

## Measuring and Improving the Quality of Medicaid-Funded Care to Reduce Disparities in Health and Health Care Outcomes: A Primer for Health Equity Advocates

Despite notable disparities in health status and access to high-quality health care in communities of color and other minority populations, the United States health care system has not prioritized achieving health equity.<sup>1</sup> Health care quality initiatives have exploded over the past two decades, yet most payers and providers still do not collect sufficient data to examine the quality of health care across racial, ethnic, and linguistic minority groups.<sup>2</sup> Adequately measuring these disparities, which is not yet common practice, is an essential step toward eliminating them. States, localities, and health care systems collectively must commit to tracking progress toward health equity through meaningful measurement approaches.

State Medicaid programs have an enormous opportunity to drive a collective approach. Because Medicaid is responsible for addressing the needs of a diverse population,<sup>3</sup> Medicaid programs should take advantage of their capacity to develop and implement a quality oversight program that focuses on health equity, thereby incentivizing improved performance and promoting interventions that reduce disparities. To start, they can adopt and build on examples from states that are 1) stratifying health measures by race, ethnicity, language, and disability (REALD), and by sexual orientation and gender identity and 2) tying those metrics to quality improvement efforts. This paper provides an overview of the equity-focused quality measurement tools that state Medicaid programs can employ, highlights best practices, and describes approaches state advocates can pursue to advance equity-focused quality measurement within their Medicaid programs.

### Tools for Equity-Focused Quality Measurement

In general, entities responsible for the delivery, payment, and accountability of health care use a variety of standardized tools and measurement sets to examine the quality of care. They collect information from administrative records, electronic health records, consumer surveys, and facility inspections, among other sources. Some illustrative examples are included here.

On its “TalkingQuality” website, the U.S. Department of Health and Human Services Agency for Healthcare Research and Quality (AHRQ) lists the major available measurement sets for various care settings.<sup>4</sup> These include, for example:

- » Health Plan Employer Data and Information Set (HEDIS), developed by the National Committee for Quality Assurance (NCQA) and used to measure plan performance and physician performance in managed care.

- » Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey, a patient survey about the experience of care developed under AHRQ.
- » National Hospital Inpatient Quality Measures, developed by the Centers for Medicare & Medicaid Services and the Joint Commission.

Each of these measurement sets includes many possible measures, and health plans and health systems do not report all of the measures in any one set. Instead, they report measures that might be selected by the Medicaid agency or by another payer or quality oversight agency.

CMS recommends states' Medicaid programs report annually on a set of adult and child core measures, including selected measures from the NCQA and AHRQ sets described above. Currently, this reporting is optional, and states can supplement or depart from these recommendations. CMS revises the core measurement sets annually, and states will be required to report the child core measurement set and the adult behavioral health core measurement set in 2024.

Importantly, some states also incorporate measures for specialized populations, and these measures might include whether indicated care was provided pursuant to a specialized needs assessment. For example, New York uses specialized managed care plans to deliver integrated physical health, mental health, and substance use services to people with significant behavioral health needs. In addition to drawing on national measurement sets, New York requires these plans to report on a few specific measures, such as whether members were assessed for home- and community-based services needs, and whether they received continuous care for substance

use, moving from inpatient rehabilitation to a lower level of care.<sup>5</sup>

The selection of quality measures is an important target for equity advocates. Equity advocates can influence which measurements a state or health system will use and push for examination of the health conditions of most concern to their communities for a focused look at how particular populations are faring.

