Meeting Notes

The sixth meeting of the Social Justice & Health Disparities Working Group was held on April 8, 2021 from 3:00-4:30pm.

Dr. Dora Hughes opened the meeting by introducing Dr. Mark Friedberg, the senior vice president for performance measurement and improvement for Blue Cross Blue Shield Massachusetts (BCBSMA).

Dr. Mark Friedberg on BCBSMA's Approach to Health Equity

BCBSMA's comprehensive plan is focused on addressing inequities in health care, maintaining an inclusive company culture and standing for equity in their communities.

On their website, they have an Equity in Health Care page that includes a section where members are invited to share their race, ethnicity, and language preferences. The page explains how the data will be used to address inequities, build solutions, and foster diversity.

Actions behind the scenes include:

- Convening an advisory council of leading local and national experts
- Becoming the first health plan in the region to collect and use comprehensive, member-level data to support and collaborate with the medical community to reduce racial and ethnic inequities
- Creating metrics and programs to address racial inequities in health care access and care
- Educating employees in cultural competence to support member engagement, service and care
- Reviewing existing contracts with medical management vendors to assess their current or future roadmap for incorporating health inequities
- Evolving the company's current Diversity, Equity and Inclusion governance structure to include health equity issues, and publishing—company-wide—an enhanced scorecard that measures progress against other best-in-class companies to ensure accountability and transparency.

Like many health plans, they currently have very little Gold Standard self-reported race and ethnicity data from their members. They largely use indirect methods for race, ethnicity, and language data collection, specifically the RAND Bayesian Improved Surname Geocoding (BISG) method. By 2023, they hope to put financial incentives in place for their provider networks that are explicitly tied to the equity of services they furnish to members, and so they are currently engaged in a number of efforts to acquire as much Gold Standard data as they can.

Gold Standard data collection efforts include:

- In December 2020, they began to invite all members to share information about their race, ethnicity, and preferred language (OMB categories) when they log onto the Blue

Cross member portal, MyBlue. The portal explains why they are collecting the data, and what they will and will not be using the data for. Approximately 1 million of their 3 million members are on MyBlue, about 315,000 of those on the app have received the pop up, and over 95,000 have provided their race and ethnicity.

- Other strategies will include soliciting member race and ethnicity data via mail, email, telephone, and employment records; having providers review methods used to collect this data; and determining provenance, data standards, and the potential for data exchange.

Data governance has been an issue, and they adopted the Fast Healthcare Interoperability Resources (FHIR) standard as a consistent data structure to intake and store race and ethnicity data. As there is no industry standard for data provenance, they are in the process of creating their own. Without knowing the data source(s) for each member (e.g., self-reported, provider-reported, account-reported, estimated, etc.) it is difficult to assess the accuracy and completeness of race and ethnicity data.

They are performing equity audits within their membership, based predominantly on estimated race and ethnicity data.

- The completed an equity audit of HEDIS measure performance, and found the greatest inequities are in measures of depression care and statin use among members with diabetes.
- They are in the process of an equity audit of patient experience. Between November 2020 and January 2021, they surveyed a portion of their members about their experience with telehealth and in-person primary care during the pandemic. They oversampled members of color in order to improve measurement reliability of inequities.
- They are in the process of an equity audit of care management enhanced algorithms.
- They are in the process of an equity audit of provider payment, specifically focused on performance incentive payments and total medical expense.

They created the D4E Opportunity Framework, “The Magnolia Model,” as an interactive tool enabling BCBSMA to apply a health equity lens to every project. The model has three primary steps:

1) See the problem landscape: inequitable health outcomes resulting from education, nutrition, community & social services, healthcare, housing & environment, economic opportunity etc.
2) Understand problem forces: individual, interpersonal, institutional, structural, and historical and persistent racism
3) Act to reduce inequities: near-, medium- and long-term solutions

<u>Presentation Questions</u>

Mila Kofman asked Dr. Friedberg which RFPs had new components on health equity built into them. Dr. Friedberg said it was the RFPs for their vendors. When they renew contracts with their providers, they are currently working to insert a shared equity initiative, although they have not yet put a financial incentive into a contract. Dr. Friedberg said that when they begin to suggest financial accountability for equity measures, they will need to provide the providers with technical assistance on how to improve equity of care.

Diane Lewis asked Dr. Friedberg if they have reviewed multiple different algorithms for algorithm bias, and Dr. Friedberg said they are broaching this issue with providers as part of their collaborative work on equity.

Purvee Kempf asked Dr. Friedberg to clarify the number of members who have filled out race and ethnicity info in MyBlue. Dr. Friedberg described the results, and also mentioned that to date, Black, Hispanic, and Asian members have been approximately 60% more likely to fill out the survey than white, non-Hispanic members.

Janice Davis asked how they acquire a representative member sample considering variations in MyBlue utilization. Dr. Friedberg says he doesn't think they have achieved a representative sample, which is why it's important not to rely just on the app to gather the data. Dr. Cara James asked if 1) they have considered that younger members may be more likely to not only use the app but also provide race and ethnicity data, and 2) what advice he would give to other plans with regard to engaging providers in this work. Dr. Friedberg said they have not considered age but they should look at that. On collaborating with providers, he did not have any advice yet because they have not yet seen any programs through to completion, but he did say the response from providers has been largely positive.

