

# **PAVING THE WAY TO EQUITY: A PROGRESS REPORT**

Centers for Medicare & Medicaid Services  
Office of Minority Health

October 2016



# Table of Contents

<b>Introduction</b> .....	<b>1</b>
<b>CMS Equity Plan for Medicare: Year 1</b> .....	<b>2</b>
PRIORITY 1: Expand the Collection, Reporting, and Analysis of Standardized Data .....	3
Increasing and Improving the Collection of Standardized Data .....	3
Making Existing Data More Accessible .....	4
PRIORITY 2: Evaluate Disparities Impacts and Integrate Equity Solutions across CMS Programs .....	6
Embedding Health Equity across the Agency .....	6
Evaluating Impacts and Addressing Health Disparities in CMS Programs .....	7
CMS' Financial Alignment Initiative .....	7
CMS Technical Assistance for Health Equity .....	8
Further Embedding Equity into the Agency .....	8
PRIORITY 3: Develop and Disseminate Promising Approaches to Reduce Health Disparities .....	10
Solutions for Health Plans .....	11
Solutions for Hospitals .....	11
Developing Solutions for Providing CLAS .....	12
PRIORITY 4: Increase the Ability of the Health Care Workforce to Meet the Needs of Vulnerable Populations .....	14
Identifying Promising Practices .....	14
Training for Providers .....	15
PRIORITY 5: Improve Communication and Language Access for Individuals with Limited English Proficiency and Persons with Disabilities .....	17
PRIORITY 6: Increase Physical Accessibility of Health Care Facilities .....	19
<b>Summary</b> .....	<b>22</b>

## Abbreviations

ACA	Patient Protection and Affordable Care Act of 2010
AHC	Accountable Health Community
ACO	Accountable Care Organization
CAHPS	Consumer Assessment of Healthcare Providers and Systems
CLAS	Culturally and Linguistically Appropriate Services
CMMI	Center for Medicare & Medicaid Innovation
CMS	Centers for Medicare & Medicaid Services
CMS OMH	Centers for Medicare & Medicaid, Office of Minority Health
CPIA	Clinical Practice Improvement Activity
DAS	Disparities Action Statement
DPP	Diabetes Prevention Program
ESRD	End-Stage Renal Disease
HCIA	Health Care Innovation Awards
HEDIS	Healthcare Effectiveness Data and Information Set
HEN	Hospital Engagement Network
HIIN	Hospital Improvement Innovation Network
HHS	U.S. Department of Health and Human Services
MA	Medicare Advantage
MLN	Medicare Learning Network
MMD Tool	Mapping Medicare Disparities Tool
PFS	Physician Fee Schedule
QIN-QIO	Quality Innovation Network-Quality Improvement Organizations
QPP	Quality Payment Program
REaL	Race, Ethnicity, and Language
SO/GI	Sexual Orientation and Gender Identity
TCPI	Transforming Clinical Practice Initiative
VRDC	Centers for Medicare & Medicaid Services, Virtual Research Data Center

## Introduction

Despite efforts to address health disparities, the Agency for Healthcare Research and Quality's *2015 National Healthcare Quality and Disparities Report* describes significantly worse health outcomes and poorer health care quality for racial and ethnic minorities and individuals with low socioeconomic status.<sup>1</sup> According to the report, there is a need to increase focus on health care quality, including care coordination, effective treatment, and patient safety. The report also highlights persistent disparities in health care access, with blacks and Hispanics less likely than whites to have a usual place to go for medical care.<sup>2</sup> Furthermore, the 2013 Centers for Disease Control and Prevention's *Health Disparities and Inequalities Report* describes significant disparities for racial and ethnic minorities in health care access and preventive services.<sup>3</sup>

In September 2015, the Centers for Medicare & Medicaid Services (CMS) released the [CMS Equity Plan for Improving Quality in Medicare](#) (CMS Equity Plan for Medicare), which provides a comprehensive and solution-driven approach to increasing understanding and awareness of the health disparities experienced by racial and ethnic minorities, sexual and gender minorities, persons with disabilities, and individuals living in rural areas.<sup>4</sup> The plan outlines a framework for creating new solutions to achieve health equity and for accelerating the implementation of measurable actions. Moreover, the CMS Equity Plan for Medicare describes the agency's path to improving the health of Medicare beneficiaries who experience a disproportionately high burden of disease, worse quality of care, and barriers to accessing care. The CMS Equity Plan for Medicare is organized into six priority areas to achieve health equity which are listed in Exhibit 1 and described in more detail in the following sections.

### Exhibit 1: CMS Equity Plan for Improving Quality in Medicare Priority Areas

**Priority 1:** Expand the Collection, Reporting, and Analysis of Standardized Data

**Priority 2:** Evaluate Disparities Impacts and Integrate Equity Solutions across CMS Programs

**Priority 3:** Develop and Disseminate Promising Approaches to Reduce Health Disparities

**Priority 4:** Increase the Ability of the Health Care Workforce to Meet the Needs of Vulnerable Populations

**Priority 5:** Improve Communication and Language Access for Individuals with Limited English Proficiency and Persons with Disabilities

**Priority 6:** Increase Physical Accessibility of Health Care Facilities

<sup>1</sup> Agency for Healthcare Research and Quality. (2016). *2015 National Healthcare Quality and Disparities Report and 5th Anniversary Update on the National Quality Strategy*. AHRQ Pub. No. 16-0015. Available at: <http://www.ahrq.gov/sites/default/files/wysiwyg/research/findings/nhqdr/nhqdr15/2015nhqdr.pdf>

<sup>2</sup> Agency for Healthcare Research and Quality. (2016).

<sup>3</sup> Centers for Disease Control and Prevention. (2013). *Health Disparities and Inequalities Report*. Available at: <http://www.cdc.gov/mmwr/pdf/other/su6203.pdf>

<sup>4</sup> Centers for Medicare & Medicaid Services. (2015). *The CMS Equity Plan for Improving Quality in Medicare*. Available at: [https://www.cms.gov/About-CMS/Agency-Information/OMH/OMH\\_Dwnld-CMS\\_EquityPlanforMedicare\\_090615.pdf](https://www.cms.gov/About-CMS/Agency-Information/OMH/OMH_Dwnld-CMS_EquityPlanforMedicare_090615.pdf)

CMS in collaboration with NORC at the University of Chicago, implements the CMS Equity Plan for Medicare as part of a broad range of work to address health disparities and achieve health equity. This progress report highlights efforts in the first year of implementing the CMS Equity Plan for Medicare.

