# Agenda: Equitable Health Care Task Force

Date: 10/24/2024

## Opening, welcome, and public comment, 1:00 – 1:10 p.m.

Overview of meeting agenda and objectives, and public comment review.

## Health care financing, 1:10 – 2:10 p.m.

University of Minnesota research team will provide an overview of health care financing.

## Learning and solutioning: NCQA health equity accreditation, 2:10 – 3:20 p.m.

Representatives from Blue Cross Blue Shield of Minnesota, UCare, HealthPartners, and Hennepin Healthcare will share their accreditation journey and learnings.

## Break, 3:20 – 3:30 p.m.

## Opportunity matrix and recommendations, 3:30 – 3:55 p.m.

The task force will provide input on the content for emerging health care equity solutions and recommendations.

## Closing, action items, and preview of December meeting, 3:55 – 4:00 p.m.

We will review our accomplishments and share upcoming next steps.

Minnesota Department of Health
Health Policy Division
625 Robert St. N.
PO Box 64975
St. Paul, MN 55164-0975
651-201-4520
health.EquitableHealthCare@state.mn.us
www.health.state.mn.us/communities/equitablehc

10/21/24

*To obtain this information in a different format, call: 651-201-4520*


# Equitable Health Care Task Force Meeting #8

October 24, 2024

Hush Naidoo Jade Photography

# Opening and Welcome

# Acknowledgement of thanks

Thank you for your continued efforts!

- Workgroup meetings and conversations
- Reading materials and preparing for meetings
- Your commitment to advance equitable health care

# Today’s objectives

- Increase a shared understanding of health care financing
- Build understanding of NCQA Health Equity Accreditation
- Discuss the opportunity matrix and recommendation development process

# Today's agenda

| | |
|---|---|
| 1:00 – 1:10 p.m. | Opening, welcome, and public comment |
| 1:10 – 2:10 p.m. | Health care financing |
| 2:10 – 3:20 p.m. | Learning and solutioning: NCQA health equity accreditation |
| 3:20 – 3:30 p.m. | Break |
| 3:30 – 3:55 p.m. | Opportunity matrix and recommendation development |
| 3:55 – 4:00 p.m. | Closing, action items, and preview of December meeting |

# Grounding: Task force charge

**The task force will**:

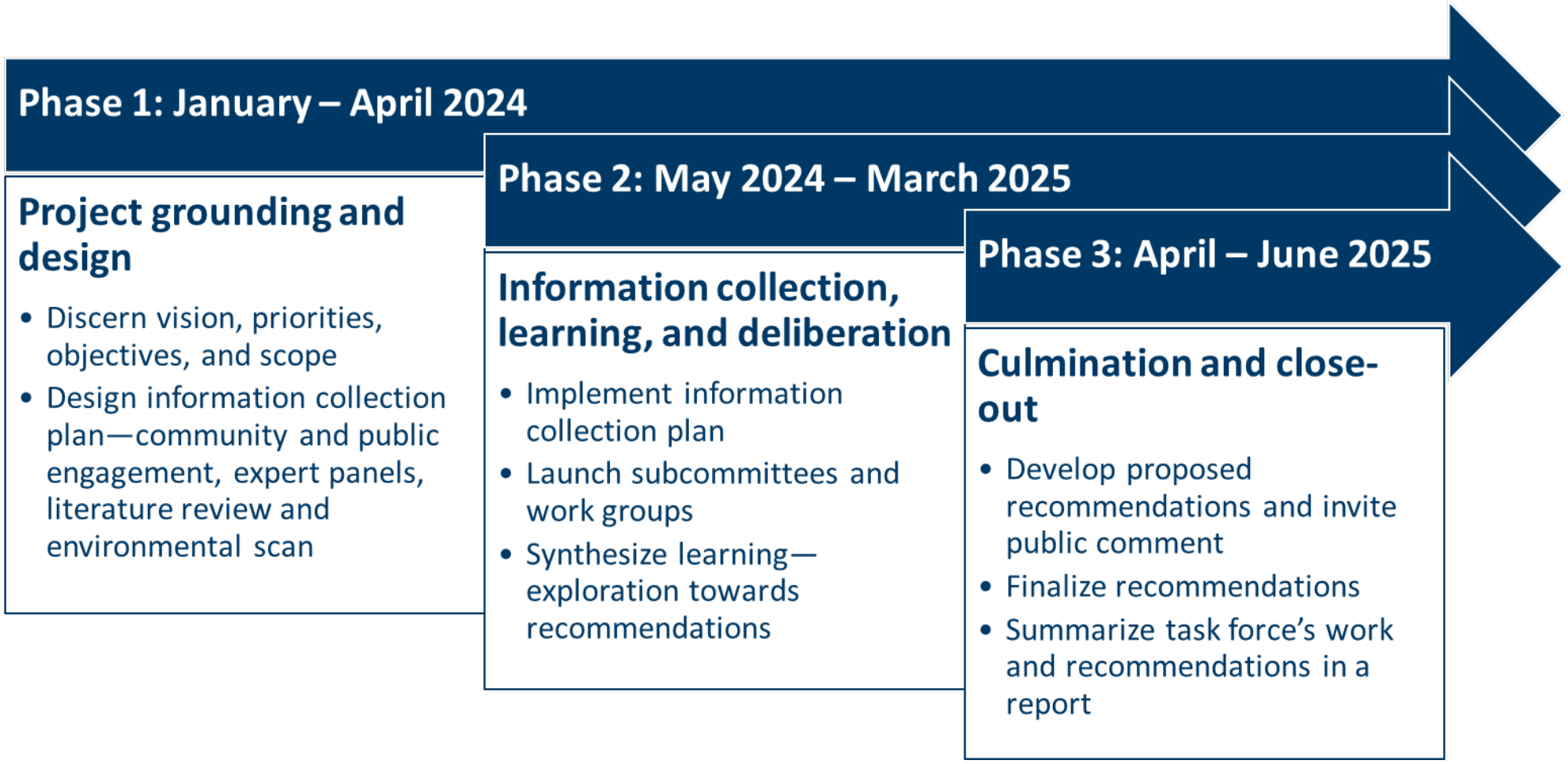
- **Identify inequities** experienced by Minnesotans in interacting with the health care system that originate from or can be attributed to their race, religion, culture, sexual orientation, gender identity, age and/or disability status.
- **Conduct community engagement** across multiple systems, sectors, and communities to identify barriers for these population groups that result in diminished standards of care and foregone care.
- **Identify promising practices** to improve experience of care and health outcomes for individuals in these population groups.
- **Make recommendations** for changes in health care system practices or health insurance regulations that would address identified issues.

# Grounding: Vision and definition

Our **vision** is that structural and institutional wrongs will be addressed, cultural practices will be newly honored, and new modes of health care delivery will be created. The Equitable Health Care Task Force will engage with entities to act on a set of actionable recommendations.

**Health care equity** means the health care system is accountable for every person achieving and sustaining self-defined optimal health outcomes throughout their lives.

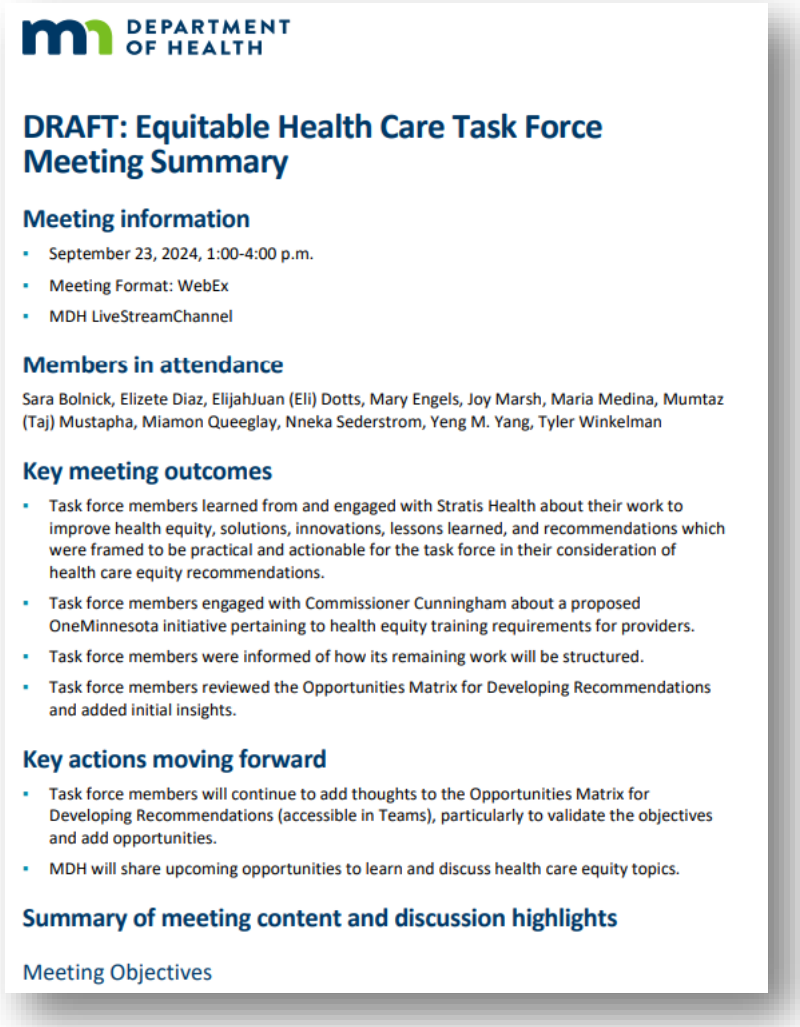
# Where we are in our process



# Summary of September meeting

High level summary of notes

- What clarification questions do you have about this summary, if any?
- What concerns do you have about this summary, if any?