In *A Roadmap for Promoting Health Equity and Eliminating Disparities*, the National Quality Forum, a nonprofit organization that endorses and incubates quality measures, provides a useful tool for this work. From the many possible measures in national measurement sets, the National Quality Forum recommends disparities-sensitive quality measures that address highly prevalent and high-impact conditions among communities of color (cancer, cardiovascular disease, diabetes, infant mortality, and mental illness). The measures address access to care as well as receipt of high-quality, evidence-based care. Appendix E of the *Roadmap* includes a list of recommended measures from which investigators might choose.<sup>6</sup> The National Quality Forum's report stresses the importance of determining whether structures are in place that have been demonstrated to reduce disparities. For example, following the principles in the Roadmap, Medicaid agencies and health systems should choose measures to evaluate each of the following factors:

- » Care is accessible, including geographically and to individuals with disabilities and those whose primary language is not English.
- » Health care providers are using specific evidence-based interventions that are known to reduce disparities.

## A Note on Stratifying Measurement by REALD and SO/GI

To identify health care disparities, states should stratify measurement by race, ethnicity, primary language, and disability (REALD). There are distinct challenges and some important state models for collecting stratified REALD data. These are described in our companion paper, [“Making Progress Toward Health Equity: Opportunities for State Policymakers to Address Health Disparities Through Payment and Delivery System Reform”](#)<sup>7</sup>

Due to privacy concerns, and the discrimination that may result from sharing information, less statewide data is available through health records to monitor disparities based on sexual orientation and gender identify (SO/GI). Electronic health records now include fields for providers to record sexual orientation and gender identity, if patients wish to provide this information. Federally qualified health centers must collect SO/GI data that patients volunteer.<sup>8</sup> Recently, 10 federally qualified health centers tested a quality improvement initiative designed to increase both documentation of SO/GI data and the percentage of LGBTQ patients screened for HIV and sexually transmitted diseases.<sup>9</sup> State Medicaid programs can similarly pilot quality improvement initiatives relevant to sexual orientation or gender identity.

- » The workforce has what it needs to advance equity.
- » The system is addressing social risk factors and assessing community needs.
- » There are safe spaces to speak up about racism and how the health care system responds.
- » Care is person- and family-centered. (See National Quality Forum’s Roadmap for more factors and possible measurement sets.)

## Best Practice for Measuring Equity-Focused Care

Several states are taking steps to measure and improve equity in hospitals and health systems, and in Medicaid managed care programs. Measures selected in those systems may differ depending upon the mix of entities to which the hospital or health system is accountable. Most report to credentialing and accrediting bodies as well as multiple payers. Understanding their measure sets can inform an advocacy approach in Medicaid as well. Below we provide examples of what states have done and how advocates influence their examination of equity.

## Addressing Equity in Hospital and Health System Quality Initiatives

There are a number of avenues to bring equity measurements forward through hospital and health system quality initiatives. Some states have established Medicaid hospital transformation initiatives or have other specific hospital quality initiatives with advocates sitting on advisory committees.<sup>10</sup> Hospital boards and state licensure agencies also have responsibilities for hospital quality, and interacting with these boards or agencies may

provide another forum to advocate for equity.<sup>11</sup> The Agency for Healthcare Research and Quality provides general information about hospital measures and datasets that examine inpatient quality, patient safety, pediatric quality, and patient experience. (AHRQ, the Joint Commission, CMS, and the Leapfrog Group are developers of hospital quality measures.)<sup>12</sup> CMS provides information on outcome disparities among Medicare patients in hospitals by the proportion of African American patients served,<sup>13</sup> but Medicare does not specifically require hospitals to address those disparities.

**Below are state-based models for measuring equity in hospitals and health system performance.**

***Colorado – Hospital Transformation Initiative***

Colorado is an example of a state with a Medicaid hospital transformation initiative. When the initiative is fully implemented, hospitals will be penalized or rewarded based on their performance on certain quality measures. Advocates sit on the advisory committee that reviews proposed quality measures and have furnished written comments.<sup>14</sup> For example, the Colorado Cross-Disability Coalition commented on the need to assess how well hospital discharge plans address both longer-term post-discharge supports and acute shorter-term post-discharge supports.<sup>15</sup> As a first step in addressing racial and ethnic disparities, Colorado plans to include a measure of reduction in racial and ethnic disparities in peripartum patient safety.

