enters it incorrectly. Is this an issue that Louisiana and Michigan experience, and if so, how is it addressed?" So I guess just say if you have any additional context on that.

We – we don't really have any, you know, additional information. I mean, yes, you know, if, you know, if there is a – a data entry error, or, you know, if the – the member, you know, reports, you know, the race incorrectly, then, you know, you know, yes, in those instances it could end up in the system that way. But, you know, we would expect and hope that would be, you know, a relatively small number of cases.

Technical Assistance Webinar: Collecting and Using Stratified Data for Quality Improvement in Medicaid And CHIP

And this is Michigan. I think from our perspective, you know, certainly when we started collecting quality measure data by race and ethnicity and starting to trend it, maybe the first year, two years, three years, you know, anomalies like this could be – could call it, maybe, into question. But after we've been trending it for now six, seven years, and the trends are consistent, and – and, again, the number of folks making up these rates is a large number, in some cases tens of thousands of people. You know, those types of issues, I guess we – we concern ourselves less with small, minute potential issues like that because of the trends over time and because of the amount of people we're measuring.

Okay. Thank you both. Another question that's come in is whether or not the states have implemented any quality initiatives to address quality disparities they found, and if not, if they have any plans to do so. So, I think you might have both touched on this a little bit, but do you have any more information on quality initiatives that you've implemented relating to reducing disparities?

This is Louisiana. We don't really have any other additional information.

So here in Michigan we have, as I said, a capitation withhold that's one percent of capitation that we set aside for performance improvement. And a portion of that capitation withhold is reserved for improving on a – a health equity measure, actually two health equity measures for each health plan. So each health plan is assigned a health equity – two health equity measures there. HEDIS-specified measures. And their – their performance is calculated out of our warehouse and is trended year-over-year to determine whether a significant change, a reduction, in the racial disparity was achieved.

In addition, we use the auto assignment algorithm to incentivize health plans to perform well on access to care, particularly for African-American populations in the city of Detroit region, and rewarding with increased assignment in that region based on their performance there.

Okay. This question's for Eddy from Louisiana. The question is, "How do you define rural?"

It's defined at the – the county level, or, you know, which in Louisiana is parish. And it's in the, you know, there are certain counties that are – you know, defined as rural, you know, versus urban. And so – so that's how we do it is at the county level.

Okay. Thank you for that. Another person is asking if both states are having their EQRO validate the rates before submitting.

(Inaudible)

Alli, this –

Go ahead.

Are you saying submitted to MACPro?

I believe so. I think that's what the question is.

Yeah. So, all – all HEDIS measures undergo a HEDIS audit relative to the health plan, so those are audited rates. I believe for several years the EQR here in Michigan was looking at a subset of some of the Core Set measures.

And this is Larry in Louisiana. I believe that would be outside the scope of the EQRO for Louisiana, but, Kolynda, if you want to speak to that.

Yes, I could speak to that. Yes, that's outside the scope of our EQRO to validate rates for MACPro. So our current EQRO does not perform that action. But, again, our HEDIS rates are validated and – by our EQRO. But not those that's entered into MACPro. That's outside their scope.

Technical Assistance Webinar: Collecting and Using Stratified Data for Quality Improvement in Medicaid And CHIP

And I will add that – this is Eddy – that, you know, we do, you know, a validation process on – on measures that we report, you know, here at the University of Louisiana. So – so, you know, we do that on all the measures.

All right. We probably have time for one or two more questions, so please feel free to send things to the Chat – the Chat box, or you can also raise your hand by pressing five star.

Looks like we have two more questions, so maybe I'll ask them at the same time and then each of the states can respond.

So the first question is whether the states have any advice for getting stratifying rates on the priority list for your state leadership. So basically like how to direct resources to this and make the argument for that.

And then the second question was about if your state has any advice on how you identified measures to report stratified data.

So, the first question is how to get it on the priority list, and the second question is how did you go about selecting measures.

This is Michigan. And while I wasn't here when this was done, I've heard the story. And the initial measures for the Medicaid Health Equity Report were chosen in collaboration with the Medicaid health plans. So there was a considerable amount of conversation, both between the Quality Improvement area and the 11 Medicaid – or I think at that time there were more – but Medicaid health plans as well as coordination with leadership to make sure that the measures selected to begin this report would be a good set to start with. That represented sort of the domains of care, so to speak, across the Medicaid population. So, it was a collaboratively-designed, I'd say, set of priorities that weren't just vetted through Medicaid leadership but also leadership at our managed care organizations.

