Applying Value-Based Payment to Health Equity: Spotlight on BCBS Massachusetts Equity Efforts with Provider Organizations

Wednesday, April 26, 2023
Agenda

• Welcome
• HCTTF Overview
• BCBS MA’s Equity Innovations within the Alternative Quality Contract
• Beth Israel Leahy Health’s Experience Participating in BCBS MA’s Innovations
• Panelist Discussion
• Audience Q&A
Established in 2014, the **Health Care Transformation Task Force** is a multi-sector industry consortium comprised of Providers, Payers, Purchasers, Patients, and Partners, committed to advancing delivery system transformation that drives rapid, measurable change for ourselves and our country.
Task Force Members
In 2015, The Task Force began its journey with the goal of members having 75% of their business in value-based payment models by the end of 2020. Our members more than doubled their progress during those six years.

Our updated goal - **75% by 2025** - reflects the significant progress to date, and our members continued commitment to advance adoption of value-based care delivery and payment models.

We look forward to continuing the journey.
Speakers

Mark Friedberg
SVP for Performance Measurement and Improvement
BCBS Massachusetts

Deanna Fulp
Sr. Director, Health Equity
BCBS Massachusetts

Juan Fernando Lopera
Chief Diversity, Equity and Inclusion Officer
Beth Israel Lahey Health
COLLABORATION BETWEEN HEALTH PLANS AND PROVIDERS TO IMPROVE HEALTH EQUITY

MARK FRIEDBERG & DEANNA FULP, BLUE CROSS BLUE SHIELD OF MASSACHUSETTS
JUAN FERNANDO LOPERA, BETH ISRAEL LAHEY HEALTH

PRESENTED AT HCTTF ON APRIL 26, 2023
• Part 1: BCBSMA’s approach to improving health equity

• Part 2: Data to measure health equity

• Part 3: Collaborating with provider systems to improve inequities
PROMISE
Always put our members first.

MISSION STATEMENT
The relentless pursuit of quality, affordable and equitable health care with an unparalleled consumer experience.

PARTNERSHIPS
• Partner with providers and market innovators
• Advise accounts to solve key needs

CAPABILITIES
• Strong financials
• Advanced tech, data & analytics
• Frictionless consumer-centric operations

PEOPLE
• Diversity, equity & inclusion
• Innovative, empathetic and agile culture
• High-performing workforce
5C: THE FRAMEWORK WE USE TO ADVANCE OUR EQUITY AGENDA

CARE
- Measure, reduce, & develop interventions to address the inequities in care among our members

COMMERC
- Deliver company products and services to meet our customers needs through the lens of diversity

CAREER
- Recruit, Respect, and Retain an inclusive, developed diverse workforce

CULTURE
- Achieve an effective and culturally competent organization through our inclusive workforce

COMMUNITY
- Support our external partners to address the health and well-being of our diverse community
Only two uses of race & ethnicity data are allowed:
1. To measure inequities in care.
2. To reduce inequities in care.
POTENTIAL SOURCES OF DATA ON RACE & ETHNICITY

• Member self-reported, direct to plan: gold standard
  • Key is to know the data are self-reported, with end-to-end documentation of all aspects of data collection

• Account-reported, via enrollment and/or employment files

• Providers and government sources
  • A mix of self-reported and not-self-reported data
  • Data provenance absent or lacking in detail → nobody really knows exactly how the data were collected
    • Our view: any data collected via interview require audit & validation, like the telephone version of any well-done survey (e.g., CAHPS, when telephonic mode present)

• Imputed

• Vended
DATA STANDARDS FOR RACE & ETHNICITY

- FHIR (Fast Healthcare Interoperability Resources)
  - Separate race & ethnicity fields
  - Federally mandated for interoperability
  - Identical to OMB 1997 standard at FHIR level 1
  - Very detailed, with 100s of categories at FHIR level 6
  - Every other federal standard maps to FHIR
    - Example: NIH Office of Minority Health data standard is subset of FHIR codes

- If combining race & ethnicity into single variable, use federal guideline: https://obamawhitehouse.archives.gov/omb/fedreg_race-ethnicity

- Data provenance: For every race & ethnicity value in your dataset, there should be a way to know where it came from, how it was collected (ideally including instrument version), when it was collected, what data standard it’s on, ...
MISSING RACE/ETHNICITY: USING DATA SOURCES OTHER THAN GOLD-STANDARD

- Even in the long term, due to member turnover rates and other barriers in the data collection process, achieving 100% self-reported data is unlikely to ever occur.

