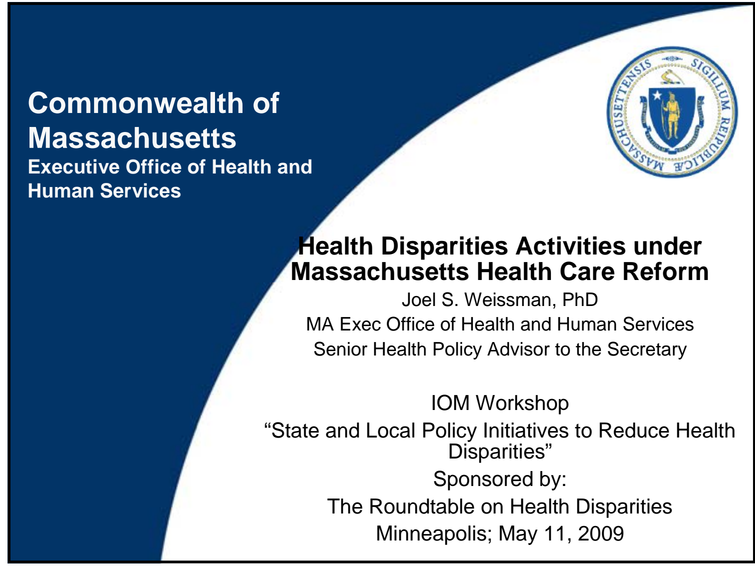
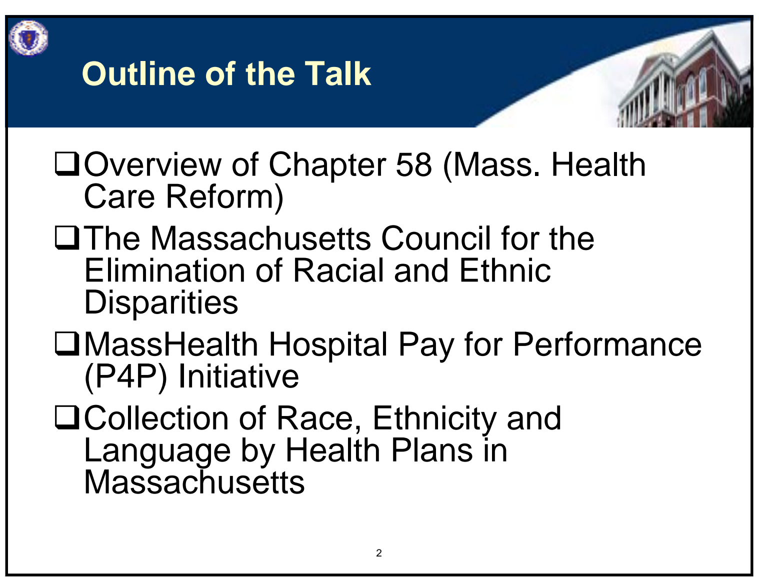
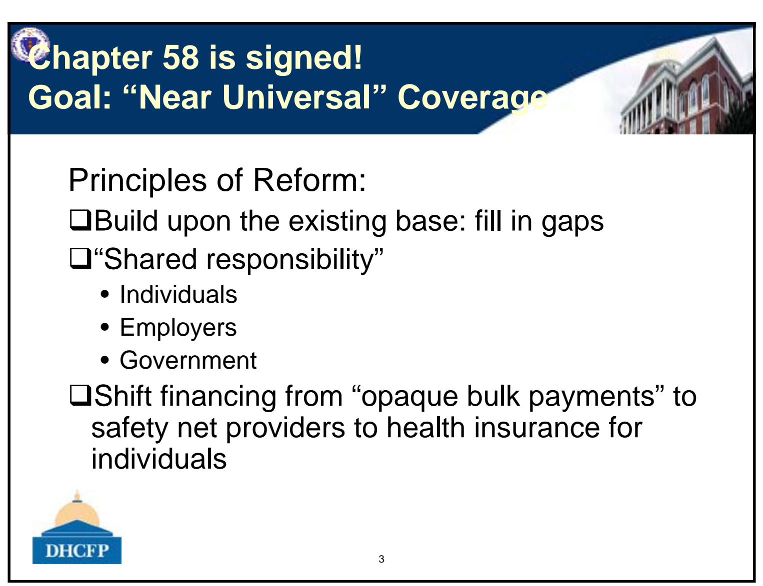