***Maryland – Patient Adversity Index***

The Maryland Citizens’ Health Initiative, an advocacy organization, participates in the performance measurement work group of Maryland’s Health Services Cost Review Commission, which has broad authority over hospital payment in Maryland. The Maryland Citizens’ Health Initiative gathered feedback

from faith leaders and community members about their concerns with hospital quality, advising the commission to consider emergency room wait times and supporting measures of pediatric quality. The work group also discussed how to address equity in risk-based measures. For example, hospitals strive to reduce the number of people who are readmitted to hospitals within 30 days of a discharge because pay-for-performance measures may reward or penalize hospitals based on their readmission rates. However, readmission rates are often particularly high in low-income communities of color, and stratification may be essential to understanding group differences in need of readmission. On one hand, a more granular understanding of readmissions is critical to determine whether more complex, higher-risk patients are being diverted from care to avoid a penalty and whether guardrails to avoid this outcome are needed (e.g., risk adjustment). On the other hand, risk adjustment could unintentionally have the effect of dismissing disparities as inevitable. Weighing these concerns, Maryland has decided to implement, in 2022, a “patient adversity index” that uses three variables to capture social determinants of health: Medicaid status as a proxy for income; race as a proxy for exposure to structural racism; and the area deprivation index, reflecting exposure to diminished access to neighborhood resources such as health care providers, transportation, and employment. Hospitals will be financially rewarded for reducing an internal gap in outcomes based on patient adversity.<sup>16</sup>

***California – Birth Equity***

Voluntary efforts, such as the California Maternal Quality Care Collaborative and the related California Birth Equity Collaborative, have scrutinized hospital care with regard to disparities in maternal and infant mortality. In partnership with the California Department of Public Health, Stanford University, and numerous hospitals,

the California Maternal Quality Care Collaborative has developed a set of quality improvement toolkits to address the leading causes of preventable deaths for mothers and infants. These toolkits include protocols to detect and address conditions such as sepsis, hemorrhage, and cardiovascular disease in pregnant and postpartum women. Through outreach, training, and systemic data collection, this project has shown impressive results: Maternal morbidity was reduced by nearly 21% among participating hospitals in two years.<sup>17</sup> However, disparities in outcomes between Black mothers and white mothers have persisted, which the California Birth Equity Collaborative attributes to multiple levels of racism. The California Birth Equity Collaborative is now testing a “patient-reported experience metric” and providing educational resources and interventions to address hospital culture and racism head-on.<sup>18</sup>

### ***Massachusetts, Minnesota, and North Carolina – Social Risk Adjustment***

In payment systems that financially reward high-quality performance or financially penalize poor performance, issues arise as to how to adjust payment for providers who treat many high-risk patients. Food insecurity, housing insecurity, and air pollution are among the social determinants that may contribute to poor health outcomes and that disproportionately affect communities of color. Health care providers who serve people with higher risks should be compensated to address these factors, and government programs should strive to reduce these risk factors.<sup>19</sup> Massachusetts and Minnesota are two states that have worked to parse out discrete social risk factors (including homelessness and poverty) for risk adjustment.<sup>20</sup> North Carolina plans to establish a fee schedule for health-related social services in the initial years of its Medicaid waiver in an effort to reduce socioeconomic disparities.<sup>21</sup>

### ***Nationwide – SO/GI Tool***

The Human Rights Campaign’s Healthcare Equality Index, an initiative in which health care facilities can volunteer to participate, reports performance based on a set of structural measures regarding SO/GI health care for facilities throughout the country. Measures include, for example, whether facilities include sexual orientation and gender identity in their nondiscrimination policies, provide for equal visitation of same-sex couples, provide employees with training in LGBTQ patient-centered care, use preferred names and pronouns for transgender patients, have affirming guidelines for room assignments, and provide trans-affirming gynecological care as well as access to gender-affirming surgeries and treatment.<sup>22</sup> States could undertake or promote similar initiatives.

