ACHIEVING VALUE THROUGH TRANSFORMATION
A Webinar Series

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

Wednesday, April 26, 2023

hcttf.org

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

Partners

committed to advancing delivery system transformation that drives rapid, measurable change for ourselves and our country.

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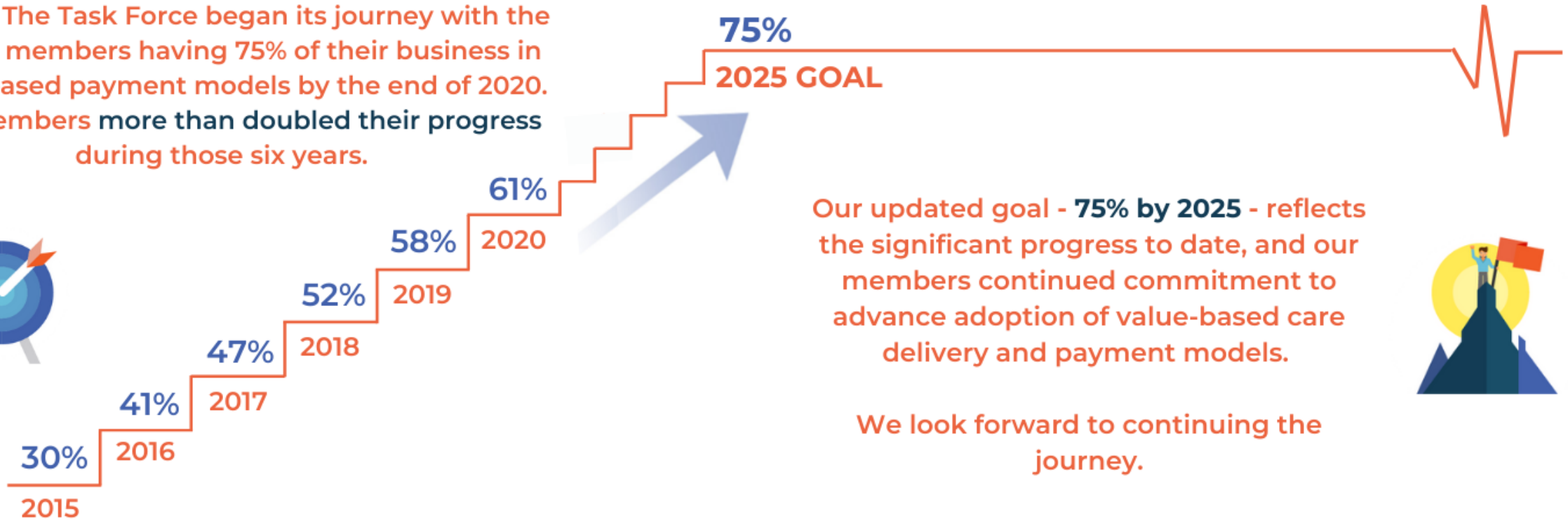
Task Force Members