## CMS Equity Plan for Medicare: Year 1

Over the past year, CMS began to address the six priorities outlined in the CMS Equity Plan for Medicare (Exhibit 1). The CMS framework for its path to achieve health equity is grounded in three domains: 1) better **understanding** and awareness of disparities, 2) identifying and creating **solutions** based on that understanding, and 3) accelerating the implementation of measurable **actions** to achieve health equity. Achieving health equity requires continuous quality improvement to fill knowledge gaps, identify best practices, support action, monitor changes, and adapt practices.

This report highlights CMS' progress in Year 1 of the CMS Equity Plan for Medicare by presenting the actions taken and progress achieved for each priority. It also outlines plans for continuation and expansion of this work in Year 2. One overarching theme of Year 1 has been to extend the footprint of the CMS Equity Plan for Medicare by engaging stakeholders within and outside of CMS—like the Quality Innovation Networks—Quality Improvement Organizations (QIN-QIOs), Hospital Engagement Networks (HENs), and federal and state partners—through knowledge sharing and collaborations that are focused on uncovering new ways to advance equitable solutions as an agency.

## **PRIORITY 1: EXPAND THE COLLECTION, REPORTING, AND ANALYSIS OF STANDARDIZED DATA**

Priority 1 focuses on increasing understanding of the value of collecting and analyzing standardized patient data, and on developing solutions that enable stakeholders to collect and analyze data in their communities. Increasing the collection of standardized demographic and language data across health care systems is an important step towards improving population health.<sup>5</sup> Comprehensive patient data—including race, ethnicity, language, sexual orientation, gender identity, and disability status—are necessary to support quality improvement.

### **Year 1**

In Year 1, CMS worked to improve the collection and accessibility of standardized demographic patient data. As part of this effort, CMS developed new resources, approaches, and tools to highlight best practices in standardized data collection. In addition, CMS worked to make existing data more accessible to quality improvement professionals, providers, researchers, and other stakeholders as well as raise awareness and provide actionable information about disparities.

#### *Increasing and Improving the Collection of Standardized Data*

While there has been an increase in evidence-based guidelines and practices for improving the collection of data on race, ethnicity, and language (REaL) in health care settings, these guidelines are often not readily available to health care providers and staff, resulting in wide variations in data collection methods that can negatively impact the accuracy and reliability of the data. To increase the uptake of best practices for standardized data collection, CMS developed the Compendium of Resources for Standardized Demographic and Language Data Collection (the Compendium) which combines data collection best practices from reports, toolkits, webinars, and training tools into a single resource that can be used by health care organizations to improve the collection of standardized data and to identify and address health disparities.<sup>6</sup>

During the last year, CMS also worked to improve the collection of sexual orientation data among Spanish speaking adults. A previous study using questions from the National Health Interview Survey (NHIS) found that, while English speakers understood questions about sexual orientation, Spanish speakers had difficulty responding accurately. In an effort to improve the accuracy of data collected from the Spanish-speaking subpopulation, CMS tested a modified version of the NHIS sexual orientation question that included response options that were not a direct translation of the English. The response option for heterosexual that is currently translated in Spanish as “heterosexual, o sea, no gay” was replaced with “no gay, o sea, heterosexual” (the term “o sea” translates to “that is”). Spanish speakers were able to respond more

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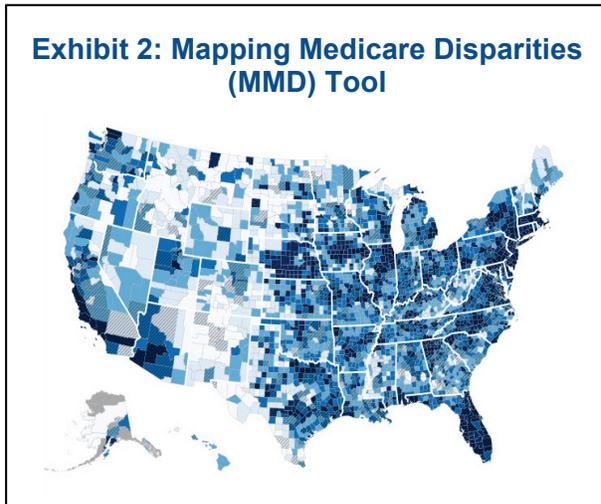
<sup>5</sup> Bhalla, R., Yongue, B. G., & Currie, B. P. (2012). Standardizing race, ethnicity, and preferred language data collection in hospital information systems: Results and implications for healthcare delivery and policy. *Journal for Healthcare Quality*, 34(2): 44-52.

<sup>6</sup> Centers for Medicare & Medicaid Services. (2015). *Resources for Standardized Data Collection*. Available at: <https://www.cms.gov/About-CMS/Agency-Information/OMH/Downloads/Data-Collection-Resources.pdf>

accurately when presented with this modified response option. Although it is not a direct translation, the modified response option more effectively conveys the desired concept.

### *Making Existing Data More Accessible*

CMS is committed to making disparities data *relevant, accessible, and easy to use* for health care organizations, quality improvement professionals, patients, and providers through interactive data visualizations like the [Mapping Medicare Disparities \(MMD\) Tool](#). This new tool uses Medicare fee-for-service data to show the prevalence of 18 chronic conditions, health care utilization, and costs by race, ethnicity, sex, disability, and age. The MMD Tool interactive web interface allows users to visualize disparities in chronic diseases and health care utilization in their communities, which enables them to target specific interventions where they are needed most (Exhibit 2).



CMS also developed innovative methods to use Medicare claims data to analyze vulnerable populations, including transgender beneficiaries, as well as released a number of [data products](#) on the Centers for Medicare & Medicaid, Office of Minority Health (CMS OMH) website (Exhibit 3).