Kolynda, do you want to take this one or would you like for us to –

No, I could go ahead and speak to it. So, if we're talking about links to some of the projects or public reports that we were discussing earlier as well as the approach that we took to identify those measures for stratification, one of the activities that we performed this year was a stakeholder engagement activity where – where we conducted regional town halls, or regional forums to receive public feedback to identify measures that would be in our current performance – well, our future performance measure set as well as measures that can be stratified. Also, we have a partnership with our Chief Medical Officer who works for the Louisiana State University Health Sciences Center. With him, as well as at the time we had a maternal health expert – in-house expert – and she also – both of those individuals were helpful and have been identifying measures that could be used for stratification to reduce health disparities.

I just wanted to kind of go back regarding the link. We do have our prematurity performance improvement project report. Those final reports are posted on our public website, and they – and you all could review those regarding some of the measures, some of the data regarding the stratification on race. They have that information included in those reports.

I would like to mention one of the aspects – one of the new things that our EQRO has done for us in regard to health disparities is that they conducted a health disparities survey on our behalf of our managed care health plans.

So, those are some of the activities that we've done this year in regards to health disparities and stratification of data.

All right. Well, I think, in the interests of time, I think we'll move on at this time, but I wanted to say a huge thank you to the state representatives. It's really valuable to hear your perspective on these calls. So, we really appreciate you taking the time to present today. Both presentations were really interesting and helpful.

Technical Assistance Webinar: Collecting and Using Stratified Data for Quality Improvement in Medicaid And CHIP

So, let's go to the next slide please. I'm just going to present over the next few slides a review of the process for reporting stratified rates in MACPro. So, go to the next slide, please.

So, for each Core Set measure there is an option to report stratified data in MACPro by the categories shown here on this slide and on the next slide. And so for each category, states have the option to add subcategories in addition to the ones shown on the screen. So go to the next slide. So that's the rest of the categories. And then the next slide, please.

And so for each measure you can navigate to the section at the bottom called Optional Measure Stratification. You can then select which stratification categories and subcategories you would like to report. And then this includes the option to add additional categories.

And for each subcategory, MACPro will display the rate, numerator, and denominator, as well as the rate definition that was used above in the aggregate section.

So, next slide, please.

For future reporting years, MACPro will be updated to align with the Department of Health and Human Service data collection standards. So this means that additional race and ethnicity subcategories will – will be added, and so those categories are shown here on this screen. And those will be added as options. But just a reminder that currently you could add any of these subcategories under the optional additional section.

So, next slide, please.

Okay. We'll just take one more moment to pause for any questions that haven't been answered yet. Again, feel free to send questions to the Q&A box.

All right. Well, seeing as there are no questions, we'll keep moving.

So I'm going to quickly walk through a few Technical Assistance resources for FFY 2019 Core Set reporting. And these are more general Technical Assistance resources, but I just wanted to remind you about all of the other resources presented earlier in Shondelle's slides that will be more specific to collecting stratified data and also reducing disparities.

So, next slide, please.

The Measure List for the 2019 Core Sets are posted on <https://www.medicaid.gov/>, along with the technical specifications for calculating the measures. And a summary of updates to the specifications from 2018.

The Data Quality Checklist includes common data errors that states should look for when reporting Core Set data.

And the Measurement Period Table specifies the measurement period for each measure according to the Core Set specifications.

So each of these resources, along with some other additional resources, are listed in the Appendix. You can find the hyperlinks there.

And I also wanted to mention that the recording from today's webinar will be available, as well as the slides, on Medicaid.gov, so you can look for it on the main Child and Adult Core Set pages which are linked in the appendix.

Next slide, please.

Additionally, we wanted to mention that there is going to be a webinar on reporting in MACPro held in September, so keep an eye out for an invitation to that webinar.

Technical Assistance Webinar: Collecting and Using Stratified Data for Quality Improvement in Medicaid And CHIP

Next slide, please.

And for technical assistance related to calculating, reporting, or using Core Set measures, you can email the TA mailbox at MACQualityTA@cms.hhs.gov. And for assistance using MACPro, you can contact MACPro_Helpdesk@cms.hhs.gov.

And I also wanted to remind you of the Technical Assistance mailbox that Shondelle had linked earlier in her slides which is more specific to promoting health – health equity and helping to stratify data. So, those resources are all available to you.

And before I pass it back to Brian to conclude, we wanted to thank you for joining the webinar and also encourage you to complete the evaluation which has a question about what technical assistance resources would be most helpful to you in order to calculate and use Core Set data, so this feedback is really important to CMS for future planning and knowing what challenges states are encountering and what could be helpful for encouraging states to report stratified data.

So, at that I will pass it back to Brian for the technical wrap up.

Thank you. This concludes the webcast for today. Please feel free to submit the survey at the conclusion of this event. If you're not able to provide your feedback at this time, you can do so on the on-demand recording. You can access the survey via the on-demand recording one day after the event at the same link you used today that was sent to you following registration.

Thank you. Have a great afternoon.