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## DRAFT: Equitable Health Care Task Force Meeting Summary

### Meeting information

- September 23, 2024, 1:00-4:00 p.m.
- Meeting Format: WebEx
- MDH LiveStreamChannel

### Members in attendance

Sara Bolnick, Elizete Diaz, ElijahJuan (Eli) Dotts, Mary Engels, Joy Marsh, Maria Medina, Mumtaz (Taj) Mustapha, Miamon Queeglay, Nneka Sederstrom, Yeng M. Yang, Tyler Winkelman

### Key meeting outcomes

- Task force members learned from and engaged with Stratis Health about their work to improve health equity, solutions, innovations, lessons learned, and recommendations which were framed to be practical and actionable for the task force in their consideration of health care equity recommendations.
- Task force members engaged with Commissioner Cunningham about a proposed OneMinnesota initiative pertaining to health equity training requirements for providers.
- Task force members were informed of how its remaining work will be structured.
- Task force members reviewed the Opportunities Matrix for Developing Recommendations and added initial insights.

### Key actions moving forward

- Task force members will continue to add thoughts to the Opportunities Matrix for Developing Recommendations (accessible in Teams), particularly to validate the objectives and add opportunities.
- MDH will share upcoming opportunities to learn and discuss health care equity topics.

### Summary of meeting content and discussion highlights

Meeting Objectives

# Public comment

**The full public comment is included in the meeting packet. The comment touched on the following topics:**

- Availability of "affordable care" options if the US President cancels current option
- MNSure refunds for excess premium overpayments
- Coverage of preventative eye care (for women 60+, children, etc.)
- How to reduce high cost of premiums
- “People powered health plans”
- Impact of consumerism
- Incentives for reductions in premiums


# Healthcare Financing Landscape

Jean Abraham, PhD, Professor, James A. Hamilton Chair in Health Policy Management, Professor and Head, School of Public Health, University of Minnesota
Elizabeth Lukanen, Deputy Director, SHADAC, Senior Advisor

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# University of Minnesota research team

- **Jean Abraham**, PhD, Professor, James A. Hamilton Chair in Health Policy Management, Professor and Head, School of Public Health, Principal Investigator
- **Christina Worrall**, MPP, Senior Fellow, SHADAC
- **Megan Lahr**, Senior Research Fellow, Rural Health Research Center
- **Mary Butler**, PhD, MBA, Associate Professor, Senior Advisor
- **Elizabeth Lukanen**, Deputy Director, SHADAC, Senior Advisor
- **J'Mag Karbeah**, PhD, MPH, Assistant Professor
- **Romil Parikh**, Senior Researcher
- **Kate Beherns**, Researcher and project coordinator
- **Andrea Stewart**, Research Fellow, SHADAC
- **Amy Claussen**, MLIS, Medical Research Librarian
- **Elliot Walsh**, Research Dissemination Coordinator, SHADAC
- TBA, Graduate Research Assistants

# Healthcare Financing Landscape

Presentation to the MN Equitable Health Care Task Force

Jean M. Abraham, PhD
Division of Health Policy and Management
University of Minnesota

October 24, 2024

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# Agenda

- Introduction and acknowledgements
- Minnesota insurance landscape
- Introduction to provider payment models and equity implications
- Potential interactions of equity-promoting financial models and current Minnesota-specific initiatives
- Questions and comments

# Introduction & Scope of Work

**UMN-HPM Team:** Faculty and staff from Division of Health Policy and Management with expertise in health equity measurement, evidence review, and public policy analysis

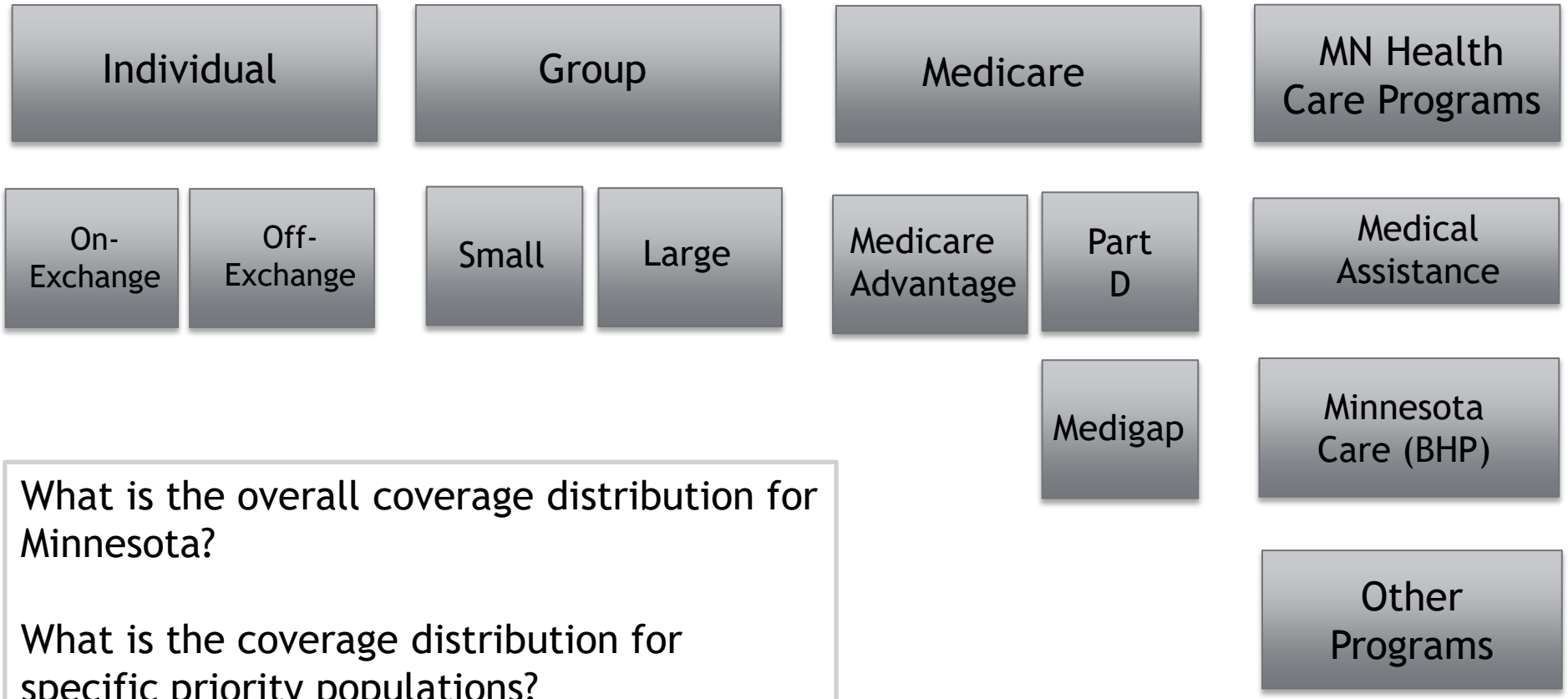
**Scope of Work**: Support the Task Force's recommendation development through information resource provision and engagement in the policy proposal development process

# Acknowledgement

*The UMN-HPM team enters this work with the goal of centering our efforts on Minnesotans whose experiences with the current healthcare delivery and financing system is less than what it could or should be in terms of accessibility, quality, experience of care received, and health outcomes achieved.*

*We approach our work with humility and recognition that many types of expertise and voices need to be around the table to develop solutions that will lead to a more equitable health system in Minnesota.*

# Health Insurance Landscape




What is the overall coverage distribution for Minnesota?

What is the coverage distribution for specific priority populations?