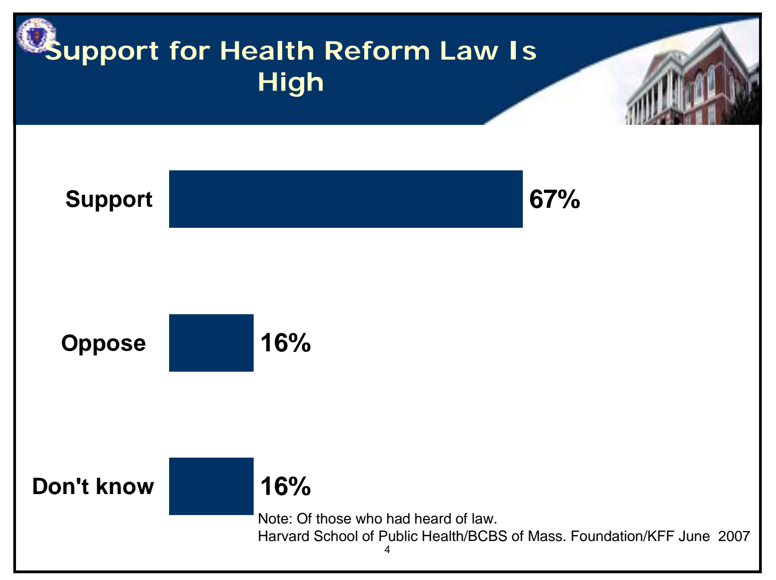
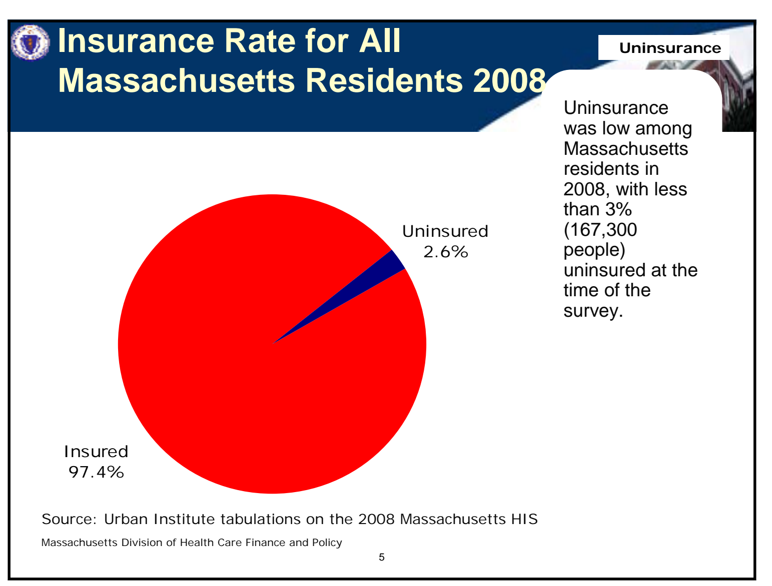

