Addressing Health Equity in Medicaid Managed Care

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The COVID-19 pandemic has pushed health equity to the forefront of policy advocacy, where it should have been all along. The vastly disproportionate effect of COVID-19 on Black, Latinx, Asian American and Pacific Islander (AAPI), and Native American people as well as people with disabilities has revealed structural bias in treatment systems, employment, and even in data collection. In many cases, the true degree of disparities remains obscure simply due to uneven and incomplete reporting on case rates, deaths, and vaccination access. As long as those reporting systems remain inadequate both during and after the pandemic, we will be flying in the fog when it comes to policies to confront and eliminate health inequities. Data disaggregation is a fundamental instrument to make visible the effects of such policies.

Advocates have long pushed states and CMS to improve Medicaid data collection and reporting on health disparities with little to show for it. The Affordable Care Act included a provision mandating data collection on a number of key demographic categories: race, ethnicity, sex, primary language, geography and disability status.[1] But that provision required dedicated appropriations to go into effect, and Congress never appropriated the funding. Civil rights laws, including Section 1557 of the ACA, support data collection to document compliance but HHS and CMS have failed to activate that lever to require data collection. More recently, in response to public comments, the 2016 update of the Medicaid managed care regulations newly required states to describe a plan to reduce health disparities for Medicaid enrollees in their quality strategy. But few states have meaningfully complied with this new requirement. The last administration failed to update its quality strategy toolkit, so states were still using 2012 forms and guidelines to update their strategies through 2020. Other initiatives to foreground health equity in quality oversight, such as performance improvement projects, have also fallen short.

Well before the pandemic struck, CMS adopted health equity as a foundational principle in its national quality strategy. It is now long past time for the agency, Congress, and other health policymakers to fulfill that principle with real and urgent action. This brief provides tools to understand the various Medicaid managed care requirements for collecting and reporting data

on health equity. Many barriers, including both a lack of funding and political will, continue to obstruct such reporting. We also explore the potential of CMS's new data reporting system, T-MSIS, for improving the quality, frequency, and transparency of health disparities data in Medicaid. Advocates may be able to use some of the federal requirements and initiatives to push for improved reporting on health disparities. Absent federal requirements, they may point to some of the more proactive states and quality measurement organizations that are implementing policies to improve health equity reporting in managed care.

About this Series

This paper is part of a larger series that updates and expands NHeLP's 2015 [Advocates' Guide to Oversight, Transparency, and Accountability in Medicaid Managed Care](#). Companion papers in this series include:

- [Medicaid External Quality Review: An Updated Overview](#) (Nov. 2020)
- [Finding and Analyzing Medicaid Quality Measures](#) (Feb. 2021)
- [Addressing Health Equity in Medicaid Managed Care Quality Oversight](#) with [Table: Links to State Quality Strategies](#) (this paper)
- State quality fact sheets: [Florida](#), [Ohio](#)
- Medicaid Managed Care: Using Sanctions to Improve Accountability (forthcoming)

Background: The Rhetoric and the Reality of Health Equity Data Reporting

Health equity should be at the forefront of any attempt to measure care quality and effectiveness. CMS's national quality strategy, finalized in 2016, sets four "foundational principles" that guide the agency's efforts to improve health and healthcare. The very first principle is to eliminate racial and ethnic disparities.[2] Throughout the document, the strategy identifies actions that could help states improve health equity, such as:

- stratifying quality reporting by race, ethnicity, disability, and primary language to help identify health inequities;
- building Information Technology infrastructure that can readily incorporate such demographic data;
- promoting stronger connections between health care settings and community resources;
- strengthening training for providers to deliver culturally competent care; and
- ensuring that educational programs, health information, and official communications are tailored to be accessible for all populations.

In this sense, the 2016 CMS Quality Strategy builds on the Affordable Care Act's never implemented requirement that "any federally conducted or supported health care or public health programs, activities or surveys" collect and report data stratified by race, ethnicity, sex, primary language, geography and disability status to the extent practicable.[3] HHS has moved to include better demographic data collection in national Medicaid population health surveys and to incorporate it into Medicaid claims database upgrades. Progress has been slow, however, with repeated examples of a lack of political will to ensure full and accurate demographic data collection and reporting. And even though demographic data is fundamental to identifying potential civil rights violations, CMS has done little to encourage data collection.

Like CMS, states with Medicaid managed care also have to develop and periodically update their own quality strategies, which should reinforce the national priorities.[4] Federal regulations lay out what those state strategies must include for managed care programs, but the prioritization of health equity has largely fallen short.[5]

Unfortunately, quality measurement in Medicaid managed care has until recently barely addressed the issue of health disparities. When CMS proposed managed care revisions in 2015, the changes did not reflect the foundational importance of health equity. In fact, commenters noted that the words "disparities" and "equity" each appeared exactly one time in the entire 200-page, triple-columned proposed rule.[6] Longstanding regulations have required states to share demographic information for each Medicaid enrollee with contracted managed care entities at the time of enrollment, but ask little more from states or from plans with regard to reporting health disparities.