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

OUTLINE

MASSACHUSETTS

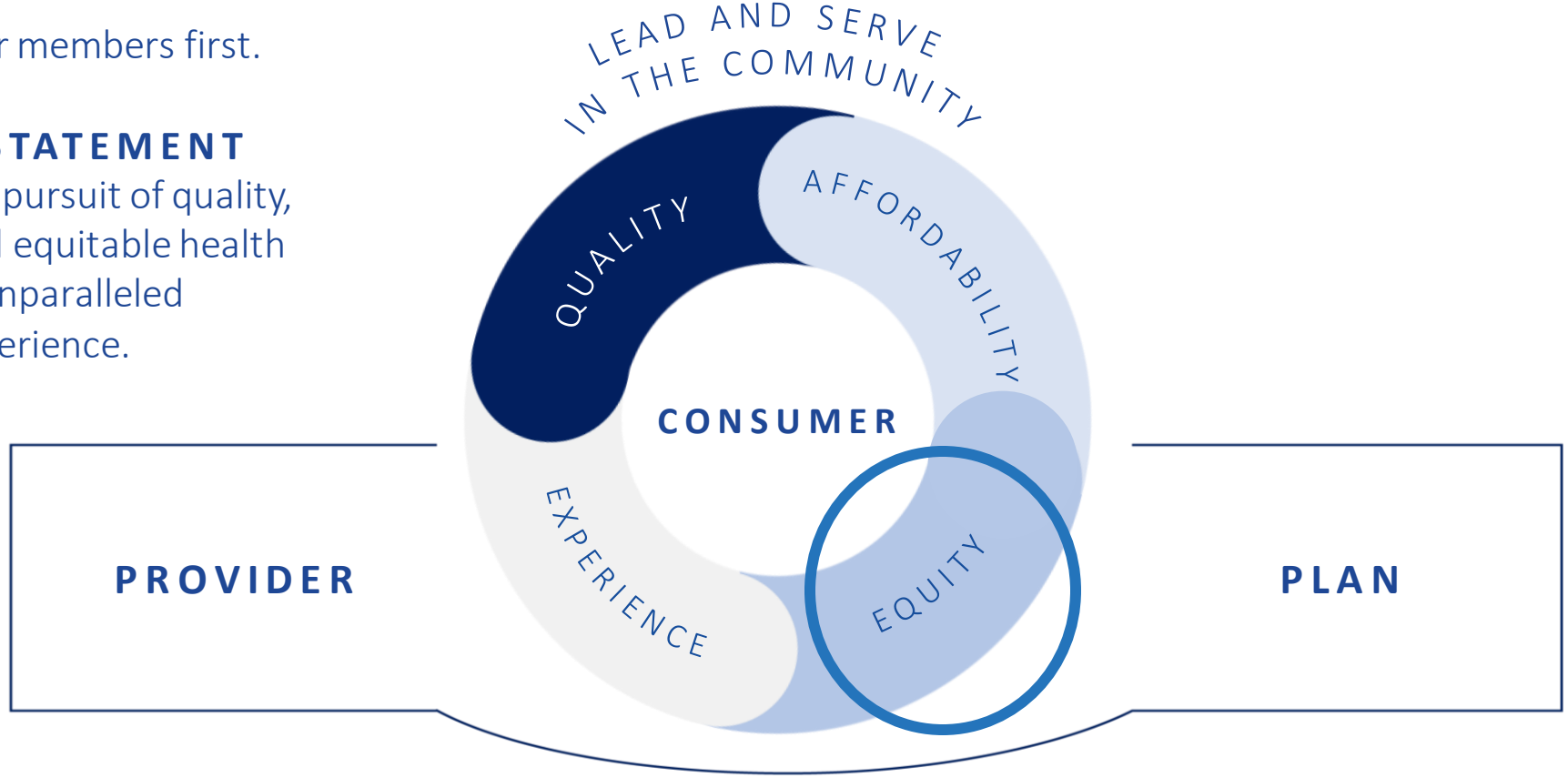
- Part 1: BCBSMA's approach to improving health equity
- Part 2: Data to measure health equity
- Part 3: Collaborating with provider systems to improve inequities

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

MASSACHUSETTS

CARE

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

COMMERCE

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

PART 2: DATA TO MEASURE HEALTH EQUITY

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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

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- 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

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- 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

MASSACHUSETTS

- 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

MASSACHUSETTS

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.

RACE AND ETHNICITY DATA COLLECTION

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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