For the first time, CMS publicly released Medicare Part C and Part D performance data stratified by race and ethnicity at the contract level. This information may be used by Medicare Advantage (MA) plans to target quality improvement activities and resources, monitor performance, and advance the development of culturally and linguistically appropriate quality improvement interventions and strategies. CMS plans to publish these reports on an annual basis.

CMS has also increased access to data by providing five researchers with Medicare and Medicaid data in order to conduct research on health disparities through the CMS Virtual Research Data Center (VRDC). The VRDC is a platform that provides access to Medicare and Medicaid program data, including direct access to approved data files, and allows researchers to conduct their analyses within the CMS secure environment.

### **Next Steps**

In Year 2, CMS will continue efforts to expand the collection, reporting and analysis of standardized data

### **Exhibit 3: Data Products Released on CMS OMH Webpage**

1. A series of data snapshots on racial and ethnic disparities for a range of chronic conditions
2. Reports on national and regional trends in health care service utilization, spending, and quality indicators for the Medicare population<sup>8</sup>
3. Medicare Part C and Part D performance data, stratified by race and ethnicity
4. A data brief on self-reported health characteristics of gay, lesbian, or bisexual older adults (age 65 years or older), using data from the National Health Interview Survey<sup>9</sup>

on REaL, sexual orientation and gender identity (SO/GI), and disability status so that stakeholders are able to better identify and address the specific needs of their target populations. In particular, CMS will develop additional resources to improve the collection of standardized data and disseminate them through the CMS OMH webpage.

In addition to developing resources that encourage providers to collect accurate data, CMS will continue to make existing data more accessible as well as begin exploring ways to examine additional data sets through a health equity lens. First, the MMD Tool will be enhanced to further increase the accessibility of disparities data to make it even more useful for stakeholders seeking data about disparities in chronic disease, health care utilization, and spending. Second, CMS will analyze the adult Medicaid Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey data to assess its utility in examining disparities in the Medicare-Medicaid dual eligible population.

CMS will also help increase access to data and strengthen awareness of disparities faced by Medicare beneficiaries through continued analysis and publication of data. CMS will explore other data sets that can be used for stratified data reporting.

Efforts to examine and disseminate data on disparities among LGB older adults and transgender beneficiaries are also planned for the coming year. CMS will begin work to use the instrument used in the Medicare Health Outcomes Survey (HOS)—an annually administered survey of a random sample of Medicare beneficiaries--- to compare LGB older adults with a matched sample to assess health disparities. The findings of this effort could provide insights on the health and quality of life challenges that older LGB adults face.

## **PRIORITY 2: EVALUATE DISPARITIES IMPACTS AND INTEGRATE EQUITY SOLUTIONS ACROSS CMS PROGRAMS**

Priority 2 focuses on **understanding** the effects that CMS programs and policies have on vulnerable populations, providing **solutions** to incorporate a health equity lens into existing and new CMS policies, programs, models, and demonstrations, and galvanizing **action** to reduce disparities. CMS works to help identify any gaps in health care quality, outcomes, and access—particularly among vulnerable populations—and to ensure that the agency’s programs, policies, models, and demonstrations are actively engaged in reducing health disparities to provide equitable care for all beneficiaries.

### **Year 1**

Race, ethnicity, disability, SO/GI, geography, and other factors have been linked to health care outcomes, quality, and access. In order to close these gaps affecting beneficiaries, CMS is working to ensure its programs, policies, and stakeholders are aligned to identify disparities, prioritize efforts where gaps are greatest, take actions to improve care, and monitor changes over time. To support this effort, CMS developed and piloted the Disparities Action Statement (DAS)—a tool that enables CMS and CMS stakeholders to evaluate the impact of a policy or program on health disparities. CMS also developed a Health Equity Technical Assistance process to provide solutions through coaching for organizations taking action on health disparities.

#### *Embedding Health Equity across the Agency*

CMS has engaged with a broad range of programs and stakeholders across the agency to understand where they are in their journey to address health equity and to discern what solutions would be most valuable. Early in Year 1, CMS worked with QIN-QIOs, HENs, and Transforming Clinical Practice Initiative (TCPI) awardees to help them understand where disparities are called out in their current Statements of Work and to identify areas of overlap with other programs. CMS heard that these organizations were struggling with how their Statements of Work crossed into other domains and programs, and early work in Year 1 helped to highlight shared goals and opportunities for collaboration and alignment among stakeholders.

Health equity is also embedded in the Clinical Practice Improvement Activity (CPIA) of the Merit-based Incentive Payment System (MIPS). For example, one subcategory is to achieve health equity, as its own performance subcategory.

CMS also worked closely with CMS Affinity Groups: supporting efforts to reduce disparities in end-stage renal disease (ESRD), embedding health equity into the goals of the Affinity Groups for Nursing Home convergence, Behavioral Health, and Patient & Family Engagement, and ensuring that equity solutions and resources are shared across the agency and regions through the Learning & Diffusion Affinity Group. CMS OMH worked with a small group of thought-leaders to draft the agency’s first framework for population health and has assumed a leadership role as Executive Champion of the Population Health Improvement Affinity Group to embed population health improvement and equity across the agency.

Finally, CMS OMH has worked with the Center for Medicare & Medicaid Innovation (CMMI) to test innovations that reduce disparities for Medicare and Medicaid beneficiaries through a number of models. Notably, the Accountable Health Community (AHC) model included a Health Equity Resource Statement as a scored part of the application package. CMS OMH has also worked closely with the AHC team to advance equity solutions, including a screening for social determinants of health, into this new model. In addition, CMS has worked closely with teams including the Health Care Innovation Awards, Population Health Group, and Accountable Care Organization teams on existing and emerging models to build an equity lens into model design, implementation, and evaluation. Through these activities, CMS observed that many organizations and federal partners recognize disparities exist but may not know what actions to take to evaluate the impact their program has on disparities and how to take action to achieve health equity. To close this gap, CMS developed the DAS to help organizations systematically evaluate disparities impacts and formed a Health Equity Technical Assistance team with the capacity, and subject matter expertise help organizations understand how to take action on disparities.