CMS responded to comments by finalizing a revised rule mandating that states to develop a plan to reduce health inequity as part of their state quality strategies. Specifically, the plan must describe how the state will "identify, evaluate, and reduce, to the extent practicable, health disparities based on age, race, ethnicity, sex, primary language, and disability status."[7]

Since this new regulation went into effect, little has happened. CMS's 2012 state quality strategy toolkit merely suggests that states may document initiatives on addressing health disparities – consistent with prior regulations. Colorado's 2019 quality strategy still lists the documentation of health equity activities as an "optional response not required by CMS," because the state relied on a the 2012 quality strategy toolkit that is cross-walked to outdated regulations no longer in effect.[8] As of this writing, CMS's webpage for managed care quality strategies still refers states to a 2013 State Health Official letter for guidance on quality strategies. It advertises that an updated toolkit is "coming soon" – just as it has since September 2017.[9]

In the meantime, few states have actually articulated a meaningful health equity plan in recently updated quality strategies.[10] Colorado's 2019 document includes only one short paragraph directly addressing health disparities and equity activities in the state.[11] Similarly, Delaware's 2018 strategy has one mention of health disparities related to how the state collects and shares info on race and ethnicity (in line with the prior regulation), but no actual plan to reduce disparities.[12] Nebraska's 2020 Quality Strategy refers to disparities only once, related to collecting data on a "special health care needs population", and includes no description of its plan to reduce disparities.[13]

Collecting Accurate Demographic Data

Perhaps the largest barrier to understanding health disparities is the failure to collect complete and accurate demographic data. The quality and completeness of race/ethnicity/language data continues to be an issue across many public programs. Other demographic data, such as disability and sexual orientation/gender identity, is rarely collected. Medicare data on Black and white enrollees is very good, but still falls far short for Asian American and Pacific Islanders (AAPI), Latinx (Hispanic), and Native American enrollees.[14] Social Security no longer collects administrative data on race/ethnicity, and so researchers rely on linking social security records to one of four major population surveys to incorporate that demographic information.[15] In most cases, these linkages limit the scope of analysis for race/ethnicity to national level data.[16] Medicaid provides some promise to obtain more fine-grained state or program level data stratified by key demographics, but that capacity varies widely across the states. Despite the fact that states request some demographic data on their applications, not all applicants provide responses. In other cases, a case worker, call center staff, or other person assisting with an application/intake/admission may assign race/ethnicity without asking. Thus, incomplete or potentially inaccurate state data, along with differences in collection methodology can complicate comparisons of health disparities across states.

CMS aims to leverage a new state data reporting system, known as the transformed Medicaid Statistical Information System (T-MSIS), to improve standardization and streamline quality reporting and stratification of data by key demographics. This system collects utilization and claims data for each Medicaid program and is the foundation for Medicaid expenditures data, beneficiary demographic information, and beneficiary and provider enrollment data.[17] T-MSIS first rolled out in 2014, and all states began to report by 2016. CMS expects demographic data quality to improve as states fine-tune their systems, though that progress has been slow. As part of the T-MSIS implementation, CMS posts data on the completeness and accuracy of each state's T-MSIS files, and in 2021 for the first time validated state claims data against samples from the American Community Survey.[18] In 2018, only 17 states achieved the "low concern" category for race/ethnicity, meaning that fewer than 10 percent of files were missing and

fewer than 10 percent of the entries had discrepancies after cross-checking against the ACS.[19] Sixteen states exhibited "high concern" (16) and four had "unusable" (4) data problems related to race/ethnicity.[20] This represents a slight improvement over 2016, when 15 states had "high concerns" and 7 submitted unusable race/ethnicity data.[21]

Over time, CMS intends to use T-MSIS as a platform to replace some of the quality measure reporting that states currently perform, including the CMS Form-416 used for oversight of state programs for Early and Periodic Screening, Diagnostic, & Treatment (EPSDT) and possibly even some core measures.[22] Having all states report consistent demographic information through the same system definitely could improve cross-state quality comparisons, but first state systems will have to improve implementation, completeness, and accuracy of T-MSIS. If that goal is achieved, CMS may be able to produce quality metrics ranging from the program to the national level stratified by age, gender, race and ethnicity without needing to rely on states to report. As long as CMS ensures the transparency of T-MSIS data, this would represent a major step forward in health disparities reporting and would allow for intersectional analysis, such as mapping the compound effect of disability and race on health care access.