- Race and Ethnicity
- Metro vs. Greater MN
- Disability Status
- LGBTQ+

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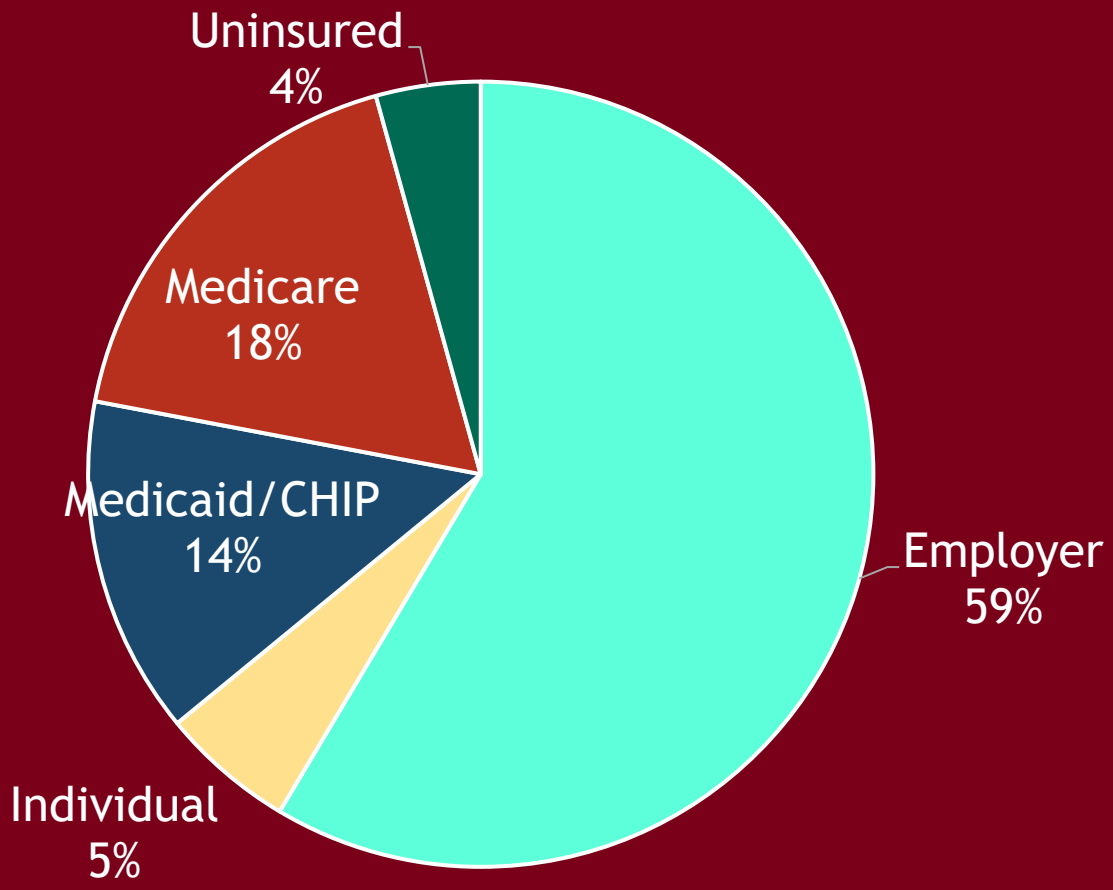
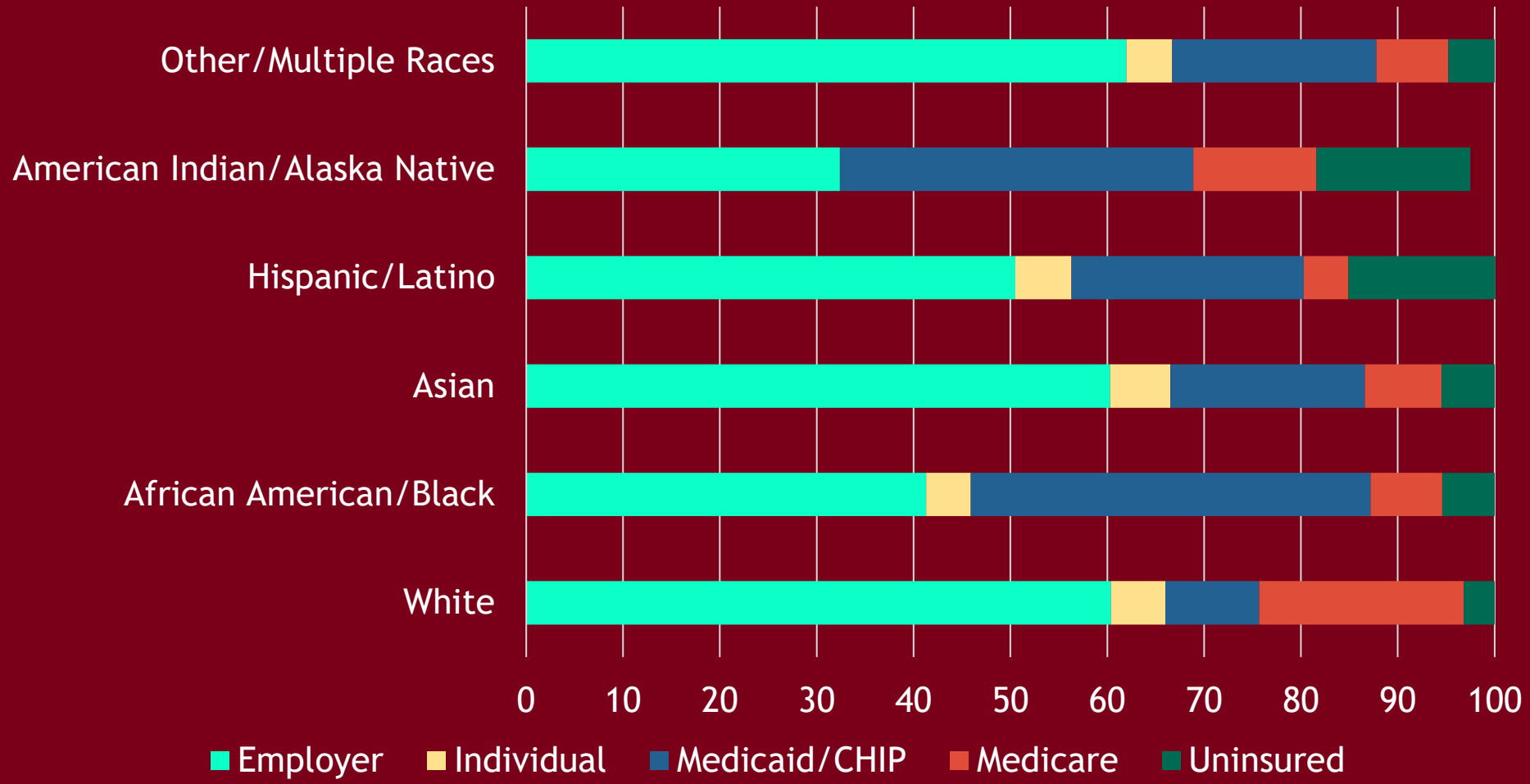
# Minnesota Primary Coverage Distribution (5.7 million persons)




Source: SHADAC analysis of the 2021-2022 American Community Survey (ACS) Public Use Microdata Sample (PUMS) files.

# MN Coverage Distribution: Race & Ethnicity




Source: SHADAC analysis of the 2021-2022 American Community Survey (ACS) Public Use Microdata Sample (PUMS) files.