### **Addressing Equity in Health Insurer and Managed Care Quality Measurement**

Health equity-focused measurement is already a requirement of Medicaid managed care and primary care case management regulations. States with any form of Medicaid managed care (almost all states) must identify, evaluate, and reduce, to the extent practicable, health disparities among Medicaid and Children’s Health Insurance Program (CHIP) enrollees that are based on race, ethnicity, sex, primary language, age, and disability status.<sup>23</sup> States must revise and update their quality measurement strategy every three years.

As part of these quality strategy reviews, states and health systems should plan interventions that will lessen the disparities they identify and improve health. In managed care, this is often done through mandated “performance improvement projects.” States can require plans to undertake performance improvement projects either specified by the state or designed by plans to ameliorate disparities. States

can monitor which projects are effective, share what works, and financially reward plans and providers that successfully improve performance.

One more way to embed equity within quality assessments is for states to require performance improvement projects to measure health equity as a central performance metric — but only a few states do this. California, for example, is focused on reducing racial and ethnic disparities, both in its marketplace plans and in its Medicaid plans, regarding diabetes, hypertension, asthma, and depression. California’s marketplace plans and Medicaid plans have identified disparities in treatment and outcomes for Black and Latinx enrollees with these conditions as compared with white enrollees. In response, California plans have undertaken performance improvement projects, such as furnishing culturally appropriate member education, provider education, and clinical guidance reminders; enhancing care teams; and engaging with public health departments and community-based organizations on population health initiatives.<sup>24</sup>

In addition, California’s Medicaid agency requires Medicaid managed care plans to report on additional measures by race and ethnicity. As an example, for 2017-2019, the agency found persistently worse blood pressure control; worse HbA1c control; less access to prenatal and postpartum care for women, and less access to preventive care for children and adolescents for Black/African American Medicaid managed care enrollees as compared with white enrollees.<sup>25</sup> Therefore, Medicaid managed care plans each designed and undertook a performance improvement project to address one identified racial/ethnic disparity in quality of care for its enrollees.<sup>26</sup>

Other states that are implementing performance improvement projects include Michigan and New York. Michigan’s Medicaid agency, which has collected information on racial disparities in health for a number of years, requires plans to develop interventions to improve low birthweights.<sup>27</sup> In a study that stratified measures both by race and by a disability, New York Medicaid examined the quality of physical health care for a subpopulation of Medicaid beneficiaries with serious mental illness. The study identified the need to improve cardiometabolic care for patients in inpatient psychiatric facilities and in their follow-up care.<sup>28</sup>

Additional approaches taken by states to promote equity in their contractual relationships with health care plans and providers include the following requirements and tools,<sup>29</sup> which explicitly include advocates or could be leveraged by advocates to advance an equity agenda. (See table “State Examples of Equity-Focused Quality Measurement” for more state examples, page 11):

» ***Partner with community organizations***

- › Work with community leaders and organizations from affected communities to improve patient education, to provide team-based care, and to learn more about barriers.

» ***Give more tools to providers***

- › Create toolkits, trainings, and clinical guidance reminders for providers regarding disparate health conditions.
- › Improve contracts with tribal providers, and ensure that Indian health clinics are part of provider networks and that American Indian members know their rights to choose American Indian health providers.

### » *Utilize data and evidence-based practice*

- › Ensure consistent administration of evidence-based processes and procedures that have been demonstrated to improve patient outcomes.
- › Better integrate data, share electronic health records, and improve workflows with regard to particular targeted diseases and disparities.