Commonwealth of Massachusetts
Executive Office of Health and Human Services
Health Disparities Activities under Massachusetts Health Care Reform
Joel S. Weissman, PhD
MA Exec Office of Health and Human Services
Senior Health Policy Advisor to the Secretary
IOM Workshop
"State and Local Policy Initiatives to Reduce Health Disparities"
Sponsored by:
The Roundtable on Health Disparities
Minneapolis; May 11, 2009


Outline of the Talk
Overview of Chapter 58 (Mass. Health Care Reform)
The Massachusetts Council for the Elimination of Racial and Ethnic Disparities
MassHealth Hospital Pay for Performance (P4P) Initiative
Collection of Race, Ethnicity and Language by Health Plans in Massachusetts
2


Chapter 58 is signed!
Goal: "Near Universal" Coverage
Principles of Reform:
Build upon the existing base: fill in gaps
"Shared responsibility"
Individuals
Employers
Government
Shift financing from "opaque bulk payments" to safety net providers to health insurance for individuals
DHCFP
3


Support for Health Reform Law Is High
Support
67%
Oppose
16%
Don't know
16%
Note: Of those who had heard of law.
Harvard School of Public Health/BCBS of Mass. Foundation/KFF June 2007
4



Insurance Rate for All Massachusetts Residents 2008
Uninsurance
Uninsurance was low among Massachusetts residents in 2008, with less than 3% (167,300 people) uninsured at the time of the survey.
Uninsured 2.6%
Insured 97.4%
Source: Urban Institute tabulations on the 2008 Massachusetts HIS
Massachusetts Division of Health Care Finance and Policy
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Will universal coverage lead to reductions in disparities?
Medicare coverage was associated with reductions in racial, ethnic, and socioeconomic health disparities in adults with diabetes and heart disease*
"…universal coverage as a possible means of reducing these types of health disparities in the general population."
– Commonwealth Fund Press Release
* J. Michael McWilliams, et al, 2009
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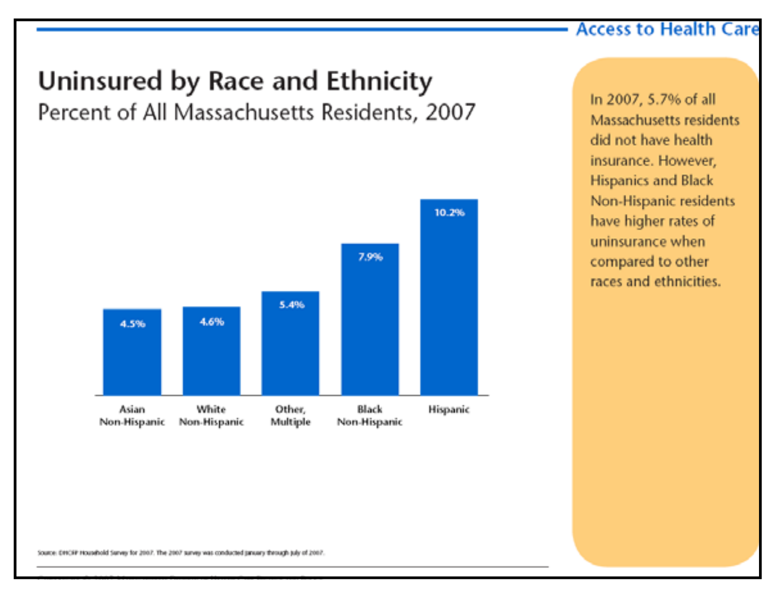
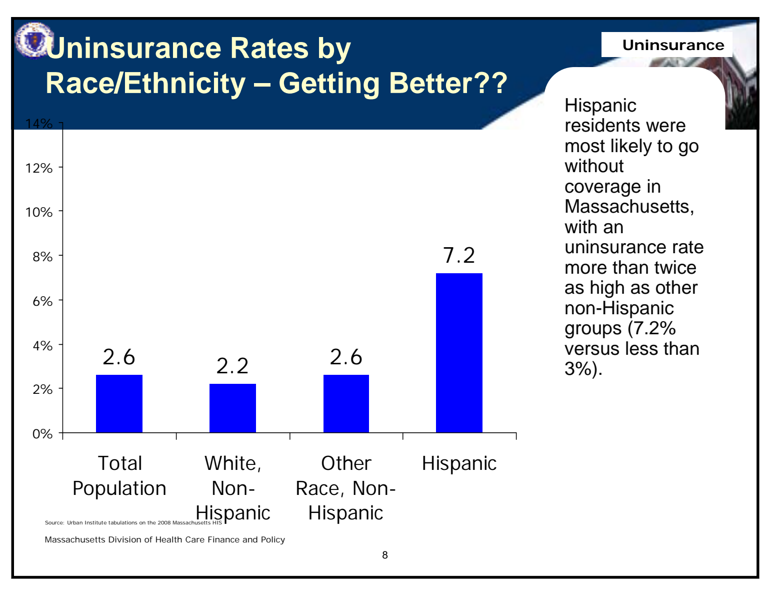