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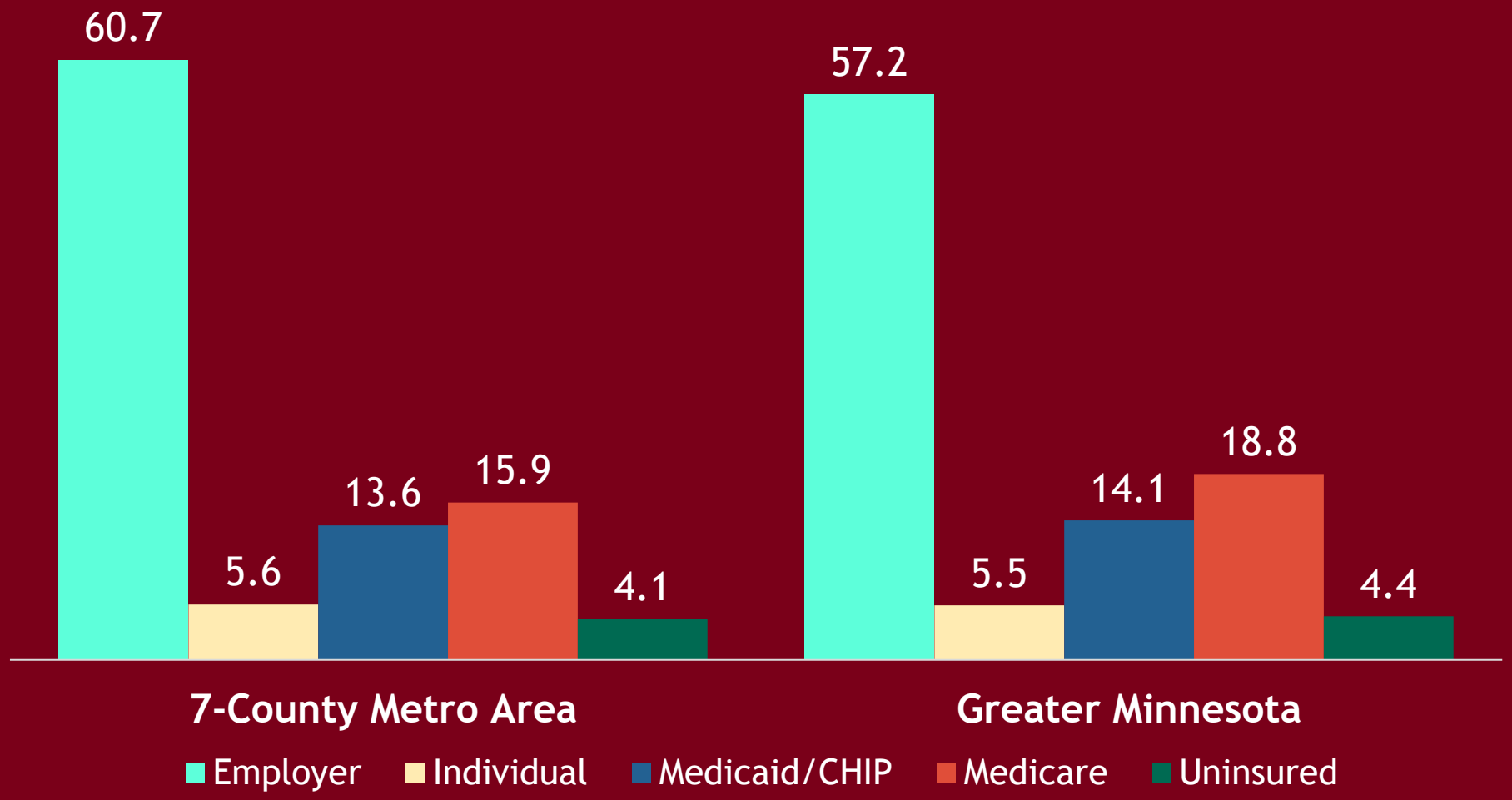
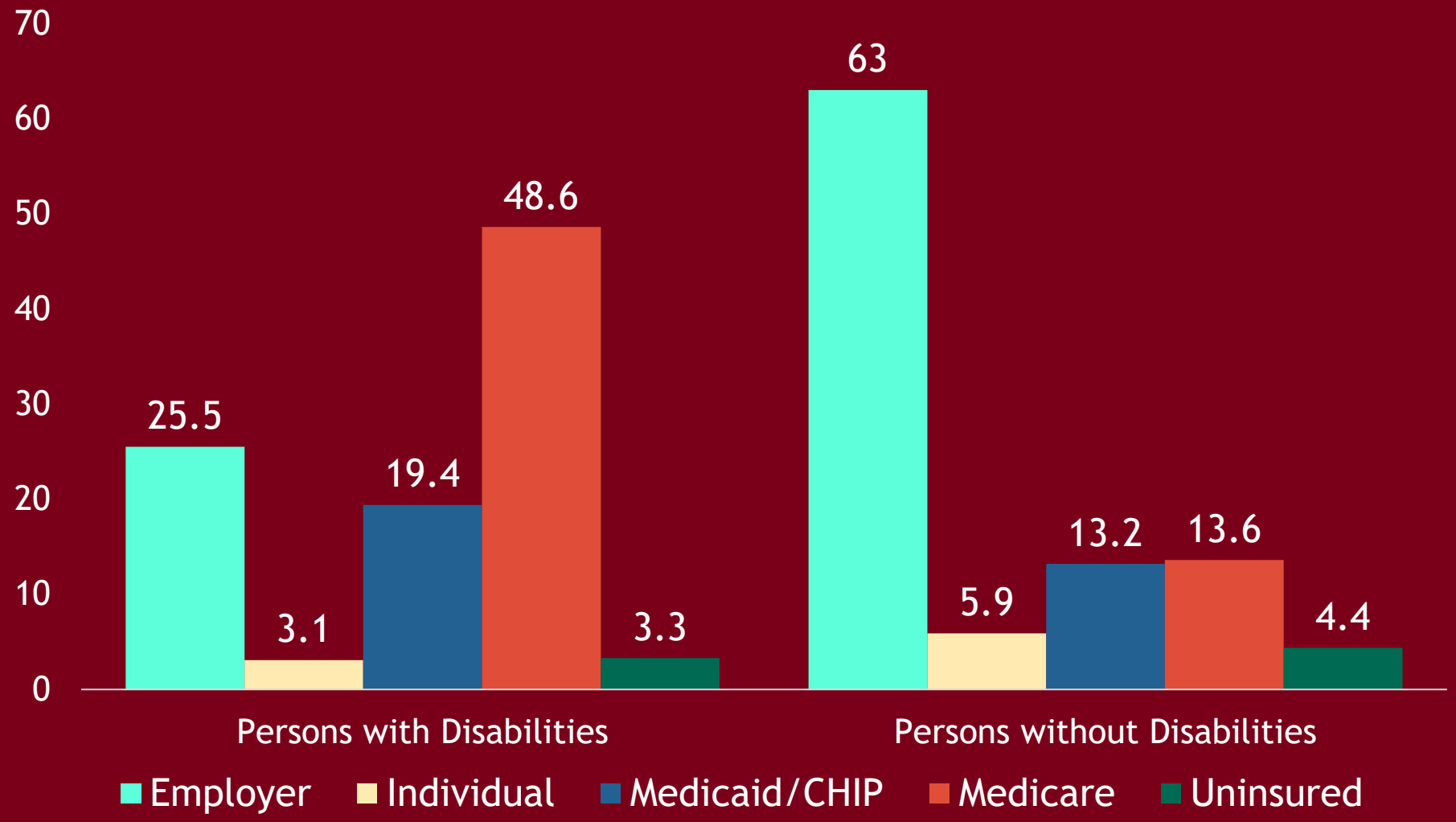
# MN Coverage Distribution: Metro Status




Source: SHADAC analysis of the 2021-2022 American Community Survey (ACS) Public Use Microdata Sample (PUMS) files.

# MN Coverage Distribution: Disability Status




Source: SHADAC analysis of the 2021-2022 American Community Survey (ACS) Public Use Microdata Sample (PUMS) files.

# National Health Interview Survey Estimates of LGB+ Coverage Distribution

**Table 2: Health Insurance Coverage among Adults by Sexual Orientation, 2019**

| | LGB+ | Non-LGB+ |
|---|---|---|
| **Insurance type** | | |
| Private, not Marketplace | 58.8% (54.7%, 62.8%) | 58.4% (57.3%, 59.4%) |
| Private, Marketplace | 4.1% (2.8%, 5.9%) | 4.0% (3.7%, 4.3%) |
| Medicaid/public | 17.2% (14.3%, 20.4%) | 10.3%*** (9.7%, 11.0%) |
| Other | 3.9% (2.6%, 5.9%) | 5.4% (5.0%, 5.8%) |
| Uninsured | 12.7% (10.2%, 15.8%) | 11.4% (10.8%, 12.1%) |
| Dual | 0.5% (0.2%, 1.1%) | 1.6%*** (1.4%, 1.8%) |
| Medicare | 2.8% (2.0%, 4.0%) | 8.9%*** (8.5%, 9.3%) |
| Missing | 3.2% | 2.9% |

Notes: Weighted estimates using the 2019 NHIS adult file. Results in each row do not include item non-responders in the denominator when calculating rates and percentages. A small number of persons were covered by both public and private plans and were included in both categories. Numbers in parentheses are 95% confidence intervals. Tests for differences between LGB+ and non-LGB+ are indicated with * for p-value < 0.05, ** for p-value < 0.01, and *** for p-value < 0.001.

Source: Bosworth et al. 2021. Available at: https://aspe.hhs.gov/sites/default/files/2021-07/lgbt-health-ib.pdf

# Implications of Coverage Type Variation

- Coverage Access and Continuity
- Coverage Affordability
- Financial Protection & Medical Care Use
- Access to Medical Providers
- Regulatory Oversight

# Minnesota Health Care Spending per Person by Payment Source

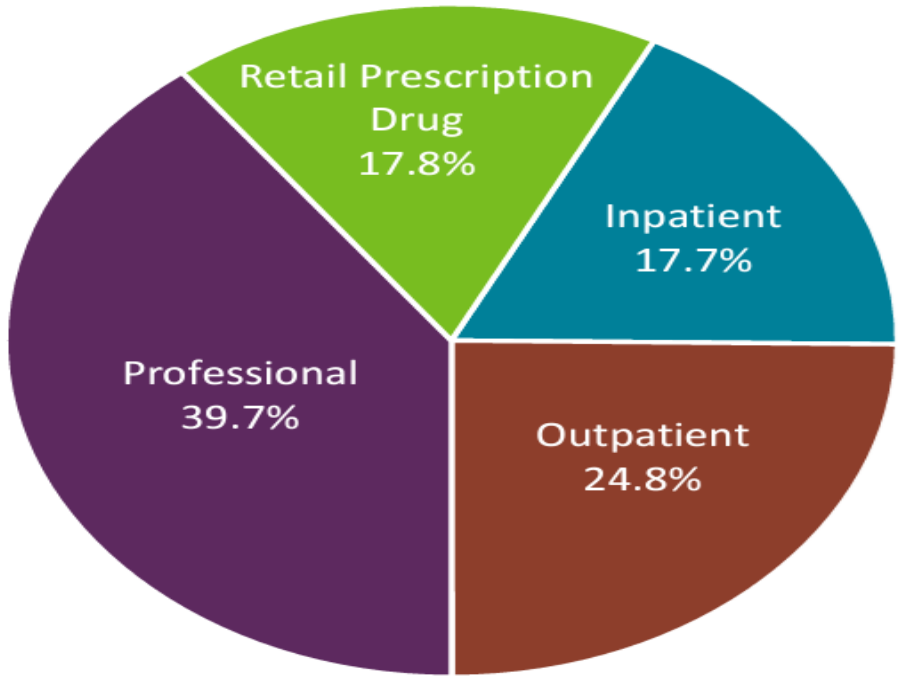
| Payer | Program | 2017 | 2018 | 2019 | 2020 | 2021 | Change from 2020 to 2021 |
|---|---|---|---|---|---|---|---|
| Public | Medicare[1,2] | $10,735 | $11,023 | $11,323 | $10,962 | $11,740 | 7.1% |
| | Medical Assistance | $10,586 | $11,096 | $11,409 | $11,763 | $12,116 | 3.0% |
| | MinnesotaCare | $4,654 | $5,247 | $5,557 | $5,872 | $5,785 | -1.5% |
| Private | Private Total[3] | $7,972 | $8,310 | $8,574 | $8,346 | $9,344 | 12.0% |
| **Overall** | **Total** | **$9,102** | **$9,549** | **$9,906** | **$10,448** | **$11,114** | **6.4%** |

***Per capita spending varies by covered population, driven by differences in demand (e.g., demographics, income, health risks) and prices (e.g., provider payment rates).***