### » *Improve and expand access to services*

- › Address access barriers, including transportation to medical appointments, hours of service, and physical access.
- › Screen patients for their preferred language, consistently offer interpretation, and improve translation and interpretation services, including through bedside technology during the COVID-19 pandemic.
- › Alter care delivery models to be more accessible, such as including group and phone visits, and use culturally tailored materials to promote home monitoring and testing of specific conditions.
- › Address social determinants of health, such as through fresh food programs and housing programs.

## Advocating to Advance Health Equity through Reporting and Quality Measures

State advocates should consider several advocacy strategies, influential partners, and particular leverage points when they will have opportunities to advance actionable use of health equity measures.

## Opportunities to Advance Health Equity

Advocates can use many leverage points to insist that Medicaid-funded health systems work to reduce disparities as part of their quality initiatives. Advocates can comment to their own state Medicaid agency and to CMS, discuss concerns with state legislators, and get involved with national efforts to improve equity and quality measurement.

### *Advocate with State Medicaid Agencies and with CMS*

- 1. Comment on proposed Medicaid managed care or other health system contracts.** States usually rebid their contracts every three to five years. Contracts may set out overall quality goals and require data collection and performance improvement projects. Advocates can review draft contracts; insist that they include requirements to collect data about race, ethnicity, language, gender, sexual orientation, and disabilities for new enrollees; and insist that quality review and performance improvement projects stratify quality measures and address disparities. In some states, advocates can readily obtain draft requests for proposals and contracts while, in other states, they may need to file public records act requests.
- 2. Advocate for quality measures relevant to Native American communities through tribal consultations.** States must consult with tribes if Native Americans will be enrolled in a Medicaid managed care arrangement.
- 3. Join Medicaid advisory committees, hospital system advisory committees, and relevant subcommittees, where advocates can learn about and influence the state's plan for reviewing quality.** Review the state's quality strategy (which the state must make available for public comment), external quality review reports, and individual plans'

performance improvement projects, and insist that they each address disparities.

4. **Comment on Medicaid Section 1115 and Section 1915 waiver proposals** during the public review period at the state level and when they are submitted to CMS. States must describe their quality measurement plans when submitting waiver proposals that would alter delivery systems or provide quality-based supplemental payments. Thus, advocates have an opportunity to comment on how the state might better measure equity.
5. **Comment to the federal government on what core measures Medicaid and CHIP agencies should collect each year, and/or comment to your state Medicaid agency** to ensure that it will collect core measures relevant to health equity. With input from various stakeholders, CMS annually updates and publishes core quality measures for states' use.<sup>30</sup> State advocates may want to reach out to national consumer advocacy organizations that routinely comment on these measures. Further, states may draw on the core measures and supplement them with others that address health equity concerns within the state. State advocates can influence which measures a state selects. In 2024, states (and the plans with which they contract) will be required to report all federal core measures, but can still supplement them and assure that they examine disparities for each core area.

### ***Advocate through State Legislatures***

6. **Raise concerns about equity and quality performance in legislative oversight hearings, including hearings about the Medicaid agency's budget.**

7. **Advocate for a statewide focus on addressing health inequities that goes beyond Medicaid-funded services.** Review the state's public health reports and other statewide health disparities data available through the AHRQ.<sup>31</sup> When new public health concerns emerge, such as COVID-19, push your state to quickly measure and publicize how they are affecting various racial, ethnic, and language groups and people with disabilities. Raise the need for such a focus to state agencies and to relevant legislative committees.
8. **Seek legislation that measures disparities for all payers.** For example, seek laws requiring public reporting of hospital quality and health plan quality. Such laws can go beyond Medicaid-funded care to require reporting for all hospitals or state-licensed health plans. Seek laws with requirements to measure, report on, and address disparities.

### ***Advocate for Health Equity Nationwide***

9. **Get involved with national efforts to improve quality measurement tools.** For example, the National Quality Forum and NCQA each open public comment periods when they are developing or endorsing measures. Though tracking such initiatives may be beyond most state advocates' capacities, disease associations and national patient advocacy organizations may flag comment opportunities.
10. **Advocate in national forums, including through federal agencies, Congress, and the courts, to prevent the country from backsliding on important health equity protections,** such as the nondiscrimination protections laid out in Section 1557 of the Affordable Care Act and related regulations.