Access to Health Care
Uninsured by Race and Ethnicity
Percent of All Massachusetts Residents, 2007
In 2007, 5.7% of all Massachusetts residents did not have health insurance. However, Hispanics and Black Non-Hispanic residents have higher rates of uninsurance when compared to other races and ethnicities.
4.5%
4.6%
5.4%
7.9%
10.2%
Asian Non-Hispanic
White Non-Hispanic
Other, Multiple
Black Non-Hispanic
Hispanic



Uninsurance Rates by Race/Ethnicity – Getting Better??
Uninsurance
Hispanic residents were most likely to go without coverage in Massachusetts, with an uninsurance rate more than twice as high as other non-Hispanic groups (7.2% versus less than 3%).
14%
12%
10%
8%
6%
4%
2%
0%
2.6
2.2
2.6
7.2
Total Population
White, Non-Hispanic
Other Race, Non-Hispanic
Hispanic
Massachusetts Division of Health Care Finance and Policy
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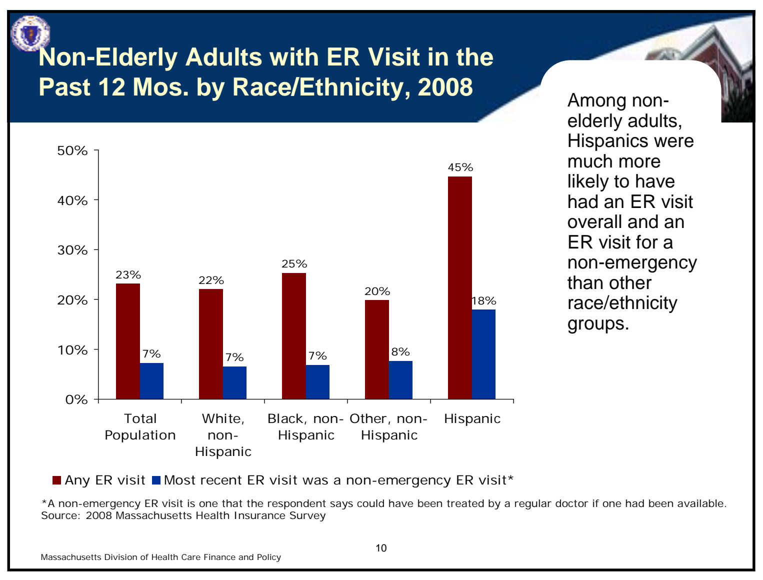
Nevertheless, Health Disparities Still Exist

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

John Auerbach, DPH Commsr, 2009

Non-Elderly Adults with ER Visit in the Past 12 Mos. by Race/Ethnicity, 2008

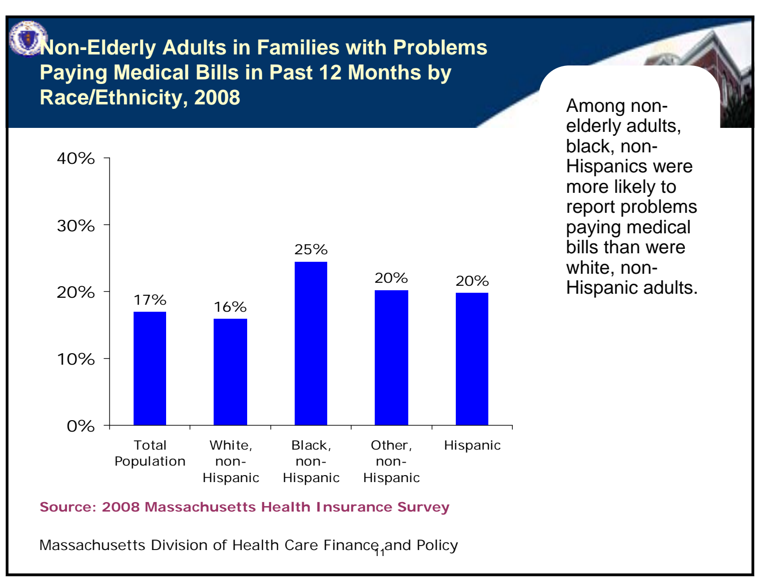


Among non-elderly adults, Hispanics were much more likely to have had an ER visit overall and an ER visit for a non-emergency than other race/ethnicity groups.