Source: MN Department of Health Economics Program
Notes: 1) Dual-eligibles have spending split across Medicare and Medical Assistance; 2) Excludes Medigap and Medicare Advantage premiums; 3) Includes Private Health Insurance out-of-pocket expenses

# Per-person Spending by Service Type

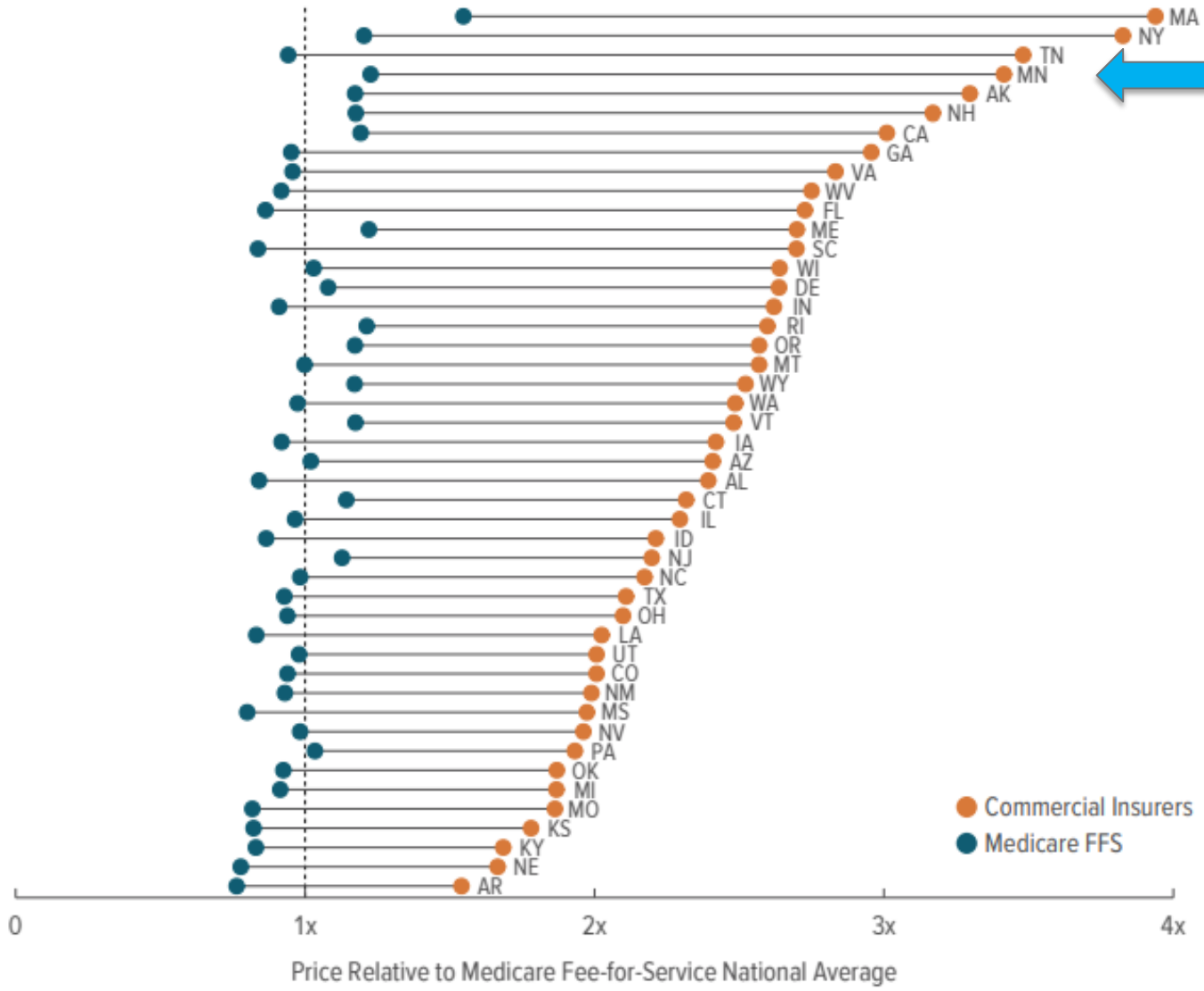
**Figure 3: Components of Per-Person Health Care Spending (2017 to 2021, combined)**




Source: Health Economics Program analysis of 2017 to 2021 data from the Minnesota All Payer Claims Database, Extract 25.

Source:
https://www.health.state.mn.us/data/economics/docs/spendingrpt2017to2021.pdf

## Average Prices for Hospitals' Inpatient Services, by State, 2018




Commercial insurers' prices for hospitals' inpatient services varied substantially among states in 2018, as did the gap between commercial insurers' and Medicare's prices. Commercial insurers' prices were highest, relative to Medicare's, in Massachusetts, New York, and Tennessee. (Source: CBO's analysis of data from Whaley and others, 2020.)

Source: https://www.cbo.gov/system/files/2022-01/57422-medical-prices.pdf

# Average Commercial to Medicare FFS Price Ratio Estimates from Scholarly Literature

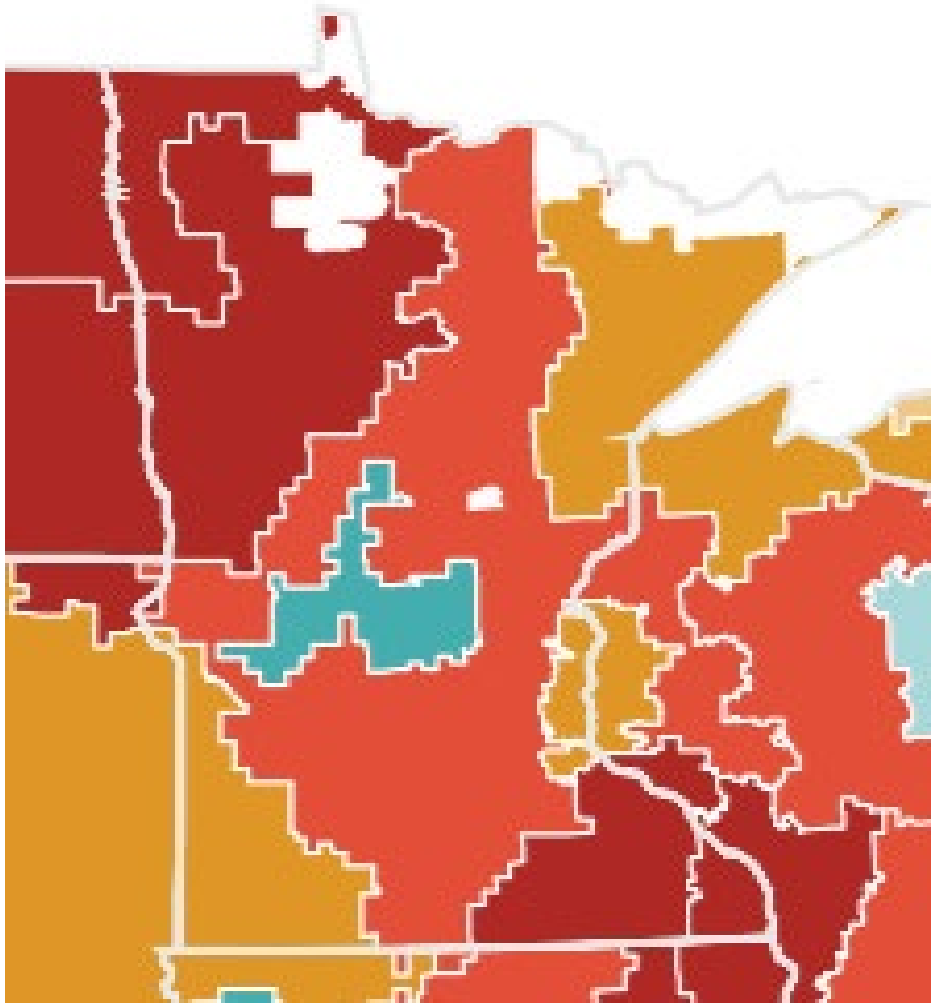
| Hospital Inpatient | Hospital Outpatient | Primary Care Services | Specialty Services |
|---|---|---|---|
| 182% | 240% | 117% | 144% |

Medicaid prices relative to Medicare or commercial are studied less often, given state variation and unique 'add-on' payments (e.g., DSH, DSRIP for states with waivers).

Opportunity to leverage MN APCD to better understand private vs. public insurance price differences

Source: https://www.cbo.gov/system/files/2022-01/57422-medical-prices.pdf

# Percentage-point change in commercial-to-Medicare hospital price ratios from 2012 to 2019, by hospital referral region (HRR)




Price ratio estimates reflect estimated commercial revenue-to-charge ratios divided by Medicare revenue-to-charge ratios. Areas with no color are not part of an HRR.