### **General Advocacy Strategies and Possible Partnerships**

Now is a pivotal moment to join forces with other stakeholders, especially those organizations that represent various populations, to advocate for equity-focused quality measurement. Advocates should also make a business case for health equity, partner with public health professionals, and find ways to raise community voices.

- » Insist that states and plans monitor relevant quality indicators (stratified by race, ethnicity, language, and disability (REALD), and sexual orientation and gender identity), publicly report those data, build payment systems that incentivize equity-focused interventions, and take action to lessen disparities over time. This year, publicized racial and ethnic disparities in COVID-19 deaths, and extremely high death rates in nursing homes, impelled policymakers to address health equity. Both now and in more normal times, health equity advocates can insist that a governor's or legislature's commitment to addressing disparities radiates throughout the publicly funded health system, within Medicaid and CHIP, and to hospitals and health facilities that the state licenses and oversees.
- » Join forces with other stakeholders to push for measurement stratification and for quality improvement plans that address disparities. Organizations representing people of color, people with disabilities, and the LGBTQ community are obvious allies. Disease associations, such as the American Heart Association and the American Diabetes Association, are well aware of racial disparities in the prevalence and severity of those conditions.<sup>32</sup>
- » Make a business case for addressing equity with providers and payers to improve health care and enhance the industry's reputation as leaders in the community.<sup>33</sup>
- » Partner with public health professionals and universities to elevate existing research and develop additional equity-focused quality improvement projects to bring additional data to advocacy. Public health professionals and universities can bring helpful research to the fore. Other good places to turn for models, data, and history are foundations that have focused on health equity, such as the W.K. Kellogg Foundation and the Robert Wood Johnson Foundation's Finding Answers project; nonprofit organizations, such as the National Quality Forum; and federal agencies, such as the U.S. Department of Health and Human Services Office of Minority Health and the Agency for Healthcare Research and Quality.
- » Bring community voices into dialogue with policymakers to deepen their understanding of the impact of health inequities on consumers, families, and communities. For example, in 2019, the California Pan-Ethnic Health Network (CPEHN) and partner organizations held a series of consumer focus groups to engage consumers with diverse identities and backgrounds in discussions about their health care experiences. CPEHN learned about stigmatizing and disrespectful treatment, difficulty navigating the health care system, and poor patient engagement, and it is using this information to educate policymakers and to press for quality improvements and further reforms.<sup>34</sup>

## Conclusion

In the midst of the COVID-19 pandemic and later in its aftermath, states and advocates are encouraged to capitalize on this pivotal moment and develop a shared health equity advocacy approach across stakeholders. Advocates have a number of leverage points to demand that Medicaid agencies and health systems continuously work to reduce health care disparities as part of their quality initiatives. The essential starting point is to call for accountability through collection of race, ethnicity, and primary language data as well as other equity-focused measures.<sup>35</sup>

Promoting equity in care through quality measurement requires a broad coalition made up of key health providers, health systems, and advocates. Given the overwhelming data showing the disproportionate COVID-19 infection rates in communities of color, now is the time for lawmakers to take a harder look at health care quality and equity. States and advocates should develop a shared, ongoing strategy to ensure that health care systems have structures in place to address discrimination and other structural barriers to care. Undoubtedly, improving the collection of stratified quality data and publicly reporting the results are essential components of holding health systems accountable for delivering equitable care.