- While race/ethnicity data collection efforts continue, to act now to measure and reduce inequities in care, methods for properly addressing high proportions of missing data are needed.

- A commonly proposed solution: Conduct a complete-case analysis, in which only members with self-reported race/ethnicity are included in race/ethnicity analyses.
  - In our dataset, this would mean conducting race/ethnicity analyses among the ~20% of members with self-reported race/ethnicity.
  - Note: in the presence of non-random missing data, a large body of statistical research has demonstrated that complete case analysis can lead to biased estimates, relative to well-done imputation—not to mention reductions in sample size.
MISSING RACE/ETHNICITY: USING DATA SOURCES OTHER THAN GOLD-STANDARD

Our Preferred Approach:

1. Collect a substantial set of gold-standard self-reported data
2. Assess the accuracy of every other data source by comparison to the gold-standard data set
3. Impute the race/ethnicity for any members with missing data
   • Use the gold-standard dataset to train the imputation method
4. Generate best-possible estimates for inequity measures by using gold-standard data when present and imputing the rest
   • Corollary 1: Do not do a complete-case analysis, using only the gold-standard data
   • Corollary 2: Do not create a hierarchy of data sources, other than the gold-standard dataset. Instead, try including all these data sources in the imputation model, as predictors of the gold-standard data.
### MyBlue results (as of 3/28/2022)
- 1,961,171 unique views of the ‘About Me’ modal
- 522,675 members have provided their race and ethnicity
- 517,638 members have completed race and ethnicity records
- 138,010 are non-White or Hispanic/Latino
- 3 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
- 6 member complaints

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

### Wave 1 – 3 mailed survey results
- Wave 1: 693,288 total surveys sent, 1,375,437 total members
- Wave 2: 94,159 total surveys sent, 211,116 total members
- Wave 3: 146,813 total surveys sent, 406,342 total members
- 148,133 member responses provided race and ethnicity
- 31,312 member responses that are non-White or Hispanic/Latino
- 75 member complaints*

*About half of these complaints voiced opposition to improving health equity. The rest were constructive criticisms or concerned issues unrelated to the survey.

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### Self-Reported Members Race Ethnicity Data: (MyBlue & Mailed Survey)

21.5% of BCBSMA current members have provided their race and ethnicity data (~24% among AQC-attributed members)

2023 Target: 35%
MEMBER CHURN EATS INTO OUR CUMULATIVE RACE & ETHNICITY DATA COLLECTION

Roughly 1.5% of members disenroll from BCBSMA each month (except January: roughly 4.5% exit)

- Between Dec 2020 – Oct 2022, nearly 500K members provided race & ethnicity data through MyBlue or Paper survey
- Roughly 80% of these members still had active medical benefits in October 2022
- As we gather more race & ethnicity data, monthly churn takes bigger bites
- It is likely that some degree of imputation will be necessary in the long term

Note: This figure is current through October 2022. Preceding slide was updated more recently.
PART 3: COLLABORATING WITH PROVIDER SYSTEMS TO IMPROVE INEQUITIES

BCBSMA has produced equity audits for provider organizations and for publication on our website.

AQC Health Equity Report

Calendar Year 2019

Colorectal Cancer Screening

Group X

Data From All AQC Groups

Health Equity Report

At Blue Cross, we have a deep commitment to quality, affordable health care, and that includes equity. As part of our commitment, each year we gather and publish data for more than 12 million of our commercial Massachusetts members, using measures widely leveraged by health plans and clinicians to monitor health care quality. See our 2020 data below.

This data has revealed racial and ethnic inequities in many areas of patient care. In partnership with the clinicians in our network, we’re using our data to make meaningful change and to work toward our shared goal of eliminating racial disparities in the care our members receive. Read Coverage for examples of how we’re partnering with Massachusetts provider organizations to address inequities in health care.