*A non-emergency ER visit is one that the respondent says could have been treated by a regular doctor if one had been available.
Source: 2008 Massachusetts Health Insurance Survey

Massachusetts Division of Health Care Finance and Policy

Non-Elderly Adults in Families with Problems Paying Medical Bills in Past 12 Months by Race/Ethnicity, 2008



Among non-elderly adults, black, non-Hispanics were more likely to report problems paying medical bills than were white, non-Hispanic adults.

Source: 2008 Massachusetts Health Insurance Survey

Massachusetts Division of Health Care Finance and Policy

Chapter 58 Sections Related to Disparities

1) Section 16O:

   lays out provisions for an ongoing "health disparities council."

2) Section 25:

   "Hospital rate increases shall be made contingent upon hospital adherence to quality standards and achievement of performance benchmarks, including the reduction of racial and ethnic disparities in the provision of health care."

3) Section 16L:

   requires the new Health Care Cost and Quality Council (HCQCC) to focus on reducing disparities

http://www.mass.gov/legis/laws/seslaw06/sl060058.htm

(1)

The Massachusetts Council for the Elimination of Racial and Ethnic Disparities

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Council's Statutory Responsibilities

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

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

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Why a Disparities Report Card?

"Although prior experience with public reporting in health care has been mixed, the rationale for its ongoing use is compelling: that report cards provide transparent public information and a clear incentive for improved performance."

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

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

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

DATA SOURCE: Weapon-related injuries, Massachusetts Department of Public Health, Weapon-Related Injury Surveillance System
DATA ANALYSIS: Boston Public Health Commission Research Office

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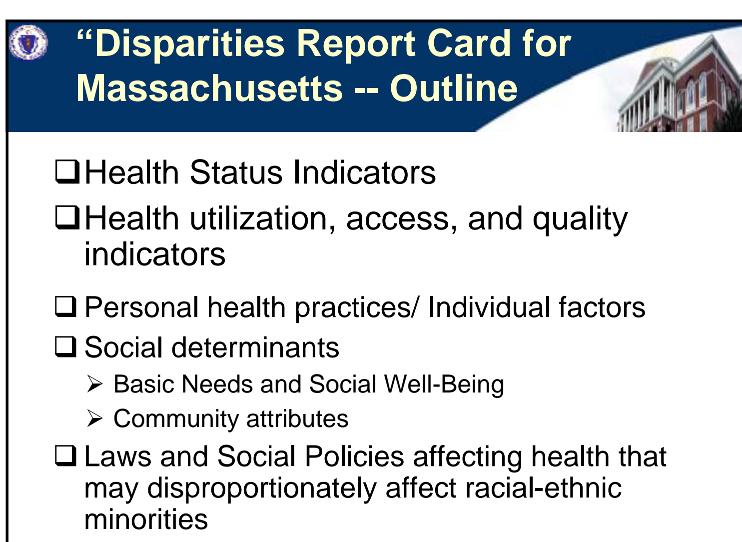

(2)

MassHealth Hospital Pay for Performance (P4P) to Reduce Disparities

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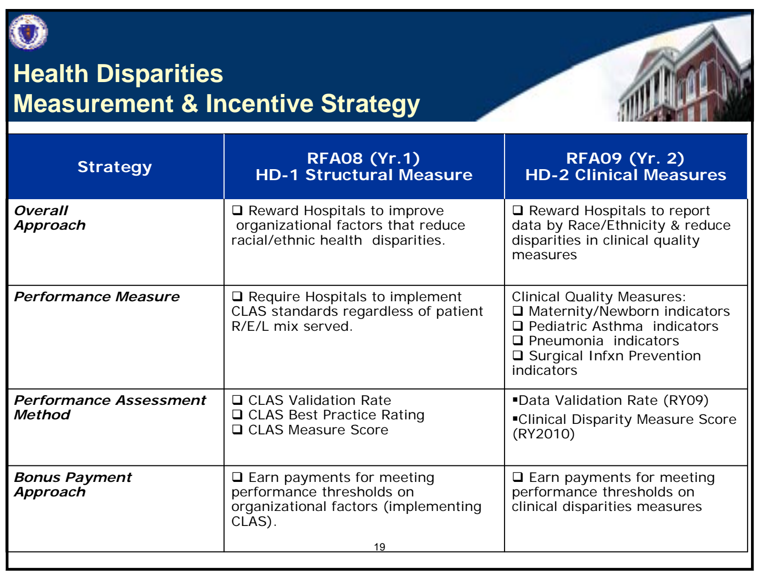