### *Evaluating Impacts and Addressing Health Disparities in CMS Programs*

To help meet the diverse needs of stakeholders, CMS developed the DAS – a tool designed to help organizations systematically identify and take steps to address disparities. Along with this new tool, CMS also developed the agency’s first Health Equity Technical Assistance team. CMS components can now refer organizations or teams in need of health equity guidance to CMS through this technical assistance process. A primary benefit of the DAS and technical assistance offered by CMS is that organizations and internal components can leverage the support of health equity subject matter experts through ongoing collaboration. The technical assistance team is trained to help organizations understand how to respond to health disparities by identifying vulnerable populations, exploring health equity solutions, and monitoring progress to drive continuous quality improvement, using a Plan-Do-Study-Act quality improvement approach. Through a series of check-ins, the technical assistance team connects stakeholders with the right tools and resources for the actions they will undertake.

Early adopters of the DAS have included various CMS stakeholders. For example, CMS piloted the DAS through CMMI’s Learning & Diffusion Group, which yielded commitments from three Health Care Innovation Awards (HCIA) awardees to implement this approach. One HCIA awardee is implementing the DAS resources through statewide providers to meet the local QIN-QIO and HCIA awardee’s shared goal of reducing disparities by 2018. Medicaid health plans and community-affiliated health plans have also joined the ranks of early adopters, building the DAS into a toolkit focused on actions health plans can take to address childhood obesity and reduce disparities in care.

### *CMS’ Financial Alignment Initiative*

As part of the evaluation of demonstration states participating in CMS’ Financial Alignment Initiative, CMS is conducting beneficiary focus groups and state stakeholder site visits with subpopulations particularly vulnerable to disparities in access to quality care. Through this effort, CMS aims to better understand how the experiences of racial and ethnic minorities, people with

limited English proficiency, people with chronic mental illness, and users of long-term services and supports participating in this initiative compare to the experiences of demonstration participants more broadly. CMS conducted focus groups and site visits from late 2015 to mid-2016 in six of the demonstration states (California, Illinois, Massachusetts, Ohio, Virginia, and Washington), and is developing issue briefs highlighting key themes and findings.

## **Next Steps**

### *CMS Technical Assistance for Health Equity*

With a strong technical assistance team, process, and the DAS framework in place, CMS is well-positioned to expand technical assistance provision into additional components and programs. The technical assistance pipeline serves two important purposes:

1. It provides a platform to infuse quality improvement efforts to reduce disparities in CMS programs and policies; and
2. It provides an important opportunity for CMS to learn from internal and external stakeholders about the challenges they face, and to identify the resources and tools that organizations and CMS components need to reduce disparities in their own program areas.

CMS will ensure that technical assistance extends across the agency, focusing on areas that have the greatest potential to improve care for Medicare beneficiaries. CMS will continue to work with CMMI models and demonstrations, bringing the DAS and technical assistance process into the Integrated Learning System in a disparities track. CMS will also focus efforts on specific, relevant models—including the Comprehensive Primary Care Plus, Next Generation Accountable Care Organizations (ACOs), and Diabetes Prevention Program (DPP)—and will continue to work closely with the AHC model team as funding is awarded. CMS is also opening the new technical assistance track to all QIN-QIOs, Hospital Improvement Innovation Networks (HIINs), TCPI Practice Transformation Networks, Support and Alignment Networks, and clinicians, and will be collaborating with organizations that expressed interest in addressing disparities in Year 1, but that may not be aware of technical assistance offerings. Importantly, CMS will also expand technical assistance offerings to health plans that identified disparities in their performance measures so that they have the tools and resources they need to respond to disparities.

### *Further Embedding Equity into the Agency*

Early in Year 2, CMS will continue to embed health equity across the agency by evaluating the impact programs have on disparities and implement solutions that advance health equity. For example, there will be a dedicated Population Health Improvement & Health Equity track at the 2016 CMS Quality Conference, which will include peer learning, tools, and coaching around health equity and approaches to improve care for vulnerable populations. We will continue to leverage the various CMS Affinity Groups as a mechanism to make progress on issues including population health, ESRD, learning and diffusion, nursing home care, patient and family engagement, and behavioral health. CMS will also continue to support the design of programs

and policies—Quality Payment Program, DPP, CMMI AHC model, CMS Right Now Tool, and the Strategic Innovation Engine—to ensure that health equity is incorporated into program requirements.

## PRIORITY 3: DEVELOP AND DISSEMINATE PROMISING APPROACHES TO REDUCE HEALTH DISPARITIES

Priority 3 focuses on developing promising **solutions** for improving equity in Medicare quality, and **actions** to replicate and adapt effective models and strategies. It includes guidance to prevent disparities in avoidable hospital readmissions, resources for health plans with disparities in chronic disease, development of health care quality measures for culturally and linguistically appropriate services (CLAS), and gathering information on what organizations are currently doing to improve health equity.

Since the passage of the Affordable Care Act (ACA) in 2010, hospitals and health plans have increased their focus on providing access to care that is cost-effective, high-quality and responsive to the needs of an increasingly diverse population. To support these efforts, CMS focused on increasing awareness of proven solutions that hospitals and health plans can use to improve health care quality and health equity in their organizations. Priority 3 complements the work of other priorities in the CMS Equity Plan for Medicare, as it is focused on identifying best practices and promising approaches in the reduction of health disparities.

### Year 1

In Year 1, CMS launched the Building an Organizational Response to Health Disparities series of resources. These resources aim to empower hospitals, plans, and other CMS stakeholders with the capacity and readiness to take action on disparities. The resources developed in this series will enable the Health Equity Technical Assistance team to provide internal and external stakeholders with tools they need.

As the CMS Equity Plan for Medicare is executed, collaborations establish a valuable feedback loop, allowing CMS to learn firsthand about the kinds of support and resources that would be most valuable to programs and stakeholders across the agency. These collaborations also represent an opportunity for CMS' team to offer assistance in established, subject-specific forums, to demonstrate how stakeholders can use CMS tools and technical assistance in their

### Spotlight: Building an Organizational Response to Health Disparities

CMS created resources for Medicare Advantage (MA) plans that focus on the use of data to improve health outcomes among racial and ethnic minority MA plan enrollees.