CHRONIC CONDITIONS

<table>
<thead>
<tr>
<th>Condition</th>
<th>Asian</th>
<th>Black</th>
<th>Hispanic</th>
<th>White</th>
</tr>
</thead>
<tbody>
<tr>
<td>Asthma Medication Ratio</td>
<td>86.80%*</td>
<td>72.30%*</td>
<td>74.60%</td>
<td>78.30%</td>
</tr>
<tr>
<td>Comprehensive Diabetic Care - HbA1c control</td>
<td>80.30%*</td>
<td>76.30%*</td>
<td>90.30%*</td>
<td>94.00%*</td>
</tr>
<tr>
<td>Comprehensive Diabetic Care - HbA1c control</td>
<td>19.30%*</td>
<td>23.60%*</td>
<td>28.30%*</td>
<td>17.66%</td>
</tr>
</tbody>
</table>

Full report here
IMPROVING INEQUITIES THROUGH PROVIDER ENGAGEMENT

Adding equity to the Alternative Quality Contract (AQC) triad

Confidential **Equity Reports** to all AQC providers distributed September 2021, updated at least annually

**Pay for Equity (P4E) Incentives** added to AQC payment program beginning in 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

P4E detail [here](#)

Grant detail [here](#)
$19.5 million in grant funding awarded by IHI by end of 2022 to AQC groups participating in the Equity Action Community.

<table>
<thead>
<tr>
<th>AQC Providers</th>
<th>Data/Infrastructure</th>
<th>Equity improvement targets/efforts</th>
</tr>
</thead>
<tbody>
<tr>
<td>Atrius Health</td>
<td>REL data collection, IT, staff trainings</td>
<td>Blood pressure</td>
</tr>
<tr>
<td>BOSTON MEDICAL</td>
<td>Diabetes registry improvements</td>
<td>Diabetes, blood pressure, missed appointments</td>
</tr>
<tr>
<td>Baycare Health Partners, Inc.</td>
<td>REL data collection</td>
<td>Diabetes, blood pressure</td>
</tr>
<tr>
<td>Boston Children’s Hospital</td>
<td>Developmental screening EHR modules</td>
<td>Well child visits, provider training in dev screening</td>
</tr>
<tr>
<td>Beth Israel Lahey Health</td>
<td>REL data collection, IT, equity dashboards</td>
<td>Diabetes</td>
</tr>
<tr>
<td>Mass General Brigham</td>
<td>REL data collection</td>
<td>Responding to racism/bias staff trainings</td>
</tr>
<tr>
<td>RELIANT MEDICAL GROUP</td>
<td>REL data collection</td>
<td>Blood pressure control, self-management tools</td>
</tr>
<tr>
<td>SONE HEALTH</td>
<td>REL data collection, geographic data</td>
<td>Primary care access to close multiple gaps in care</td>
</tr>
<tr>
<td>South Shore Health</td>
<td>REL data collection, IT support</td>
<td>Implicit bias training for providers</td>
</tr>
<tr>
<td>Southcoast Health</td>
<td>REL data collection, staff trainings</td>
<td>Diabetes</td>
</tr>
<tr>
<td>Steward</td>
<td>Equipment to support access</td>
<td>Diabetes, cancer screenings, enhanced access</td>
</tr>
<tr>
<td>Tufts Medicine</td>
<td>REL data collection</td>
<td>Blood pressure</td>
</tr>
</tbody>
</table>
$3.5 million in grant funding reserved for (and majority awarded to) small groups participating in EAC

<table>
<thead>
<tr>
<th>AQC Provider Group</th>
<th>Data/Infrastructure Focus Area(s)</th>
<th>Equity Improvement Focus Area(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acton Medical Associates</td>
<td>Race &amp; ethnicity data infrastructure</td>
<td>Diabetes, access for underserved populations</td>
</tr>
<tr>
<td>Community Care Cooperative</td>
<td>Workforce training on race &amp; ethnicity data collection</td>
<td>Diabetes, hypertension</td>
</tr>
<tr>
<td>Lawrence General Hospital</td>
<td>Race &amp; ethnicity data infrastructure</td>
<td>Breast cancer screening</td>
</tr>
<tr>
<td>Valley Health Partners, Inc.</td>
<td>Expand race &amp; ethnicity data collection</td>
<td>Diabetes and metabolic health</td>
</tr>
</tbody>
</table>