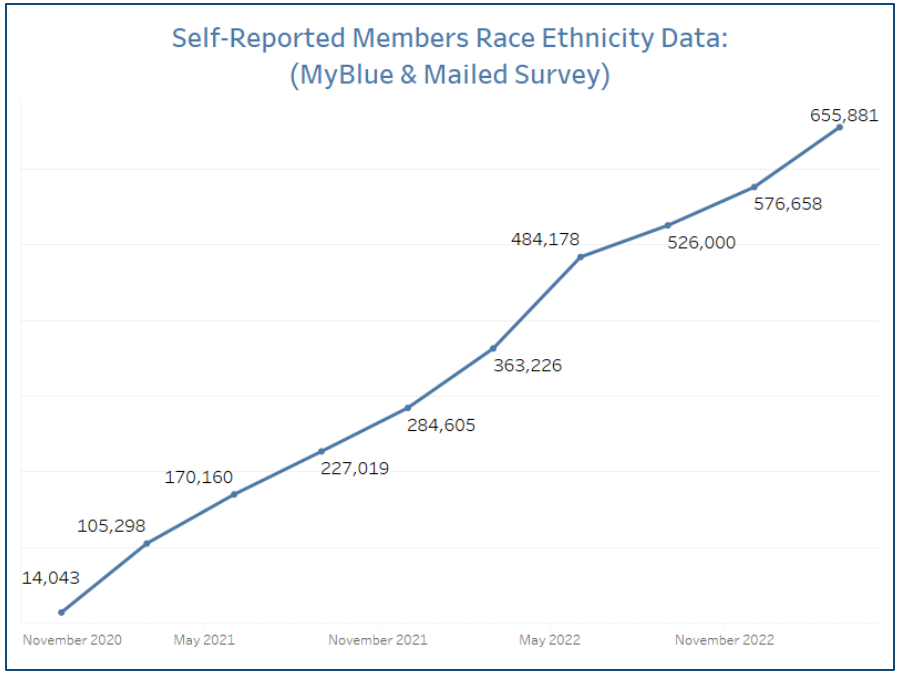
- 55,600 total surveys sent, 139,024 total members
- 9,294 member responses that provided race and ethnicity
- 1,398 member responses that are non-White or Hispanic/Latino
- 6 member complaints

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.