Table: State Examples of Equity-Focused Quality Measurement

State	Approach to equity-focused quality measurement	Stratification	Stratification required by state legislation and/or administrative action	Status (excluding COVID-19 emergency period)
California	<p><b>For all qualified health plans and Medicaid managed care:</b></p> <p>Plans use <a href="#">measures</a> from the Agency for Healthcare Research and Quality (AHRQ) and the Health Plan Employer Data and Information Set (HEDIS) from the National Committee for Quality Assurance (NCQA) regarding asthma, depression, diabetes, and hypertension for equity quality improvement.</p>	Race, ethnicity	State law and administrative action (See <a href="#">Attachment 7</a> to qualified health plan contract.)	Implemented; new measures planned December 2019
	<p><b>For Medicaid managed care specifically:</b></p> <p><a href="#">See 2018 Health Disparities Report</a></p> <p>Managed care organizations report measures of preventive screening and children’s health, preventive screening and women’s health; care for chronic conditions, and appropriate treatment and utilization, from HEDIS (NCQA).</p>	Race, ethnicity, primary language, age, gender	Administrative action	Implemented
	<p><b>For public hospitals and health systems:</b></p> <p>Public hospitals and health systems must develop and execute a plan to address a disparity in a performance improvement project. <a href="#">2019 projects</a> were for blood pressure control, colorectal screening, diabetes care, heart disease, and tobacco cessation/ screening.</p>	Race, ethnicity, primary language, sexual orientation and gender identity	Administrative action — part of Public Hospital Redesign and Incentives in Medi-Cal (PRIME) waiver	Race, ethnicity, and language implemented; SO/GI stratification newer

Table: State Examples of Equity-Focused Quality Measurement

State	Approach to equity-focused quality measurement	Stratification	Stratification required by state legislation and/or administrative action	Status (excluding COVID-19 emergency period)
<b>California</b>	<p><b>For voluntary hospital, public health, university effort:</b></p> <p>The California Maternal Quality Care Collaborative and <a href="#">California Birth Equity Collaborative</a> developed hospital quality measures (endorsed by the National Quality Forum) and toolkits to address leading causes of preventable deaths for mothers and infants. A new patient-reported experience metric was introduced in 2020.</p>	Race, ethnicity	Voluntary	New focus on racism and birth equity
<b>Maryland</b>	<p><b>For hospitals:</b></p> <p>The Maryland Health Services Cost Review Commission is recommending a new <a href="#">disparities measure</a> regarding avoidable readmissions. It uses a patient adversity index to adjust for patient mix and rewards hospitals that reduce disparities after three years.<sup>36</sup></p>	Race, Medicaid status, geography are part of a “patient adversity index”	Administrative	Planned for 2022
	<p>All acute care hospitals participating in Medicaid pay for performance must collect race and ethnicity data from inpatient hospital visits, observation unit stays, and emergency department visits. The Massachusetts Office of Health and Human Services requires hospitals to use a composite disparities measure.<sup>37</sup></p>	Race, Hispanic ethnicity	Regulation 114.1 CMR 17.00	Implemented
<b>Michigan</b>	<p>Quality measures focus on disparities in postpartum care and low birthweight. See 2017 report and pages 167-173 of the fiscal year 2020 <a href="#">Medicaid managed care contract</a> for other measures.<sup>38</sup></p>	Race, ethnicity	Public Act 653	Implemented; measures revised annually

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<b>Minnesota</b>	<p><a href="#">The Minnesota Statewide Quality Reporting and Measurement System</a> requires physicians, clinics, and hospitals to report information on a standardized measurement set that is updated annually. 2014 legislation required stratification of quality measures in consultation with organizations representing diverse communities.<sup>39</sup></p>	Race, ethnicity, preferred language, country of origin (Providers collect gender, health insurance type, age, and ZIP code for all measures.)	Minnesota Laws 2014, Chapter 312, Article 23, Section 10	Implemented; measures revised annually
<b>New York</b>	<p><b>For Medicaid managed care generally:</b></p> <p>New York Medicaid <a href="#">periodically</a> sets overall focus areas for quality in all of its Medicaid managed care programs, as well as measures for its specialty programs (such as HARP below). Medicaid managed care plans report HEDIS, Consumer Assessment of Healthcare Providers and Systems (CAHPS), and New York-specific measures. A <a href="#">public dataset</a> includes demographic quality data for commercial and Medicaid managed care plans. In 2017, New York produced a Medicaid-specific quality report on <a href="#">disparities</a>, which identified, for example, disparities in management of respiratory conditions for members with substance use disorder; disparities in medications, behavioral health, and asthma management for Black members; and disparities by income.<sup>40</sup></p>	Race, ethnicity, preferred language, disability status  (Assessment tools collect gender identity, sexual orientation, and religion data as well.)	Administrative action	Implemented; measures revised annually