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

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.
### HOW P4E DESIGN PRINCIPLES LEAD TO SPECIFIC P4E COMPONENTS IN YEAR 1

<table>
<thead>
<tr>
<th>P4E design principle</th>
<th>Corresponding P4E component</th>
</tr>
</thead>
</table>
| Incentivize improvements in equity measures                                          | Zero payment if no equity improvement  
Max payment if inequity eliminated completely*                                                                                           |
| Maintain validity                                                                    | Draw P4E measures from existing AQC P4P measures (already valid)                                                                                         |
| Maintain reliability (i.e., limit risk of performance misclassification due to chance/luck) and  
Apply greater financial incentives when inequities are larger in magnitude and affect larger populations | For each contract, include in P4E only measures that:  
• have low enough risk of misclassification due to chance, and  
• have large enough sample sizes in performance year                                                                       |
| Do not pay for equity improvements that result from performance declines for any race/ethnicity category | Zero P4E gate score for any measure when there is a true performance decline for any race/ethnicity category                                           |
| Emphasize collaboration over competition                                              | Base P4E in longitudinal, within-group improvements in equity rather than cross-sectional comparisons between groups (i.e., each group incentivized to do better than own past performance, rather than do better than other groups) |
| Do not penalize providers who serve more diverse patient populations                  | Equity alone will not put a provider organization in deficit                                                                                          |

*Max payment if observed inequity is consistent with complete elimination of true inequity, accounting for measurement imprecision*
### Pay-for-Equity: Five Alternative Groups Participating in 2023

<table>
<thead>
<tr>
<th>AQC Provider Group</th>
<th>Equity measures included</th>
</tr>
</thead>
</table>
| Steward                  | • Colorectal cancer screening  
                          • Controlling high blood pressure                                                      |
| Beth Israel Lahey Health | • Comprehensive diabetes care: blood pressure control  
                          • Comprehensive diabetes care: HbA1c poor control  
                          • Controlling high blood pressure                                                      |
| Boston Medical           | • Colorectal cancer screening  
                          • Controlling high blood pressure                                                      |
| Mass General Brigham     | • Controlling high blood pressure                                                      |
|                          | • Colorectal cancer screening  
                          • Comprehensive diabetes care: HbA1c poor control  
                          • Controlling high blood pressure  
                          • Child and adolescent well-care visits                                                |

Together, these five AQC groups provide care to 53% of BCBSMA’s in-state members and 67% of those in risk contracts.

#### 2023 goals:

1. **Bring all remaining eligible AQC groups into P4E, to go live January 1, 2024.** This would bring the total to 8 AQC groups engaged in P4E. Eligibility depends on population size, population diversity, and baseline inequity measurements.

2. **Publish P4E methodology.** We hope this will help other payers synchronize with us, reducing provider burden and improving program effectiveness. To date, payer interest in P4E program details has been high.
About Beth Israel Lahey Health

A comprehensive, high-value system of care across Eastern Massachusetts and Southern New Hampshire

- Primary Care
- Specialty Care
- Behavioral Health
- Ambulatory Surgery

- Community Hospitals
- Tertiary and Academic Hospitals

- Home Care
- Hospice & Palliative Care
- Preferred SNF Network

- Population Health Management

Key Facts

<table>
<thead>
<tr>
<th>Facilities</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospitals</td>
<td>13</td>
</tr>
<tr>
<td>Major Ambulatory Facilities</td>
<td>25</td>
</tr>
<tr>
<td>BILHPN PCPs</td>
<td>850</td>
</tr>
<tr>
<td>Total BILHPN Physicians</td>
<td>4,300</td>
</tr>
<tr>
<td>Nurses</td>
<td>9,000</td>
</tr>
<tr>
<td>Estimated Paneled Lives</td>
<td>1.3 million</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Clinical Operations</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Operating Revenue</td>
<td>$6 billion</td>
</tr>
<tr>
<td>Employees</td>
<td>35,000</td>
</tr>
<tr>
<td>Discharges</td>
<td>152,000</td>
</tr>
<tr>
<td>ED Visits</td>
<td>380,000</td>
</tr>
<tr>
<td>Outpatient Encounters</td>
<td>4.8 million</td>
</tr>
</tbody>
</table>
We create healthier communities – one person at a time – through seamless care and ground-breaking science, driven by excellence, innovation and equity.