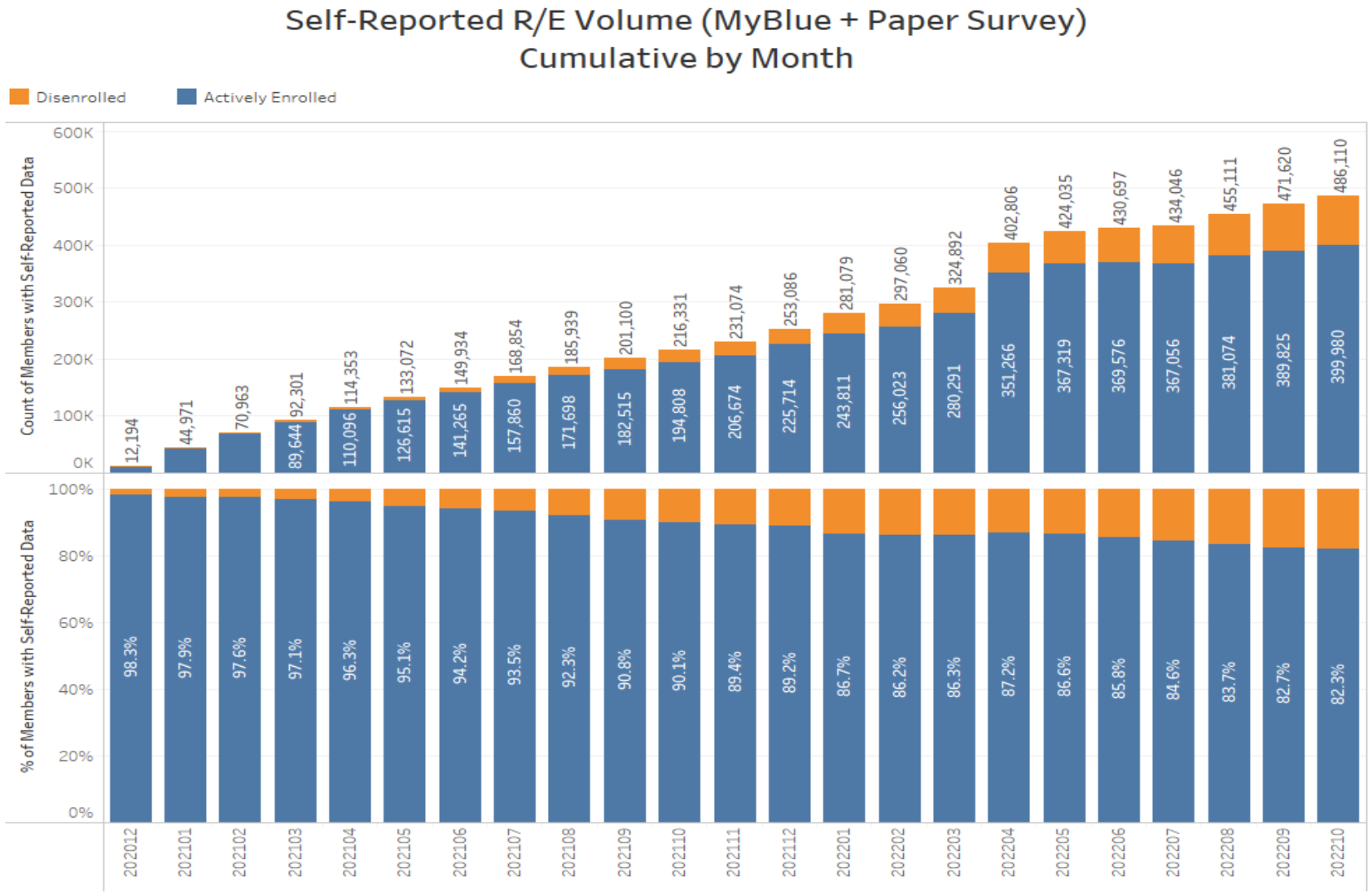
21.5%

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)

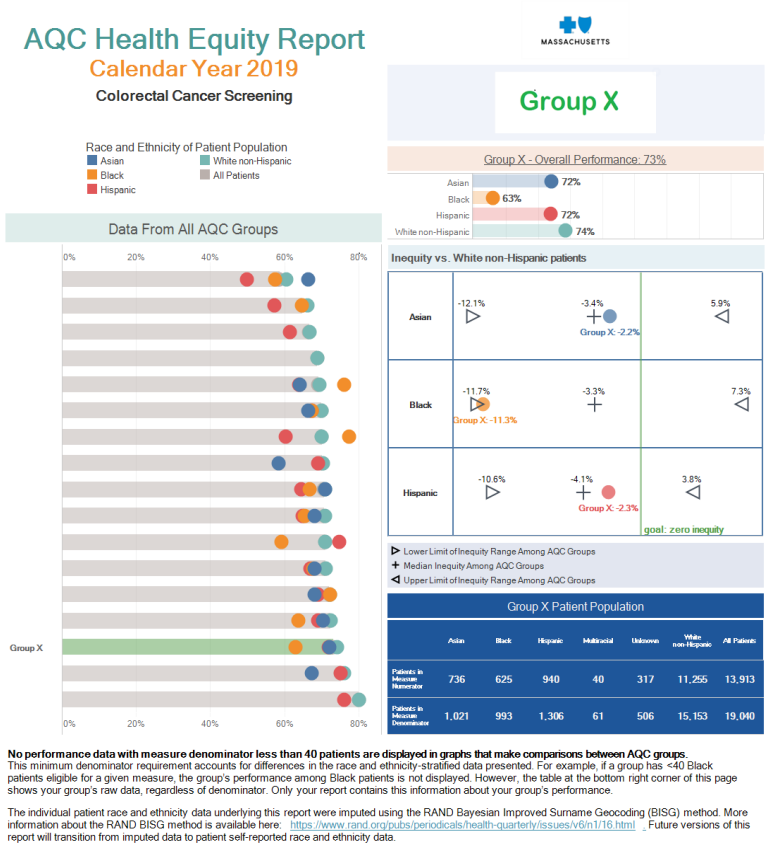


- Between Dec 2020 – Oct 2022, nearly 500K members provided race & ethnicity data through MyBlue or Paper survey
- Roughly 80% of these members still had active medical benefits in October 2022
- As we gather more race & ethnicity data, monthly churn takes bigger bites
- It is likely that some degree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



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

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

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 1.2 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.