The first two resources in the Building an Organizational Response to Health Disparities series use examples of promising strategies to monitor health and drug plan performance and to advance the development of culturally and linguistically appropriate quality improvement interventions:

- [\*Building an Organizational Response to Health Disparities - Resource Guide\*](#). This resource outlines the essential steps for addressing health disparities, including building a culture of equity, improving data collection and data analysis, and using a quality improvement process.
- [\*Building an Organizational Response to Health Disparities - Targeted Intervention: Colorectal Cancer Screening\*](#). This guide outlines how MA health plans can use a quality improvement cycle to address disparities in colorectal cancer screening. This resource supports action to address disparities in one of the stratified HEDIS measures in the MA report.

own work, and to highlight the return on investment from reducing disparities in the programs and policies they support.

### *Solutions for Health Plans*

Research examining chronic disease disparities among MA plan populations (using data from the Healthcare Effectiveness Data and Information Set [HEDIS]) has established that black MA enrollees are substantially less likely than whites to have control of their blood pressure, cholesterol, and glucose. Enrollment of minorities in lower-performing plans was linked to half of the disparities in these measures.<sup>7,8,9</sup> To increase understanding of differences in health care, CMS [released data](#) on 12 measures from the HEDIS and Consumer Assessment of Healthcare Providers and Systems (CAHPS) datasets stratified by race and ethnicity for each of the MA plans.<sup>10</sup> The release of these MA reports marked the first time CMS stratified HEDIS and CAHPS measures by race and ethnicity at the national and contract level.

To support this data release, CMS launched two targeted resources (described in the Spotlight above) that MA health plans can use to address disparities among their members in order to achieve health equity.

### *Solutions for Hospitals*

Populations with language, access, health literacy and social support barriers are more likely to be readmitted to the hospital within 30 days of discharge for chronic conditions like congestive heart failure when compared with the general population.<sup>11,12,13</sup> Reducing readmissions while serving an increasingly diverse population has become a significant concern for hospitals and hospital leaders. CMS recognized the need for additional guidance on how hospitals can focus on both system-wide redesign, as well as on targeted and specific efforts at preventing readmissions among minority and vulnerable populations. In Year 1, CMS developed the [Guide to Preventing Readmissions among Racially and Ethnically Diverse Medicare Beneficiaries](#) (Guide to Preventing Readmissions Among Diverse Medicare Beneficiaries) to support hospital

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<sup>7</sup> Trivedi, Amal N., et al. (2005). Trends in the quality of care and racial disparities in Medicare managed care. *New England Journal of Medicine*, 353(7): 692-700.

<sup>8</sup> Trivedi, Amal N., et al. (2006). Relationship between quality of care and racial disparities in Medicare health plans. *JAMA*, 296(16): 1998-2004.

<sup>9</sup> Ayanian, J. Z., et al. (2014). Racial and Ethnic Disparities among Enrollees in Medicare Advantage Plans. *New England Journal of Medicine*, 371 (24):2288-2297.

<sup>10</sup> Centers for Medicare & Medicaid Services. (2015). *Part C and D Performance Data Stratified by Race and Ethnicity*. Available at: <https://www.cms.gov/About-CMS/Agency-Information/OMH/research-and-data/statistics-and-data/stratified-reporting.html>

<sup>11</sup> Ash, M., & Brandt, S. (2006). Disparities in asthma hospitalization in Massachusetts. *American Journal of Public Health*, 96(2): 358-362.

<sup>12</sup> Jiang, H. J., Andrews, R., Stryer, D., & Friedman, B. (2005). Racial/ethnic disparities in potentially preventable readmissions: The case of diabetes. *American Journal of Public Health*, 95(9): 1561-1567.

<sup>13</sup> Rathore, S. S., Foody, J. M., Wang, Y., Smith, G. L., Herrin, J., Masoudi, F. A., & Krumholz, H. M. (2003). Race, quality of care, and outcomes of elderly patients hospitalized with heart failure. *JAMA*, 289(19): 2517-2524.

leaders in addressing avoidable readmissions for diverse populations.<sup>14</sup> The Guide to Preventing Readmissions among Diverse Medicare Beneficiaries provides high-level solutions and steps that hospitals can take to address health disparities and reduce readmissions.

CMS followed the release of the Guide to Preventing Readmissions among Diverse Medicare Beneficiaries with a number of educational forums for providers and other stakeholders to increase understanding and awareness of why disparities in readmissions matter, why it is important to address these disparities, and how providers can create new methods to drive change in rates of readmissions.

### *Developing Solutions for Providing CLAS*

The provision of culturally and linguistically appropriate services (CLAS) and the monitoring of health care quality among at-risk populations are important approaches for addressing persistent disparities,<sup>15,16</sup> yet there is little national data available to characterize the provision of CLAS or the relevant quality measures that can be used to monitor and engage the health care system. CMS examined the current state of health quality measures addressing CLAS and disparities, characterized gaps in existing measures and their implementation, and identified measurement opportunities to address these gaps among racial and ethnic minorities, people with limited English proficiency, people with low health literacy, people with disabilities, and sexual and gender minorities. Despite key differences, CMS identified overlapping issues across populations, as well as the following opportunities to address gaps:

- ▶ Develop or adapt measures to assess organizational capacity to address CLAS
- ▶ Increase and enhance data collection efforts with input from research and advocate organizations for SO/GI and people with disabilities
- ▶ Enhance the use and stratify reporting of existing measures for at-risk populations
- ▶ Enhance the use of patient-reported measures addressing CLAS and patient experiences

### *Next Steps*

CMS will continue to engage hospitals to reduce disparities by supporting their efforts to reduce readmissions. In Year 2, CMS will provide hospitals with an opportunity to share the challenges and successes they are experiencing in delivering patient-centered care to diverse Medicare beneficiaries through stakeholder listening sessions. During these sessions, CMS will capitalize on the expertise of hospital and provider audiences by seeking feedback and identifying

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<sup>14</sup> Centers for Medicare & Medicaid Services. (2015). *Guide to Preventing Readmissions among Racially and Ethnically Diverse Medicare Beneficiaries*. Available at: [https://www.cms.gov/About-CMS/Agency-information/OMH/Downloads/OMH\\_Readmissions\\_Guide.pdf](https://www.cms.gov/About-CMS/Agency-information/OMH/Downloads/OMH_Readmissions_Guide.pdf)

<sup>15</sup> Betancourt, J. R., et al. (2003). Defining cultural competence: A practical framework for addressing racial and ethnic disparities in health and health care. *Public Health Reports*, 118(4): 293-302.