Health Disparities Measurement & Incentive Strategy

Strategy	RFA08 (Yr.1) HD-1 Structural Measure	RFA09 (Yr. 2) HD-2 Clinical Measures
Overall Approach	❑ Reward Hospitals to improve organizational factors that reduce racial/ethnic health disparities.	❑ Reward Hospitals to report data by Race/Ethnicity & reduce disparities in clinical quality measures
Performance Measure	❑ Require Hospitals to implement CLAS standards regardless of patient R/E/L mix served.	Clinical Quality Measures: ❑ Maternity/Newborn indicators ❑ Pediatric Asthma indicators ❑ Pneumonia indicators ❑ Surgical Infxn Prevention indicators
Performance Assessment Method	❑ CLAS Validation Rate ❑ CLAS Best Practice Rating ❑ CLAS Measure Score	▪Data Validation Rate (RY09) ▪Clinical Disparity Measure Score (RY2010)
Bonus Payment Approach	❑ Earn payments for meeting performance thresholds on organizational factors (implementing CLAS).	❑ Earn payments for meeting performance thresholds on clinical disparities measures

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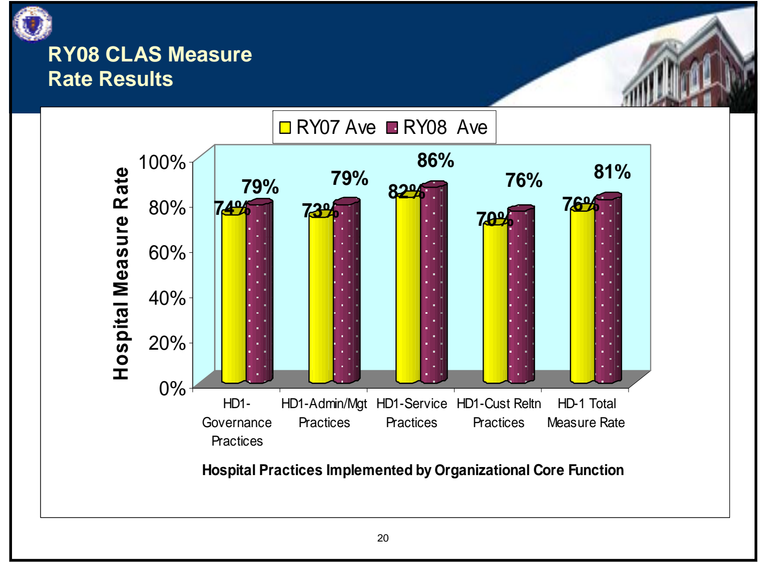
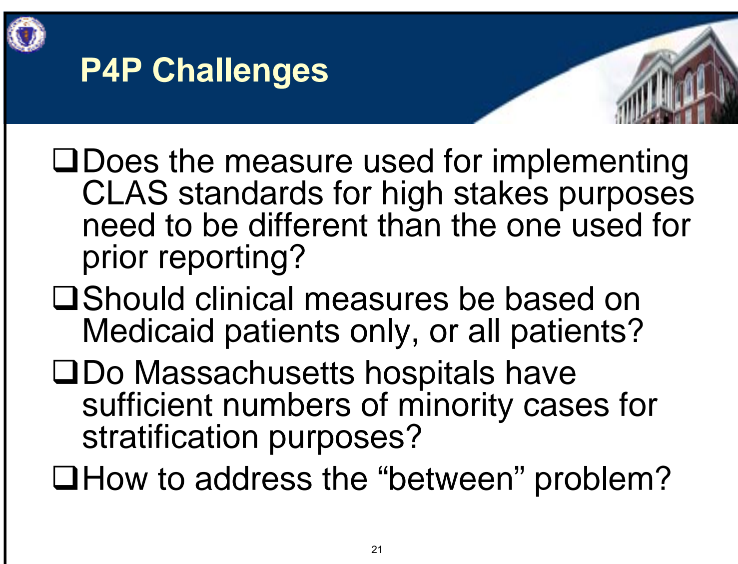
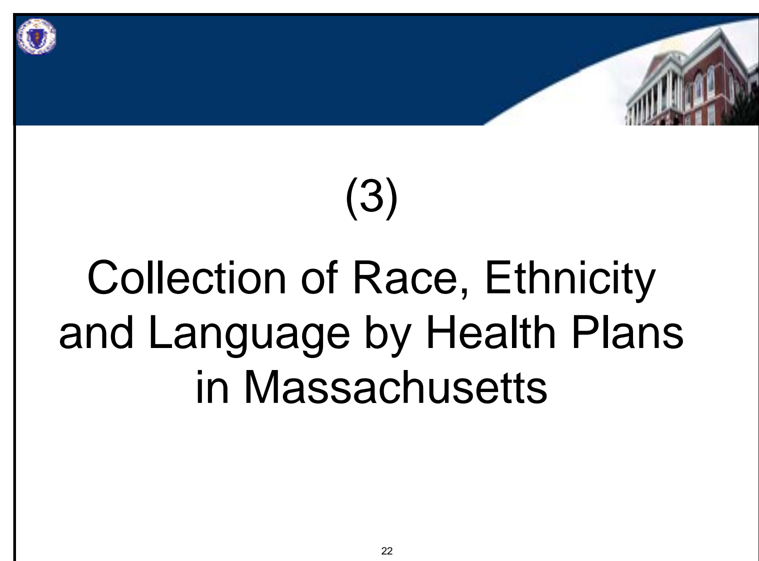
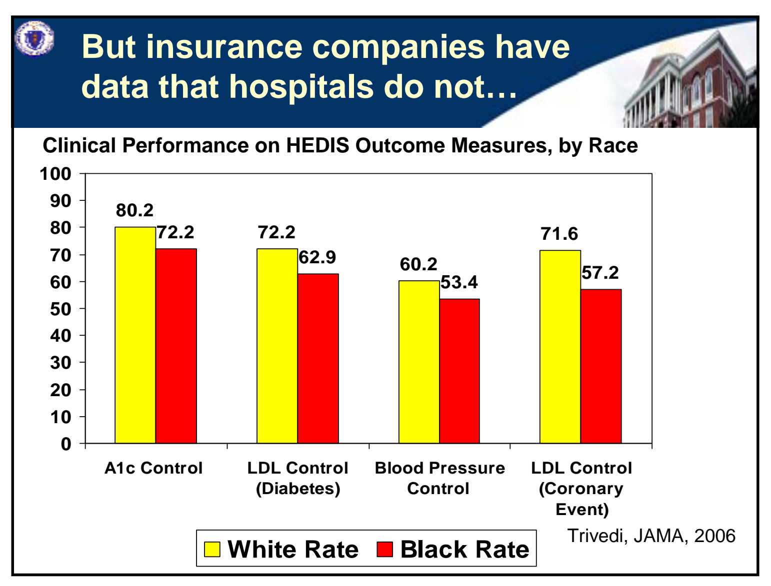






Massachusetts already requires collection of R/E from ***hospitals***

- ❑The Division of Health Care Finance and Policy adopted regulation 114.1 CMR 17.00 to require the reporting of Hospital Inpatient Discharge Data
- ❑Race and Ethnicity are required fields