LEARN MORE

CHRONIC CONDITIONS

	Asian	Black	Hispanic	White
Asthma Medication Ratio Details	86.60%*	72.80%	74.60%	78.10%
Comprehensive Diabetes Care - BP control Details	85.10%	74.10%*	80.10%*	84.50%
Comprehensive Diabetes Care - HbA1c poor control (lower rates indicate higher quality care) Details	15.50%*	23.60%*	26.30%*	17.40%

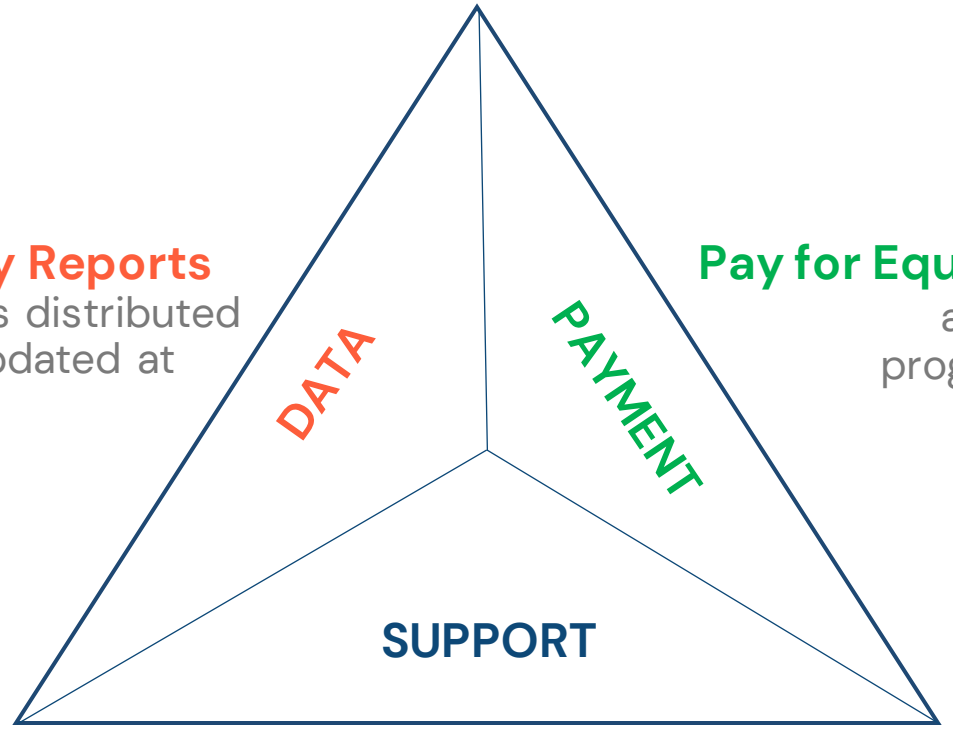
Full report here

IMPROVING INEQUITIES THROUGH PROVIDER ENGAGEMENT

Adding equity to the Alternative Quality Contract (AQC) triad

MASSACHUSETTS

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

P4E detail here

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

Grant detail here

EQUITY ACTION COMMUNITY

Grant Awards Summary

$19.5 million in grant funding awarded by IHI by end of 2022 to AQC groups participating in the Equity Action Community.

AQC Providers	Data/Infrastructure	Equity improvement targets/efforts
Atrius Health	REL data collection, IT, staff trainings	Blood pressure
Boston Medical Center	Diabetes registry improvements	Diabetes, blood pressure, missed appointments
Baycare Health Partners, Inc.	REL data collection	Diabetes, blood pressure
Boston Children's Hospital Until every child is well	Developmental screening EHR modules	Well child visits, provider training in dev screening
Beth Israel Lahey Health	REL data collection, IT, equity dashboards	Diabetes
Mass General Brigham	REL data collection	Responding to racism/bias staff trainings
Reliant Medical Group	REL data collection	Blood pressure control, self-management tools
SOMNE Health	REL data collection, geographic data	Primary care access to close multiple gaps in care
South Shore Health	REL data collection, IT support	Implicit bias training for providers
Southcoast Health	REL data collection, staff trainings	Diabetes
Steward	Equipment to support access	Diabetes, cancer screenings, enhanced access
Tufts Medicine	REL data collection	Blood pressure