<sup>16</sup> Institute of Medicine. (2002). *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care*. Available at: <http://www.iom.edu/reports/2002/unequal-treatment-confronting-racial-and-ethnic-disparities-in-health-care.aspx>

opportunities to further refine the Guide to Preventing Readmissions among Diverse Medicare Beneficiaries.

CMS will also continue to gather information on what organizations are currently doing to improve health equity, and engage hospitals, plans, and purchasers of health insurance that are well positioned to address health equity within their organizations. As part of the Building an Organizational Response to Health Disparities series, CMS will develop additional tools to help organizations address non-health care factors that influence disparities. CMS will also be conducting case studies of innovators that are integrating health equity and disparities-reduction approaches into their strategy and operations to disseminate best practices and to continually inform future work.

## **PRIORITY 4: INCREASE THE ABILITY OF THE HEALTH CARE WORKFORCE TO MEET THE NEEDS OF VULNERABLE POPULATIONS**

Priority 4 focuses on increasing the **understanding** of health care workforce innovations that reduce disparities for vulnerable populations; developing **solutions** to equip the health care workforce to increase the provision of culturally and linguistically appropriate and effective care for beneficiaries; and driving **action** to adopt and adapt promising practices that enhance the workforce's ability to improve quality of care and outcomes for the populations served.

The health care workforce is undergoing a profound transformation, and CMS is uniquely positioned to support providers and systems that serve vulnerable populations. The nation has experienced significant progress by making health coverage more accessible, but additional efforts are needed to enable providers to deliver equitable care to racial and ethnic minorities, sexual and gender minorities and people with disabilities. CMS has actively sought to engage providers and organizations that serve as safety nets for vulnerable populations. CMS has engaged a broad range of stakeholders to gain a stronger sense of what role CMS should play in strengthening the workforce. The initial work of this priority has been exploratory.

### **Year 1**

In Year 1, CMS conducted research to identify strategies to leverage health care workforce innovations. Around the country, multidisciplinary care teams (including nurses, pharmacists, health educators, community health workers, and others) are using innovative workforce models to reduce health disparities in vulnerable populations. These innovations are also being recognized as adding value and improving patient care. CMS also developed trainings for providers and engaged internal and external stakeholders in activities to further the agency's efforts to improve health equity.

#### *Identifying Promising Practices*

The Year 1 work under Priority 4 began with the research of workforce innovations that demonstrated promising evidence in reducing disparities. CMS completed a review of promising practices that improve patient satisfaction and health outcomes. Strategies highlighted in the review focused primarily on community health workers, multidisciplinary teams, and CMS-funded workforce initiatives. With multidisciplinary programs under way across the country, a key part of the review included understanding the role CMS played or could play in fostering and disseminating these workforce innovations. In sharing these promising workforce approaches, CMS would encourage the adoption of these strategies in other communities aiming to achieve health equity.

In July 2016, CMS held a stakeholder listening session that included a broad mix of programmatic directors (e.g. quality improvement or workforce initiative directors), professors, clinical providers, and executive directors/CEOs. Stakeholders discussed the novel workforce strategies, practices, and approaches being implemented in their communities, and barriers that CMS could address to foster increased innovation in order to eliminate disparities in health and health care quality.

Following this event, CMS developed a thematic synthesis of the findings from the listening session and next steps for further CMS collaboration and policy exploration. Participants identified promising practices to train existing staff, to expand care teams with new providers or expanded roles, to train incoming providers still in the pipeline, and to improve data collection related to the workforce. These themes were also reflected in the summary of opportunities and next steps for CMS, including areas for engagement with existing workforce training efforts at CMS and other U.S. Department of Health and Human Services (HHS) agencies.

### *Training for Providers*

While evidence-based standards for REaL data collection are well established, best practices for how the workforce should collect SO/GI data are only beginning to emerge. Since sexual and gender minorities face health disparities and discrimination in health care settings, collecting SO/GI data in clinical settings can help improve our understanding of the problem and lead to efforts to improve the quality of care for lesbian, gay, bisexual, and transgender individuals. However, there are few resources that provide guidance on how to collect and use these data.

To address this need, CMS created a Medicare Learning Network (MLN) training module to raise awareness of the importance of collecting SO/GI data for health care providers and developed a set of standards for collecting SO/GI status in clinical settings.

Partnering with the MLN—the predominate mechanism for engaging and educating providers about changes to CMS programs—will allow CMS to embed health equity into existing provider resources. CMS is updating existing continuing education trainings for providers on the MLN with information about health equity and will incorporate health equity content into several of the MLN's most popular publications.

The updated trainings will be widely disseminated through the MLN and other CMS channels. Incorporating a health equity lens into these trainings will further expand provider cultural competencies and reinforce the importance of including health equity approaches at all levels of the health care workforce.

### *Next Steps*

CMS is evaluating the findings and implementing workforce solutions from its research during Year 1 to identify additional strategies to leverage workforce innovations in reducing health disparities in vulnerable populations. For example, CMS will provide Quality Payment Program (QPP) technical assistance to small practices (15 or fewer clinicians), with priority given to those located in rural areas, health professional shortage areas, and medically underserved areas, as well as practices with low MIPS composite scores, to ensure these clinicians are able to successfully participate in MIPS and Alternative Payment Models under the QPP. As new workforce initiatives emerge and promising strategies are implemented and tested, CMS will identify tools and resources and share them through web-based trainings, online resources, and stakeholder engagement. CMS will also engage with stakeholders, including QIN-QIOs, to obtain feedback on dissemination materials and elicit ideas to continually improve the

effectiveness of outreach strategies. Additional outreach will focus on efforts to increase the diversity of the workforce as well as the training and use of multidisciplinary teams.