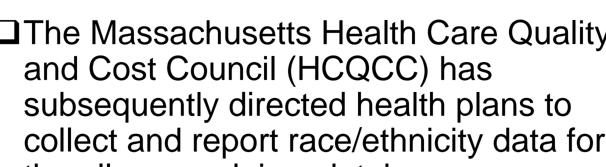


The problem is that R/E/L data collection by health plans is inconsistent

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

Nerenz, et al. 2002

The HCQCC

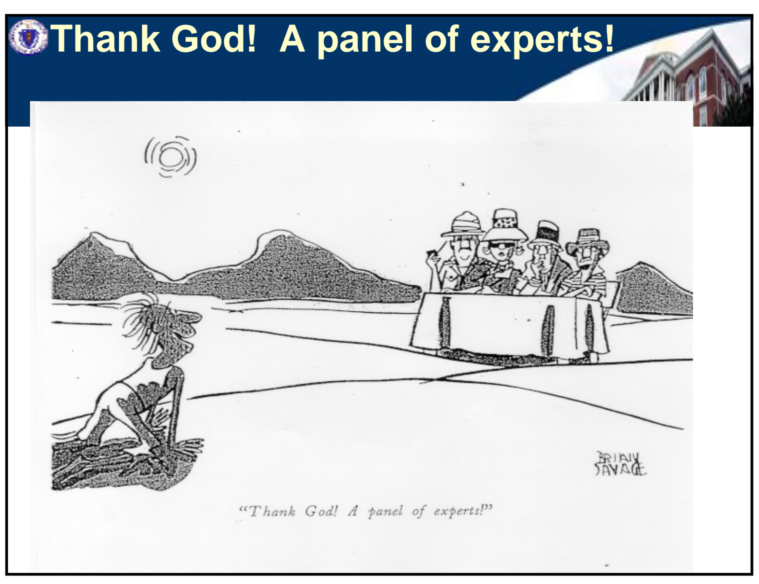


- ❑ The Massachusetts Health Care Quality and Cost Council (HCQCC) has subsequently directed health plans to collect and report race/ethnicity data for the all-payer claims database
  - per regulations promulgated in 129 CMR 2.00 “Uniform Reporting System For Health Care Claims Data Sets”

HCQCC Relationship with Brookings

- ❑ The Brookings Institute is working with the HCQCC to do the following:
  - Assessment of health plans’ current status and plans for collecting R/E/L data.
  - Assessment of member preferences for data collection and reporting
  - TA to health plans

Thank God! A panel of experts!



“Thank God! A panel of experts!”

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

1. Require health plans to report R/E data self-reported by members or guardians
2. Amend 129 CMR 2.00 to include patient preferred spoken language **and** written language as required fields in the Member Eligibility File.
3. Require health plans to report race, ethnicity and language data at specified thresholds beginning July 1, 2010.

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

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

Meanwhile, while we waiting for good R/E/L data to be reported…

What is indirect estimation?

- Indirect Estimation methodologies use an individual's name and address to estimate the probability that the person is white, the probability that the person is black, Hispanic, Asian, and so on. Researchers can “roll up” these probabilities to estimate the racial make-up of population, and disparities in the quality of care received by different minority groups.
- For example, the QCC (or any health plan) could use this method to estimate the percentage of Blacks that received a mammogram versus the percentage of whites that received a mammogram.

Indirect Estimation generated a lot of discussion among stakeholders

- ***We already tried indirect measures and they were too unreliable to be of much use***
  - New methods are superior
- ***This method is inaccurate because it would misclassify me***
  - Indirect measures do NOT classify individuals as a single race or ethnicity
- ***Given that self-reported race/ethnicity is the gold standard, why divert time and resources to settle for imprecise and unreliable measures?***
  - Direct measurement will take time; this is an interim measure
- ***We don’t understand how to use probabilities that a member belongs to one racial/ethnic group or another.***
  - Aggregation can be done basic algebra and simple probability
- ***How can indirect estimates be used? When is it appropriate and inappropriate to use indirect estimates?***
  - To identify populations and groups that have disparate quality of care.
  - Not to perform outreach to individual members

Comparing Disparities from Self-Report vs RAND method in a health plan of 2 million

(~30k diabetics)	Racial Disparity (White vs Black)	
	Direct Method	Indirect Method
B-Blocker	22.7	23.1
HgbA1c	14.5	14.5
Lipids	21.6	21.3
Eye Exam	7.6	7.4

Fremont, et al, Health Affairs 2005

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Motion 4

- The HCQCC will explore indirect estimation of race and ethnicity on a pilot basis with health plans...to address the feasibility of using the software and the potential benefit to the QCC …to track disparities in quality of care.
- The QCC will use indirect estimates to supplement, not replace, directly self-reported data.

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SUMMARY

- The effect of Massachusetts HCR on disparities is still unknown
- The Massachusetts Health Disparities Council is ready to make an impact in the next year
- MassHealth is implementing financial incentives to reduce racial-ethnic disparities in hospitals
- The QCC is poised to make Massachusetts the first state in the nation to stratify HEDIS-type quality measures by race-ethnicity

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Questions???

Joel S. Weissman, PhD

Senior Health Policy Advisor to the Secretary

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