Table: State Examples of Equity-Focused Quality Measurement

State	Approach to equity-focused quality measurement	Stratification	Stratification required by state legislation and/or administrative action	Status (excluding COVID-19 emergency period)
<b>New York</b>	<p>For behavioral health and Health and Recovery Plan (HARP):</p> <p>The <a href="#">Value Based Payment Quality Measure Set for 2020</a> includes measures from HEDIS and CAHPS (NCQA) plus some New York state measures: stable housing status, pharmacotherapy for substance use, preventable health readmission, arrests, continuity from inpatient rehab to lower levels of care, various asthma control measures, personalized recovery service, etc.</p> <p>Public reporting of stratified measures is inconsistent but still exists. For example, an <a href="#">external quality review organization study</a> that examines clinical care includes racial disparity.<sup>41</sup></p>	Race, ethnicity, preferred language (Assessment tools collect gender identity, sexual orientation, and religion data as well.)	Administrative action	Implemented as part of Section 1115 waiver; measures revised annually
<b>North Carolina</b>	<p>An external quality review organization is to develop an annual health equity reporting and tracking report examining timely access to care, unmet resource needs, and disparities reduction. Planned measures are in <a href="#">Appendix A, Page 55 of North Carolina's Medicaid Managed Quality Strategy</a>.<sup>42</sup></p>	Race, ethnicity, age, sex, primary language, disability status, geography (where feasible)	Administrative action through waiver proposal; Office of Minority Health established through state law	Pending

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State	Approach to equity-focused quality measurement	Stratification	Stratification required by state legislation and/or administrative action	Status (excluding COVID-19 emergency period)
<b>Oregon</b>	<p>The Oregon Health Authority collects data through its Section 1115 Medicaid waiver to implement coordinated care organizations (CCO) across the state. There are CCO incentive measures that are eligible for payment based on performance and state quality measures that are required to be reported to the Centers for Medicare &amp; Medicaid Services based on the Section 1115 waiver. <a href="#">Performance reports</a> stratify by race/ethnicity, and, in 2021, Oregon will <a href="#">include</a> a measure of meaningful language access to culturally responsive health care services.<sup>43</sup></p>	Race, ethnicity, primary language, disability status	Administrative action through waiver proposal	Implemented through Section 1115 waiver; measures revised annually

## Endnotes

- <sup>1</sup> Alina Baciu et al., ed., “Disparities and Their Roots” in *Communities in Action: Pathways to Health Equity* (Washington, DC: National Academies Press, 2017), [https://www.ncbi.nlm.nih.gov/books/NBK425839/#sec\\_000020](https://www.ncbi.nlm.nih.gov/books/NBK425839/#sec_000020); Samuel L. Dickman, David U. Himmelstein, and Steffie Woolhandler, “Inequality and the Health-Care System in the USA,” *The Lancet* 389, no. 10077 (April 2017): 1431–1441, [https://www.thelancet.com/journals/lancet/article/PIIS0140-6736\(17\)30398-7/fulltext](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(17)30398-7/fulltext).
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  - Care of acute and chronic conditions (e.g., appropriate testing and management of certain prevalent conditions).
  - Behavioral health (e.g., risk assessment, follow-up care, and medication management).

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