Over the course of Year 2, CMS will monitor the evaluation of CMMI projects that serve vulnerable populations and review disparities-focused research funded by the Patient-Centered Outcomes Research Institute and the Health Resources and Services Administration. Best practices that are identified may be incorporated in the development of future resources, such as MLN training modules.

Additionally, CMS will continue to develop new MLN content as part of the Building an Organizational Response to Health Disparities series. To communicate with the workforce, we will use diverse communication channels to amplify the reach of these solutions. One example of this is the MLN Connects Provider eNews, and MLN Matters Special Edition, which reaches 280,000 national subscribers, 700,000 Medicare Administrative Contractors, and 143 provider partner associations participating in Medicare Fee-For-Service, to inform the workforce about resources and tools developed under the CMS Equity Plan for Medicare.

## **PRIORITY 5: IMPROVE COMMUNICATION AND LANGUAGE ACCESS FOR INDIVIDUALS WITH LIMITED ENGLISH PROFICIENCY AND PERSONS WITH DISABILITIES**

Priority 5 focuses on **understanding** and raising awareness of barriers and facilitators to the provision of communication and language access services, disseminating **solutions**, and enabling **action** from providers to overcome those barriers.

An estimated 8 percent of Medicare beneficiaries are persons with limited English proficiency, and according to the 2010 U.S. Census, approximately 18 percent of the U.S. population has a disability of some type, including nearly 15 percent with hearing impairments and 8 percent experiencing vision impairments. Many of these individuals need the support of communication or language access services, like an interpreter or materials provided in alternate formats, in order to communicate effectively with their health care providers. Federal laws and regulations like Title VI of the Civil Rights Act and Section 1557 of the ACA include provisions that prohibit discrimination against these individuals, but disparities persist and beneficiaries do not always receive the assistance they need. These requirements apply to providers receiving Medicare Parts A, C, and D funds<sup>17</sup>.

Communication is essential to the delivery of high-quality health care that is safe, patient-centered, efficient, and equitable. Local communication needs may vary between communities based on a number of factors, including migration and resettlement patterns. Health plans, hospitals, and health centers need to identify the needs of the communities they serve in order to develop and execute strategies that are culturally and linguistically competent.

### **Year 1**

In Year 1, CMS reviewed and analyzed national data sources to determine their utility for understanding the language and communication needs of Medicare beneficiaries. Through this analysis, language and communication needs were estimated at national, state, and local levels. CMS is developing a data brief on these geographic profiles highlighting how providers can use data to determine and meet the needs of their limited English proficient and vision- and hearing-impaired patients.

### **Next Steps**

CMS will continue to raise awareness about the importance of the provision of appropriate communication and language access services for Medicare beneficiaries. In addition, CMS will provide local-level language needs information through an enhancement to the interactive MMD

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<sup>17</sup> Section 1557 also affirmatively requires health programs and activities to take reasonable steps to provide meaningful access to LEP individuals, 92.21(a)(1), and in some instances requires health programs and activities to provide qualified interpreters to LEP individuals, 92.201(d)(1); and requires auxiliary aids and services to be provided to individuals who are deaf, hearing-impaired, and with other disabilities affecting communication. 45 CFR Sec. 92.202(a)-(b), incorporating 28 CFR Sec. 35.160. Section 504 of the Rehabilitation Act also applies to the Department, 29 USC Sec. 794, and implementing regulations require the Department to take appropriate steps to ensure effective communications with applicants, participants, and the public. 45 CFR 85.51(a).

Tool displaying data on languages spoken at the county level. CMS will also explore opportunities to embed language assistance services in various programs and processes across the agency like provider directories, and will identify physician spoken language data sources that could be aggregated and added to the Physician Compare website.

CMS will also research communication and language access promising practices across different health care settings across the nation (e.g., health centers, health systems, and hospitals). Based on this work, CMS will develop case studies that highlight practices that are being used to identify and address beneficiary needs. CMS will then share these promising practices with health care stakeholders. Future efforts will also include the development and dissemination of technical assistance to help CMS stakeholders understand implications of Section 1557 of the ACA and how to meet the nondiscrimination requirements of the recent final rule.

## **PRIORITY 6: INCREASE PHYSICAL ACCESSIBILITY OF HEALTH CARE FACILITIES**

Priority 6 focuses on building shared **understanding** of the physical accessibility of health care facilities, identifying **solutions** to increase physical accessibility of health care facilities, and facilitating **action** to make health care facilities more accessible to beneficiaries with physical disabilities.

Individuals with disabilities experience significant disparities in health status, are less likely to obtain preventive care services, and are more likely to delay getting needed medical care. The drivers of these disparities include the lack of accessibility of hospitals, clinics, and provider offices.

### **Year 1**

In Year 1, CMS focused on increasing understanding of key issues around physical accessibility of health care facilities and services for individuals with disabilities, and on identifying opportunities to leverage CMS and other federal partners' mechanisms to increase physical accessibility for this population.

CMS hosted a listening session with stakeholders with expertise in a variety of disability issues, researchers, and patient advocates focused on barriers to care for persons with physical disabilities. Participants noted that the lack of physically accessible medical equipment creates significant barriers for people with disabilities to receive services. Lack of staff trained to address the needs of individuals with disabilities creates additional barriers. Physical barriers outside of health facilities, like a lack of designated parking or ramps to enter buildings, and inside health care facilities, such as lack of physical space to accommodate wheelchair access or inappropriate lighting and signage, create additional challenges for persons with disabilities in obtaining medical care and treatment. Experts and patient advocates identified a number of promising approaches and potential mechanisms to increase physical accessibility of health care facilities, including enforcement and monitoring of existing federal requirements under the Americans with Disabilities Act (ADA) and Section 504 of the Rehabilitation Act, creating incentives for providers to improve physical accessibility, and increasing awareness of the barriers to care and rights of people with disabilities among both providers and patients.