SMALL GROUPS: GRANTS AND EQUITY ACTION COMMUNITY

$3.5 million in grant funding reserved for (and majority awarded to) small groups participating in EAC

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AQC Provider Group	Data/Infrastructure Focus Area(s)	Equity Improvement Focus Area(s)
Acton Medical Associates – Adult & Pediatric Primary Care	Race & ethnicity data infrastructure	Diabetes, access for underserved populations
Community Care Cooperative	Workforce training on race & ethnicity data collection	Diabetes, hypertension
Lawrence General Hospital	Race & ethnicity data infrastructure	Breast cancer screening
Valley Health Partners, Inc.	Expand race & ethnicity data collection	Diabetes and metabolic health

Small Group Equity Action Community: First workshop on race & ethnicity data collection and data management took place January 25, 2023.

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

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

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

MASSACHUSETTS

P4E design principle	Corresponding P4E component
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

AQC Provider Group	Equity measures included
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 Center	• 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

Community / Ambulatory	Acute	Post-Acute
▪ 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

Facilities	Hospitals	13
	Major Ambulatory Facilities	25
Clinicians	BILHPN PCPs	850
	Total BILHPN Physicians	4,300
	Nurses	9,000
	Estimated Paneled Lives	1.3 million
Clinical Operations	Operating Revenue	$6 billion
	Employees	35,000
	Discharges	152,000
	ED Visits	380,000
	Outpatient Encounters	4.8 million

BILH Purpose Statement & Values

A "purpose-driven, values-based" organization

Beth Israel Lahey Health

Purpose

We create healthier communities – one person at a time – through seamless care and ground-breaking science, driven by excellence, innovation and equity.

Values

WE CARE

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

Beth Israel Lahey Health

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

Beth Israel Lahey Health

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

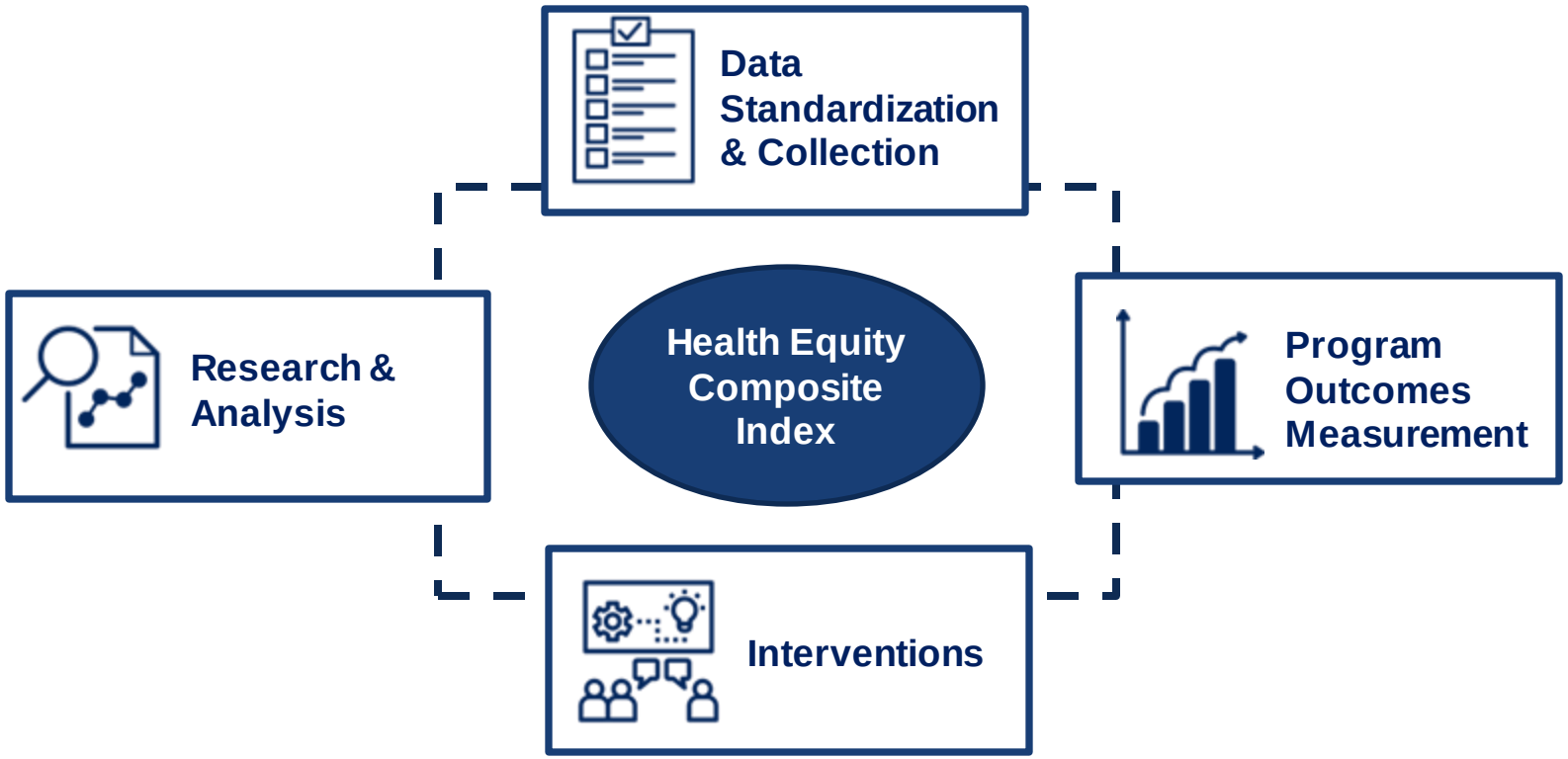
Supplier Diversity: Increase spend with diverse businesses by 20% over FY21 baseline