Notes: Authors' analysis of 2012-2019 Hospital Cost Report Information System data. Source: Levinson et al. Health Affairs, 2022

# How do we finance health insurance?

| | Individual | Employer-sponsored Insurance (ESI) | Medicare | Minnesota Health Care Programs |
|---|---|---|---|---|
| Individual contributions | X | X | X | X |
| Employer contributions | | X* | X | |
| State tax revenues (designated or general) | | | | X |
| Federal tax revenues (designated or general) | X | | X | X |

*Employer contributions (and often individual contributions) for ESI are tax exempt (Source: Kaiser Family Foundation)

# Takeaways for Coverage Distribution, Spending, and Financing Landscape

- Private-public system of health insurance with historically underserved population segments more concentrated in public programs or uninsured
- Coverage sources have tradeoffs
  - State oversight concentrated in the individual, fully-insured group, and MN Health Care Programs.
- Per capita spending trajectories differ by coverage source
  - Rising prices driving commercial spending growth
- Commercial-to-Medicare price ratios also growing with variation by service category
- Financing of health insurance varies by source
  - Heavy reliance on state and federal tax revenues as well as individual and employer contributions

# Provider Payment Systems & Equity Implications

# Provider Payment Models: Historical Dichotomy of Fee-for-Service vs. Capitation

| | Advantages | Disadvantages |
|---|---|---|
| **Fee-for-service**: amount administratively set or negotiated for each service delivered by contracted provider. Each service billed separately. | • Provider compensated for each service rendered<br>• Administratively simpler to implement once fee schedule established | • Rewards volume/resource use<br>• No distinction between high and low-value care<br>• Promotes 'reactive' care<br>• Fee schedule may not fully adjust for resources to deliver high-quality care for those with greater health-related social needs |
| **Capitation**: pre-determined payment paid to a provider on a per member per month for a specified scope of services (e.g., primary care) | • Encourages preventive care to keep patients healthy<br>• Offers flexibility to allocate resources toward non-medical services | • Avoidance of high-risk patients<br>• Rates (even risk-adjusted) may not cover true cost of complex patients<br>• Clinical transformation often needed to manage risk from capitated arrangements |

Source: NASEM

# Medicare's Influence on Payment Systems

- **Inpatient Prospective Payment System (IPPS)**
  - 766 severity-adjusted Diagnosis Related Groups (MS-DRGs)
  - Reflects operating and capital base costs with adjustments for hospitals treating Disproportionate Share (DSH) of low-income patients
  - Other adjustments based on hospital type (rural, isolated, or critical access), uncompensated care, and quality
- **Physicians & Other Health Professionals**
  - Fee schedule using Healthcare Common Procedure Coding System (HCPCS)
    - 8,000 distinct services
  - Relative value units (RVUs) designated for each, including work, practice expense, and professional liability
  - Conversion factor to translate into dollars

Source: https://www.medpac.gov/document-type/payment-basic/

# Medicare Fee Schedule Innovation in 2024

- **Social Determinants of Health (SDOH) risk assessments (G0136)**
  - Assessment with valid tool when a practitioner believes there are unmet SDOH needs that could interfere with diagnosis and treatment of a condition or illness.
- **Community Health Integration (CHI) services (G0019/G0022)**
  - Services provided by certified/trained auxiliary personnel, including a community health worker, under the direction of a physician or other practitioner, to address social determinants of health that affect medical treatment
- **Principal Illness Navigation (PIN) services (G0023, G0024, G0140, G0146)**
  - Services provided by certified/trained auxiliary personnel, including patient navigators or certified peer specialists, under the direction of a physician or other practitioner, to help patients diagnosed with a serious, high-risk condition

Sources: https://www.cms.gov/newsroom/press-releases/cms-finalizes-physician-payment-rule-advances-health-equity; https://www.cms.gov/files/document/health-related-social-needs-faq.pdf

# Paying for Value vs. Paying for Volume

*"Value-based purchasing rewards providers who deliver better outcomes in health and health care for the beneficiaries and communities they serve at lower cost."*

Van Lare and Conway, *NEJM*, July 26, 2012

Desired Outcomes:

- Safe
- Timely
- Effective care
- Efficient care
- Equitable care
- Patient-centered

Source: https://www.ahrq.gov/talkingquality/measures/six-domains.html

# Key Features of Existing Value-based Purchasing Arrangements

Link payment to performance on pre-determined outcome measures

Shift payment 'unit' from a service to clinical episode or population-based structures

Improve alignment of financial rewards and risk between payers and providers

# Performance Measures

| Measure Type | Definition | Examples |
|---|---|---|
| Clinical Processes of Care | Steps that should be followed to provide good care | HEDIS-based prevention measures (e.g., CRC-screening) |
| Intermediate Clinical Outcomes | Clinical indicator or result that leads to a longer-term outcome | HbA1c < 8.0%<br>Controlling high blood pressure |
| Utilization | Amount of service use in a specified population and time period | Hospital readmissions rate |
| Health Outcomes | Measures that reflect the results of care, including clinical events, recovery, and health status | Pre-term birth; 30 day mortality after hospital admission |
| Patient Experience | Measures that capture the experience of care directly from patient, family, or caregiver | CAHPS measures related to respect, communication, access |

Sources: Quality Measures | AAFP; Minnesota Community Measurement

# Financial Risk and Rewards Spectrum


| Pay-for-Performance | Risk Sharing: Upside only | Risk Sharing: Two-sided | Full Risk, Capitation, Global Budget, % of Premium |
|---|---|---|---|
| Providers receive bonus or penalty based on performance on 1+ pre-determined measures (including quality and efficiency) | Benchmark spending level set for an attributed population. If actual spending < benchmark, then providers are eligible to "share" in a portion of the savings with the payer | Benchmark spending level set for an attributed population. If actual spending < benchmark then shared savings; otherwise shared risk/losses | Providers are paid a prospectively set amount for covered set of services of attributed population. Reap full savings or take full losses. |

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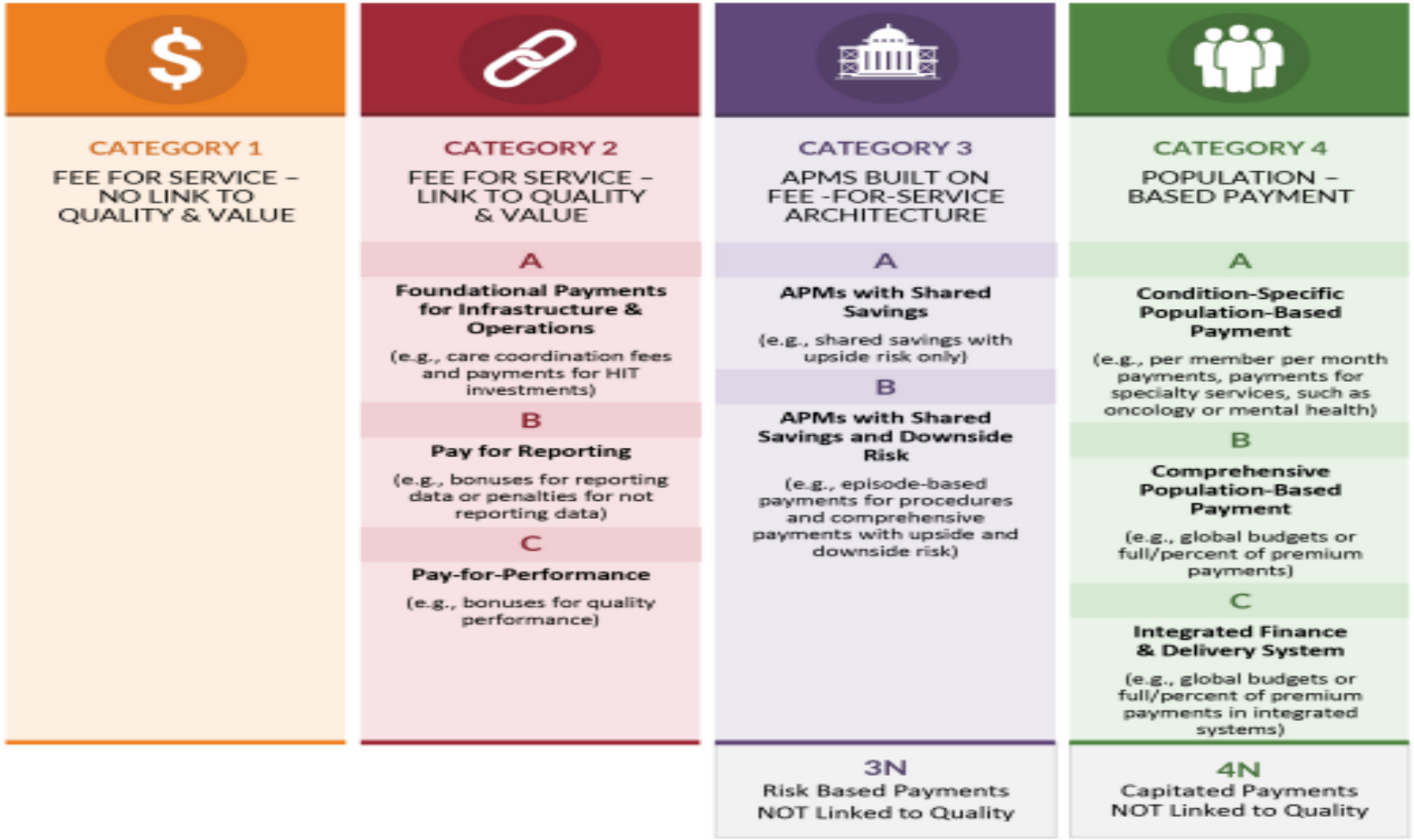
# Health Care Payment Learning & Action Network (LAN)




Health Care Payment Learning & Action Network (2019)

# Pay-for-Performance

- Definition: Payment arrangement that includes added incentives or penalties linked to a provider's performance on pre-defined quality or efficiency measures; earliest forms of 'value-based' purchasing

**Advantages:**

1) Prioritizes quality improvement in care delivery by providers

**Disadvantages:**

1) P4P draw focus toward specific measures that may be to the detriment of non-measured areas

2) Avoidance of underserved patients who might require more resources to improve performance

3) Reduction in income and resources for providers serving communities that are more racially diverse and/or may have greater health-related social needs.