CMS also initiated a collaboration with federal stakeholders and hosted a meeting with other HHS agencies and CMS offices in an effort to share strategies, identify collaboration opportunities, and develop new solutions. Participants in the meeting discussed activities

### **Spotlight: Stakeholder Engagement**

To increase understanding and awareness of the barriers to care and treatment for persons with physical disabilities, CMS has engaged with stakeholders with expertise in a variety of disability issues, health care providers, and federal partners through two stakeholder engagement sessions.

Participants in these stakeholder engagement sessions identified promising approaches from across the country and noted potential mechanisms to reinforce existing accessibility requirements and use federal levers to improve physical accessibility.

occurring in their agencies and offices related to addressing the physical accessibility of health care facilities and mechanisms for continued interagency collaboration.

In June, CMS participated in a National Academies of Medicine roundtable meeting on the Intersections among Health Disparities, Disabilities, Health Equity, and Health Literacy as part of a broader effort to increase understanding of health disparities and their causes and to ensure that the health care workforce is able to meet the needs of vulnerable populations through culturally competent care. In addition to discussing the intersection of disability, race and ethnicity, panels of speakers explored provider attitudes toward people with disabilities, family perspectives, physical access and systemic barriers to care, and tools for assessing care needs.

Finally, as part of efforts to improve Medicare payment accuracy, CMS proposed a change to the Medicare Physician Fee Schedule (PFS) for Calendar Year 2017, in order to improve quality and access to care for individuals with mobility-related disabilities.<sup>18</sup> The proposed rule included a new payment code to recognize the increased resource costs associated with the medically necessary use of specialized mobility-assistive technology, such as adjustable height chairs or tables, patient lifts, and adjustable padded leg supports, during an office visit. CMS received many supportive comments from the public; however, some commenters raised concerns regarding the application of the cost sharing requirements for separate payment for these services. Although CMS did not finalize payment for the code for Calendar Year 2017, the Agency intends to engage with interested beneficiaries, advocates, and healthcare suppliers to continue to explore improvements in payment accuracy for care of people with disabilities.

### **Next Steps**

CMS will continue to collaborate broadly with disability, health care, and federal and state partners to increase awareness among providers and patients of the importance of physical accessibility to high-quality care. CMS will work collectively with partners to expand the collection and reporting of standardized disability data to fill research gaps. Finally, CMS will work to increase the uptake of existing opportunities to increase physical accessibility of health care facilities. The MMD Tool will be updated to include disabilities data to give health care organizations better information on the needs of Medicare beneficiaries at the county, state, and national level.

In the coming year CMS is developing an educational toolkit for health care providers. The web-based toolkit will introduce the topic of physical accessibility, address the need for accessible provider settings, and provide guidance for making offices more physically accessible. The toolkit will also highlight existing tools and resources for providers to assess the physical accessibility and usability of their offices and will include promising practices from providers.

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<sup>18</sup> Federal Register. (2015). Revisions to Payment Policies under the Physician Fee Schedule and Other Revisions to Part B for CY 2017. Available at: <https://www.federalregister.gov/articles/2016/07/15/2016-16097/medicare-program-revisions-to-payment-policies-under-the-physician-fee-schedule-and-other-revisionsp>

During Year 2, CMS will also begin to assess providers' knowledge of ADA, Section 504, and Section 1557 physical accessibility requirements. In addition, CMS will identify operational access barriers to durable medical equipment (DME) for beneficiaries. CMS will analyze claims data to identify beneficiaries with physical impairment and link with CAHPS data to compare with beneficiary experiences of care. Finally, CMS will document patient experiences with physical accessibility of health care settings through video vignettes (e.g., IOM Roundtable on People Living with Disabilities).

## Summary

The CMS Equity Plan for Medicare is an action-oriented effort to advance health equity by improving the quality of care provided to racial and ethnic minorities, sexual and gender minorities, persons with disabilities, and populations living in rural areas. The CMS Equity Plan for Medicare provides a framework ensuring better care, smarter spending, and healthier people.

In Year 1, CMS leveraged the agency's existing work and identified new high-value opportunities to expand CMS' impact on health equity. CMS made advancements across the six priorities outlined in the CMS Equity Plan for Medicare and integrated a disparities-reduction focus throughout key CMS programs, models, demonstrations, and stakeholder groups serving Medicare beneficiaries. Specifically, CMS worked on increasing **understanding** and awareness of health disparities through the release of the MMD Tool, which allows users to visualize disparities in chronic diseases and health care utilization in their communities. CMS also disseminated a series of data snapshots that provide information on racial and ethnic disparities for a range of chronic conditions. CMS provided tools and resources to health care providers and staff that can be used to create actionable **solutions** for collecting and analyzing standardized data on REaL and SO/GI, and for reducing health disparities in hospital readmissions among Medicare beneficiaries. CMS coordinated knowledge sharing among experts and stakeholders around barriers to physical accessibility of health care facilities and accelerated the implementation of measurable **actions** through the proposed rule to ensure Medicare PFS payments are based on the accurate relative resource costs of services furnished to people with disabilities. In addition, through attending symposiums, conferences, and web-based trainings, CMS developed new relationships to expand the network of stakeholders working to achieve equity.

The ongoing support of CMS centers, offices and stakeholders, including QIN-QIOs, HIINs, CMS regional staff, and staff across HHS, is essential to addressing the goals of the CMS Equity Plan for Medicare. Continued collaboration is crucial to maintaining momentum and making progress in developing new solutions, deepening CMS' engagement with stakeholders, and ensuring that concerted efforts to address health equity are sustained over time.

### Exhibit 4: Year 1 CMS Equity Plan for Medicare

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**Resources and Tools  
Developed**

- Building an Organizational Response to Health Disparities—Resource Guide
- Building an Organizational Response to Health Disparities—Colorectal Cancer Screening
- Compendium of Resources for Standardized Demographic and Language Data Collection
- Data Snapshots
- Disparities Action Statement
- Guide to Preventing Readmissions among Racially and Ethnically Diverse Medicare Beneficiaries
- Health Equity Technical Assistance
- Mapping Medicare Disparities Tool
- Medicare Learning Network Training Publications
- Part C and D Performance Data Stratified by Race and Ethnicity
- Standards for Collecting Sexual Orientation and Gender Identity Data in Clinical Settings