Exceeded Goal — 44% increase ($29M to $42M), while generating cost savings

Health Equity Framework

Beth Israel Lahey Health

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

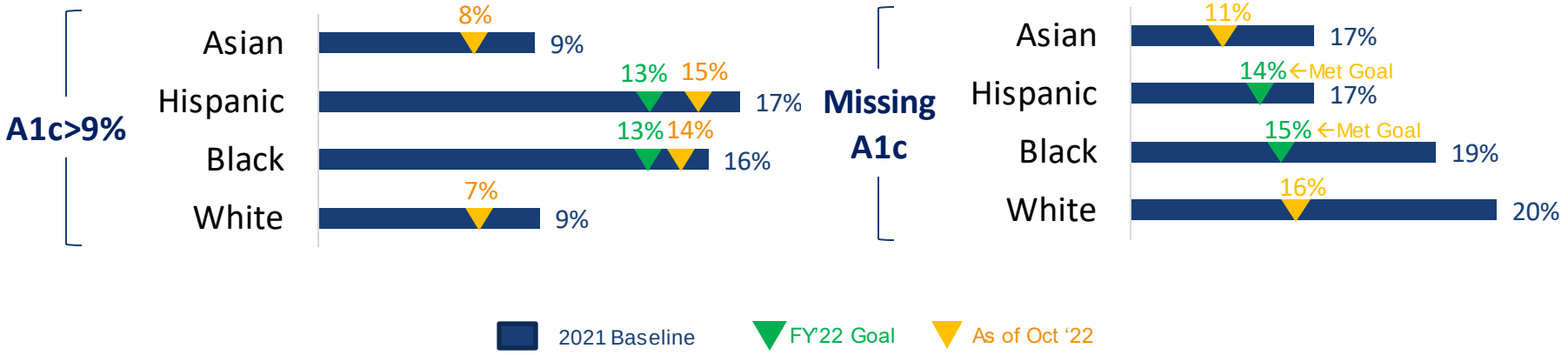
- Measurement and continuous improvement of program outcomes

Diabetes Disparities and Interventions

Beth Israel Lahey Health

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



Interventions


Patient Outreach


Pharmacists


Health Navigators


Continuous Glucose Monitoring

Panelist Discussion

Providers

Payers

Purchasers

Patients

Partners

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