Dr. James also asked 1) what percentage of member data does BCBSMA think they need to be able to use if from an incentive standpoint, and 2) have they had any conversation with their peers on Gold Standard data collection on race and ethnicity? Dr. Friedberg said they are able to talk with other health plans and providers that participate in the Task Force on Performance Measurement convened by the Executive Office of Health and Human Services in Massachusetts. So far no other health plan has volunteered that they are doing this work, and the providers are all over the map in terms of gathering data. Concerning how much data is enough data, they do not have an answer but they are working to determine if it is a question they can solve. NCQA says 80%, but BCBSMA wants to take a more empirical approach to the question.

Colette Chichester asked Dr. Friedberg to describe their journey to stand up this initiative. Dr. Friedberg said BCBSMA began laying the groundwork at least 10 years ago, and this summer they moved from inner facing work to outer facing work for their members.

Dr. Hughes asked if they interact with the marketplace in MA on BCBSMA's equity work. Dr. Friedberg said the marketplace is not on the taskforce. The taskforce is composed of plans and provider organizations, and is mainly focused on ACO type contracts.

Discussion

Dr. Pamela Riley shared some of DC Medicaid's equity work, and their goals for the future. They plan to establish a staff position to lead diversity, equity, and inclusion efforts at an organizational level. To date, their external facing work has primarily relied on comparing DC Medicaid's population and performance with other populations and state Medicaid programs in order to identify areas of improvement. A majority of their population, over 80%, are in their managed care program, and that is where they have the greatest opportunity to advance equity. They are currently in the process of planning value-based payment program specifications that they want to include in their MCO contracts. DC Medicaid also has a data warehouse that aggregates claims data, but they are missing race and ethnicity data for approximately 30% of their population. The biggest challenge to acquiring that data appears to be self-report at the time of application, and they are looking at ways to improve their data collection efforts. Dr. Riley concluded by saying that it would be great if DCHBX and DC Medicaid could align their equity work to have a greater impact.

Mila Kofman responded by stating that the goal of this working group is both to determine what DCHBX can do by themselves *and* what they can do with others to have a greater impact. Part of the mid-term vision is to get other payers to the table to establish a set of standards, benefit structures, and so on. She appreciates that Dr. Riley mentioned collaboration and doing something together.

Janice Davis added that during the pandemic she has noticed how many enrollees have moved between the Exchange and DC Medicaid—in part due to changes in employment—and they do compare benefits, so coordination just makes sense.

Mila Kofman asked Dr. Riley if they have thought about doing something similar to their quality improvement report cards in the equity space. Dr. Riley said they have not made it that far, but they are aware that stratifying data by race and ethnicity will be an important part of developing a more comprehensive quality improvement strategy.

Dr. Cara James asked Dr. Riley to expand on the challenges they are facing to do this work, and what could help advance the work. Dr. Riley said having the internal capacity and bandwidth to do this work is always a challenge, so the work needs to be prioritized. Dr. James then asked if they have engaged in efforts to capture and document data on the social determinants of health. Dr. Riley said they are working on developing a database that they plan to integrate with their HIE in order to access some of the data on social determinants.

Diane Lewis asked Dr. Riley if they are also considering the issue of algorithm bias. Dr. Riley said she does not know if any of the plans have looked into that.

Dr. Hughes then reviewed the list of "deep dive" issues discussed to date (the full document is available as part of this week's materials). She asked the working group if there were any issues they would like to add to the list. Janice Davis mentioned that provider access is a common complaint in certain wards. Dr. Cara James wondered to what extent plans are looking at the quality or provenance of data they have, and also mentioned that it would be interesting to hear directly from NCQA. Dr. James also commented that we may want to consider opportunities to incentivize equity. To Dr. James' point, Colette Chichester responded by saying that this year they put a requirement in their contractual arrangements for their PCMH providers related to cultural competency training and other initiatives, and we may want to add a bullet point about how to best target the provider community to assist with some of this work.

Janice Davis asked if DC Health Link tracks how many members use the HSA and HRA approach. Mila Kofman said they do not have HSA information, they only have data on who enrolls in HSA compatible products. Debra Curtis added that they also do not have the race and ethnicity data necessary to determine if there is a disparity in the use of HSAs and HRAs.

Colette Chichester asked if it would be helpful to have someone articulate the District's approach to provider access, and Dr. Riley asked if we should call out strategies like community health workers or navigators.

Dr. James asked what other Exchanges are doing in this equity space. The California and Massachusetts Exchanges were mentioned.

Dr. Hughes concluded the meeting with a brief overview of our plans for the next session.

Attendees

Dora Hughes
Helen Mittmann
Cara James
Mila Kofman
Diane Lewis
Purvee Kempf
Debra Curtis
Anneta Arno
Allison Mangiaracino
Chikarlo Leak
Ciana Creighton
Collette Chichester
Janice Davis
Karima Woods
Marybeth Senkewicz
Pamela Riley
Philip Barlow
Tamara Watkins

Tonya Vidal Kinlow
Yulondra Barlow