4) Administratively challenging to coordinate programs across payers

Source: Casalino 2007; NEJM Catalyst 2018

# Bundled Payments and Episodes of Care

- Definition: Provider organization receives a prospectively-determined payment for delivering a *bundle of services* deemed medically appropriate for a specific type of patient. Payment may be conditional on meeting quality goals.

**Advantages:**

1) Incentive to reduce low-value utilization and spending
2) Improve care coordination
3) Incentive to reduce complications or readmissions

**Disadvantages:**

1) Challenging for chronic conditions
2) Administratively complex to implement
3) May not affect overall volume of episodes

Sources: Shih et al. 2015; LaPointe 2017; Ellimoottil, 2017

# Episode-based Programs in Use

| Medicare | Medicaid | Commercial |
| --- | --- | --- |
| • IPPS – MS-DRGS<br>• Comprehensive Joint Replacement | • Ohio's Episodes Program<br>• Tennessee's Episodes of Care | • Carrum Health for spinal fusion, bariatric surgery, major joint replacement<br>• BCBS of Hawaii for PCI |

# Population-based Payment Models

- Definition: Model in which a contracted provider organization receives prospective payments that cover a defined scope of services for a defined attributed population over a specified time period with financial risks and rewards incorporated into the arrangement

**Advantages:**

1) Encourage more investment in health-related social needs and prevention.
2) Encourage care coordination

**Disadvantages:**

1) Effective risk-adjustment is important to address potential variation in clinical and social risks within population.
2) Require mature analytics
3) Require provider buy-in

https://aspe.hhs.gov/sites/default/files/private/aspe-files/207901/common-apms-reference-guide-2021.pdf

# Accountable Care Organization (ACO) Arrangements

- ACOs are groups of doctors, hospitals, and other health care providers, who come together voluntarily to give coordinated high-quality care to their patients (e.g., Medicare or other covered population).
  - Hospital-led or Physician-led
- Responsible for *full range of covered services* over a designated *time period* for a *designated population*
- Financial risk-based arrangements
  - Shared savings and/or shared risk
  - Full risk
- Quality often linked to financial risk-sharing
- More than 1000 ACOs as of 2022 with combined 32 million lives

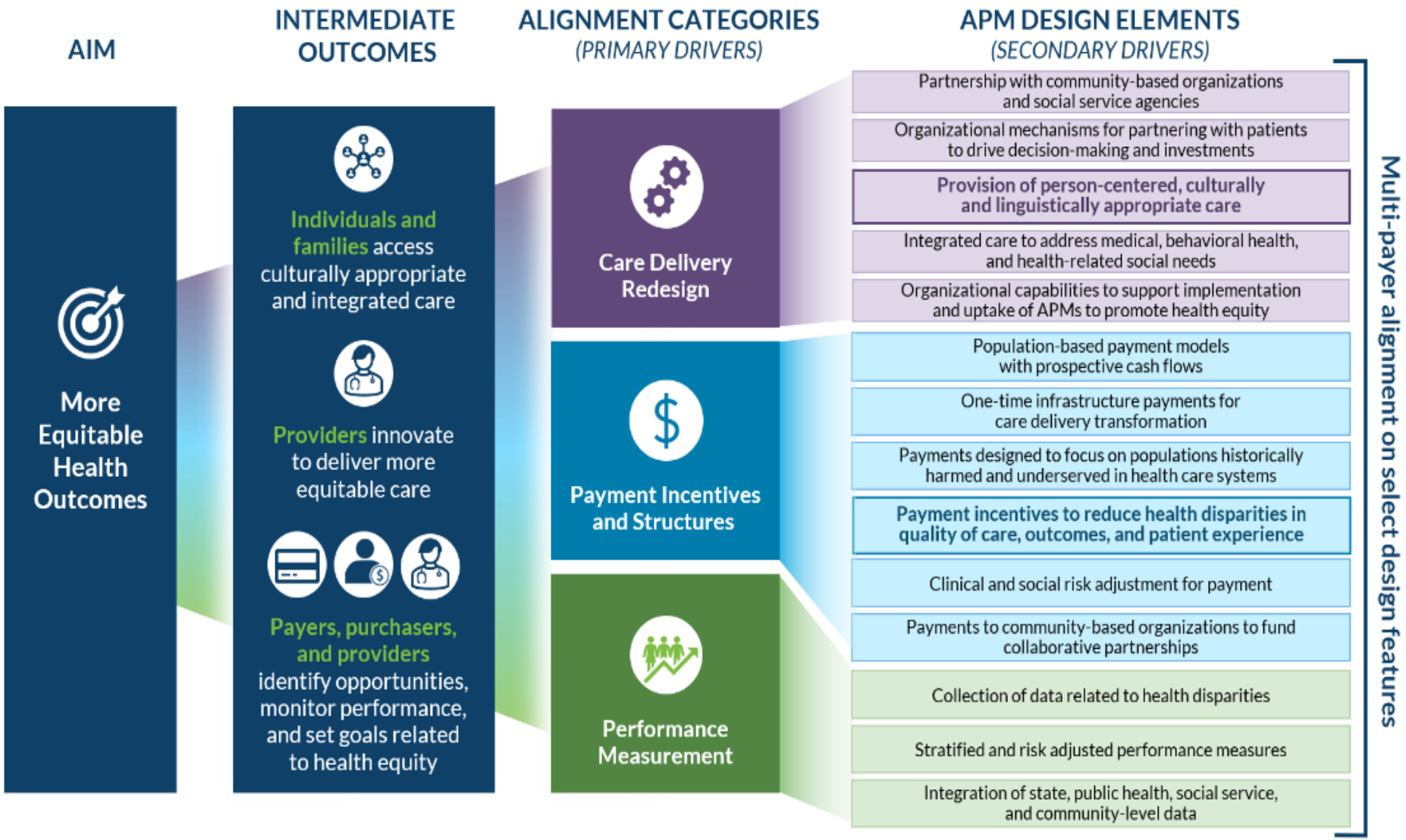
CMS, 2020; Muhlestein et al. 2020

# ACO/TCOC Models in Use

| Medicare | Medicaid | Commercial |
| --- | --- | --- |
| • Medicare Shared Savings Program (MSSP)<br>• REACH (3 Twin Cities based health systems participating) | • Minnesota's Integrated Health Partnerships<br>• Oregon's Coordinated Care Organizations<br>• Medical Home Network | • BCBS of HI 3PC<br>• BCBS of MA Alternative Quality Contract |

Sources:
https://www.cms.gov/priorities/innovation/innovation-models/aco

# Promoting Health Equity through Population-based Models: Theory of Change




https://hcp-lan.org/apms-theory-of-change/

# Minnesota-specific Investments and Initiatives

# Minnesota's Data and Measurement Assets

# Minnesota's Care Delivery and Financing Innovations and Investments

- MN Managed Care Comprehensive Quality Strategy and Equity-focused Performance requirements
- MN Medicaid Integrated Health Partnership ACO program
  - Health equity performance measurement
- MN Health Care Homes and MN Behavioral Health Homes
- MN proposal for CMS' Transforming Maternal Health Model (application submitted September 2024)
- Center for Health Care Affordability and Prescription Drug Affordability Board

# Concluding Remarks

- The healthcare financing and delivery landscape is complex, evolving, and influenced my many factors, including public policy.
- Benefit designs and payment systems influence behavior of individuals, providers and insurers with important tradeoffs to consider.
- Value-based purchasing models are not new, but explicit consideration of equity-focused outcomes is recent.
- If possible, policy recommendation development should leverage existing Minnesota investments

# Questions & Discussion

Learn more: sph.umn.edu



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# Learning and Solutioning: NCQA Health Equity Accreditation

Bukata Hayes, VP and Chief Equity Office, Center for Racial and Health Equity, Blue Cross Blue Shield of MN
Pleasant Radford, Jr., Health Equity Office, UCare
Ross Owen, Director of Improvement and Integration, HealthPartners
Angelique Harbin, Project Manager, Portfolio and Project Management, Hennepin Healthcare
Nneka Sederstrom, PhD, MPH, MA, FCCP, FCCM, Chief Health Equity Officer, Hennepin Healthcare

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# National Committee for Quality Assurance (NCQA)

- ✓ Measure and accredit health plans
- ✓ Measure provider quality
- ✓ Patient-centered medical home recognition

# NCQA's Health Equity Accreditation


3-Year Standards-based program

Designed for **organizations beginning their health equity journey** or **looking for structure and accountability to improve existing health equity work.**

Focused **on collecting data** to understand members' or patients' needs, then **identify and act on opportunities to reduce disparities and improve the cultural and linguistic appropriateness of care.**

- Organizational Readiness
- Race/Ethnicity, Language, Gender Identity & Sexual Orientation Data
- Access & Availability of Language Services
- Practitioner Network Responsiveness
- Cultural & Linguistically Appropriate Services (CLAS) Programs
- Reducing Health Care Disparities