**Wellbeing** We provide a health-focused workplace and support a healthy work-life balance

**Empathy** We do our best to understand others’ feelings, needs and perspectives

**Collaboration** We work together to achieve extraordinary results

**Accountability** We hold ourselves and each other to behaviors necessary to achieve our collective goals

**Respect** We value diversity and treat all members of our community with dignity and inclusiveness

**Equity** Everyone has the opportunity to attain their full potential in our workplace and through the care we provide
Diversity, Equity & Inclusion (DEI) Vision and Goals

Transform care delivery by dismantling barriers to equitable health outcomes and become the premier health system to attract, retain and develop diverse talent.

We aim to have a workforce that mirrors the increasing diversity in the communities that BILH serves, with a focus on representation in leadership and care delivery roles.

We aim to eradicate disparities in health outcomes within our diverse population of patients.

We aim to expand investments in underrepresented communities to close socio-economic disparities that impact population health.
2022 DEI System Goals

**Leadership**: Achieve a significant increase in BIPOC representation among new leadership hires (directors and above) with an aim of at least 20% representation

*BIPOC – Black, Indigenous and People of Color*

- **Exceeded Goal**
  - 22% BIPOC in new leadership hires; 56% women

**Diabetes Disparities**: Conduct racial and ethnic disparity analysis for a measure of diabetes care, with an aim to reduce the racial/ethnic gap by 20% over 2021 baseline

- **Partial Goal Met**
  - Modest improvement in A1c though marked improvement in A1c screenings

**Supplier Diversity**: Increase spend with diverse businesses by 20% over FY21 baseline

- **Exceeded Goal**
  - 44% increase ($29M to $42M), while generating cost savings
The partnership with BCBSMA/IHI was a catalyst for advancing health equity system-wide and establish foundational infrastructure.

Data Standardization & Collection
- REaL, SO/GI, Pronouns, Disability, etc.
- SDoH screening

Research & Analysis
- Quality dashboards stratified by demographics and social factors
- Health disparity research and best practices
- Disseminate health equity reports across the system

Interventions
- Clinical standards of care, culturally and linguistically-oriented programs
- Cultural training and education
- Social services infrastructure to address SDoH

Program Outcomes Measurement
- Measurement and continuous improvement of program outcomes
Diabetes Disparities and Interventions

Based on marked diabetes disparities affecting Black and Hispanic patients, we established dual goals, to: (a) improve A1c outcomes by 20%, and/or 2) to achieve a 20% reduction in patients missing an A1c test.

### Goal

<table>
<thead>
<tr>
<th>Group</th>
<th>2021 Baseline</th>
<th>FY'22 Goal</th>
<th>Met Goal</th>
<th>As of Oct '22</th>
</tr>
</thead>
<tbody>
<tr>
<td>White</td>
<td>9%</td>
<td></td>
<td></td>
<td>9%</td>
</tr>
<tr>
<td>Black</td>
<td>13%</td>
<td>13%</td>
<td>16%</td>
<td>16%</td>
</tr>
<tr>
<td>Hispanic</td>
<td>15%</td>
<td>15%</td>
<td>17%</td>
<td>17%</td>
</tr>
<tr>
<td>Asian</td>
<td>11%</td>
<td>17%</td>
<td>17%</td>
<td>17%</td>
</tr>
</tbody>
</table>

### Interventions

- Patient Outreach
- Pharmacists
- Health Navigators
- Continuous Glucose Monitoring
Panelist Discussion
For more information on our recent releases, please visit hcttf.org.

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