# NCQA's Health Equity Accreditation Plus

3-Year Standards-based program

**Builds on NCQA's Health Equity Accreditation** (its prerequisite).

**Designed for organizations progressing to the next step of their health equity journey.**

Focused **on partnering with community-based organizations and cross-sector partners to address social needs** of individuals served and **mitigate social risks of the community.**

# Process

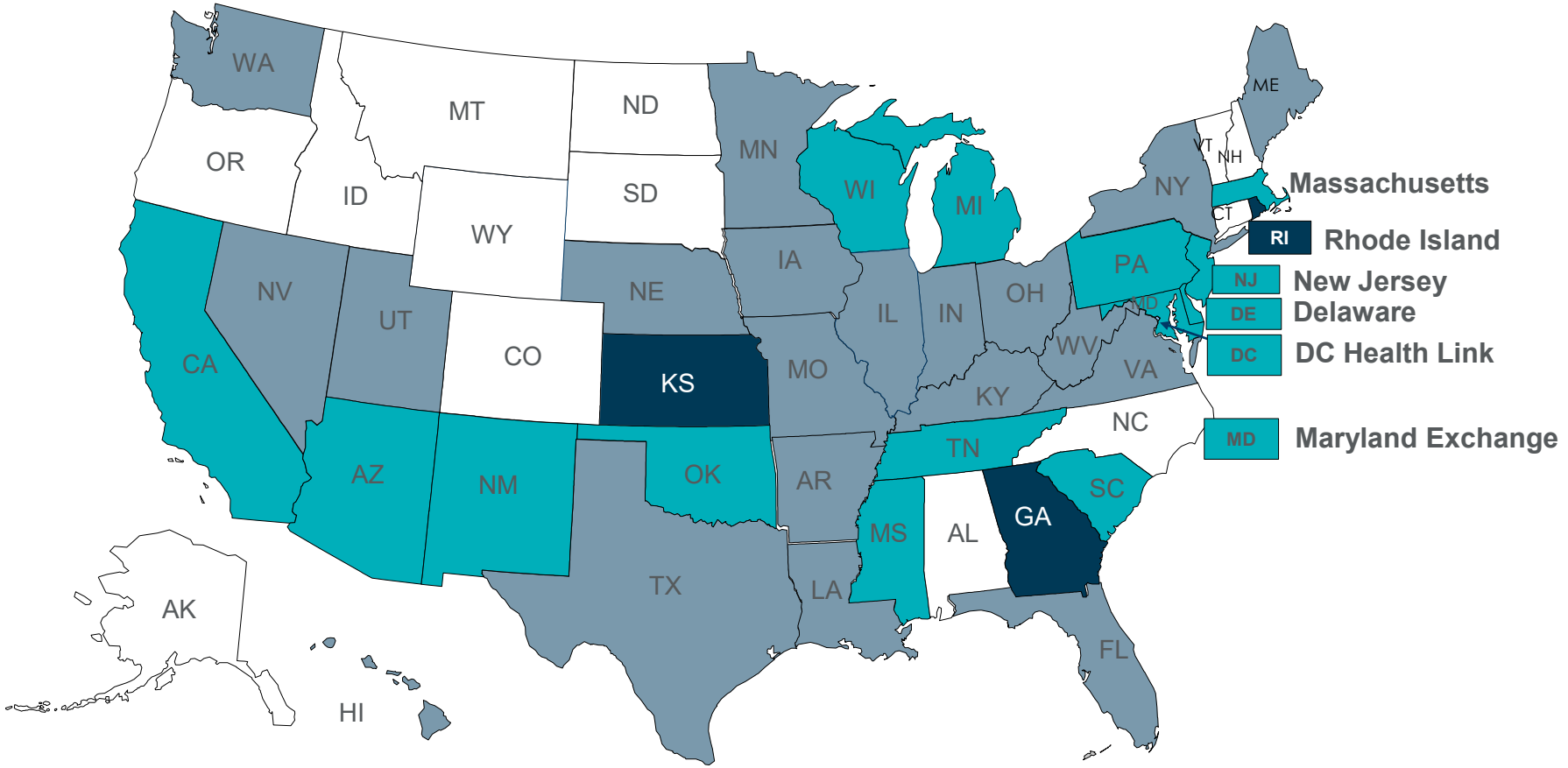
- Pre-application
  - Overview discussion
  - Purchase standards and survey tool
  - Perform gap analysis
  - Submit pre-application form
  - Submit online application
- Post-application
  - Align with NCQA requirements
  - Submit the survey tool
  - Earn health equity accreditation

**Process takes approximately 12 months from application submission to decision*

# Health Equity Accreditation/ Health Equity Accreditation Plus

**36M+ covered lives in NCQA Health Equity Accreditation**

**Organizations:**
**HEA: 515**
**HEA+: 71**




Required to Achieve NCQA's Health Equity Accreditation (14 States + D.C)

Required to Achieve NCQA's Health Equity Accreditation Plus (3 States)

States with voluntary adoption of HEA (formerly Multicultural Health Care Distinction) by plans serving one or more populations (Medicaid, Exchange, Medicare or Commercial).

*Note: As of July 2024*

# Panel

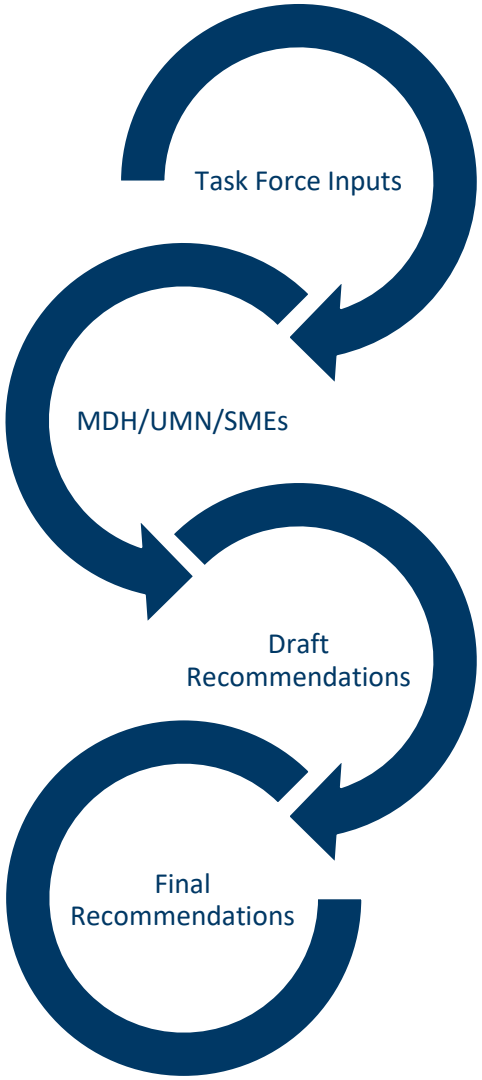
| Organization | Accreditation | Type | Panelist |
|---|---|---|---|
| Blue Plus | Health Equity Accreditation<br>Health Equity Accreditation Plus<br>Multicultural Health Care | Medicaid HMO | Bukata Hayes |
| UCare | Health Equity Accreditation | Medicaid HMO | Pleasant Radford, Jr. |
| HealthPartners, Inc. | Health Equity Accreditation | Medicaid HMO | Ross Owen |
| Hennepin Healthcare | Health Equity Accreditation<br>Health Equity Accreditation Plus | Health System | Angelique Harbin<br>Nneka Sederstrom |

# Break


# Opportunity Matrix and Recommendations

DEPARTMENT OF HEALTH

# Recommendation development process




**Task Force's Role:**

- Identify and highlight health care equity opportunities within the Opportunity Matrix.
- Provide input/advice on draft recommendations

**MDH, UMN, and Subject Matter Expert Support:**

- Provide technical support and help craft recommendations based on task force's discussions and inputs.

**Iterative Development:**

- MDH, with UMN and SMEs, will draft recommendations using task force input and ongoing matrix updates.
- Continuous feedback loops with task force and community input to refine recommendations.

# Recommendation process, continued

- Timeline:
  - Currently working with SMEs to develop recommendations for task force input.
    - Potential review of some draft recommendations in December meeting.
  - Ongoing recommendation development through Spring 2025.
    - Some recommendations will evolve faster than others.
  - Refinement and completion by end of June 2025.
- Matrix :
  - Are the matrix objectives clear and comprehensive?
  - Are there opportunities or health care equity issues missing or needing more detail?

# Feedback on recommendation development process

- Questions to inform a structured recommendation and prioritization process:
  - What specific health care equity issues are we addressing? How significant is the impact?
  - What policies, training, technology, or financing are needed?
  - How do we ensure accountability (e.g., incentives or regulations)?
  - Who needs to act, and when (short-term, mid-term, long-term)?
  - What impact or results do we envision? How will we measure success and monitor outcomes?
  - What community members should provide input?

Daniel Tanase

# Meeting Close

# Closing and action items

- Task force members will:
  - Contribute to the Opportunity Matrix for Developing Recommendations (saved in Teams)
- Project team will:
  - Summarize today's meeting
  - Provide meeting slides to the task force
- Virtual learning sessions:
  - November 8, 9:00 – 10:00 a.m. - Oral health care
  - December 6, 11:00 – 12:00 p.m. – Topic TBD
- Next meeting is December 9, 12:00 – 3:00 p.m.
  - Presentation and discussion of the University research team's preliminary findings on health care delivery innovations, evidence, and policy and practice levers
  - Continue to move our discussions toward potential solutions
  - Social get-together

# Thank You!

See you December 9, 2024!