For now, though, T-MSIS's promise remains largely aspirational. In addition to a number of issues with the quality and completeness of some categories, data has become available for analysis only after substantial data lags. CMS first streamlines complex raw T-MSIS data into files suitable for research and analysis, known as T-MSIS Analytic Files (TAF).[23] Later, CMS makes additional changes and then releases a version available to Medicaid researchers, known as TAF Research Identifiable Files (TAF RIFs). The most recent TAF RIF files now available are from 2018 data, with 2019 TAF RIFs expected to become available later in 2021.[24] Hopefully these lags will decrease in coming years and allow for more timely analysis of health disparities data. In the meantime advocates can look to other oversight tools, like EQR reports and CMS Form 416 data, which are already available for FY2019 but may not be disaggregated.[25]

Demographic Data Collection: Additional Barriers

Reporting on health disparities often focuses on racial and ethnic differences in health care access and outcomes, but these are by no means the only salient demographic metrics for health disparities. The COVID-19 pandemic has also reveals starkly disproportionate effects based on age, geography, disability, and sexual orientation and gender identity (SO/GI).[26] Collecting Medicaid demographic data for some of these demographic categories is both sparse and inconsistent. Very few states systematically collect Medicaid data on SO/GI categories or for intersex individuals.[27] A 2015 final rule did require that certified Electronic

Health Records systems have to have the capability of collecting SO/GI data, but does not require states or providers to collect that data.[28] "Disability" is a very difficult word to define, and so the parameters used and questions asked have a tremendous effect on the size and characteristics of the population of people with disabilities.

For example, Medicaid managed care regulations stipulate that "disability" for quality-related reporting is, at a minimum, those individuals who qualify for Medicaid through a disability-related eligibility category.[29] But many Medicaid disability-related categories rely on strict Social Security criteria for defining a disability. We also know from various studies that roughly 20 to 30 percent of uninsured, low-income adults who qualify through Medicaid expansion group report living with a disability.[30] Such individuals would not be included in the group of "disabled adults" unless a state went beyond the minimum standard.

It is important to understand the current limitations in collecting demographic data on Medicaid beneficiaries, and to qualify analyses based on those limitations. But these current limitations should not overshadow the need for states and CMS to prioritize data collection and disaggregation now. Improvements in data collection techniques should accompany, not precede, the current advocacy push to disaggregate demographic data in quality reporting.

Policymakers working to improve data collection should plan to build in capability to analyze Medicaid data across multiple demographic groups. To really understand the effects of health inequity, researchers need to understand the compounding effect of marginalization. That is, rather than looking at race or disability, researchers and analysts should be able to disaggregate the data to look at race disparities among people with disabilities.

Addressing Health Equity through External Quality Review (EQR)

Several states have taken proactive steps to engage health equity directly through their External Quality Review (EQR) activities. EQR requires states with Medicaid managed care to contract with independent organizations to conduct oversight and quality-related activities for managed care plans. Required activities include validating quality measures and performance improvement projects, testing network adequacy, and conducting periodic compliance reviews of each managed care organization.[31] States can also add a range of optional activities – from beneficiary surveys, testing the accuracy of encounter claims, or implementing projects to identify and reduce disparities.[32] EQR can be an attractive option for states because the activities generally qualify for enhanced federal matching rates of 75 percent.[33] To this point, states have taken only fairly modest steps using this tool to provide a clearer picture of health disparities. These initial efforts could serve as launching point for similar activities in other states.

California contracted its External Quality Review Organization (EQRO), HSAG, to conduct focused studies on improving health equity, which has culminated in a series of health disparities reports.[34] The 2019 report disaggregates data from 10 different measures based on race/ethnicity, county, and primary language. Prior reports stratified up to 28 measures and also included trends over time, age, and gender for some measures.[35] In its 2018 quality strategy, the state selected a required Performance Improvement Project (PIP) topic for managed care organizations focused on addressing health disparities.[36]

Minnesota has also been active on this front since 2001, when the state Legislature created the Eliminating Health Disparities Initiative, a grant program for direct care organizations that focused on racial and ethnic disparities in eight priority health areas.[37] In late 2013, the state created a Center for Health Equity and shortly thereafter issued a landmark report that recognized the key role structural racism plays in health outcomes and included multiple health measures documenting health disparities in the state.[38] More recently, the MN Department of Human Services issued a 2019 Health Care Disparities Report comparing performance of the state's Medicaid and Basic Health Plan populations in managed care against Medicare and private insurance plans. [39] The report also stratifies nine quality measures by race and ethnicity for the Medicaid/Basic Health programs. While the report does not document trends in actually reducing health disparities, it represents one of the few state-led efforts to report regularly on health disparities among lower income Minnesotans.[40]

Alongside these efforts, Minnesota required Medicaid plans to conduct and report on three-year PIP to improve racial and ethnic disparities in depression management in its External Quality Review (EQR) technical report.[41] Unfortunately, the results were disappointing. Of eight participating plans, two showed markedly *worse* disparities after three years, three more showed little change in overall rates or disparities, two did not disaggregate their data by race, and the last two did not report or had too small a data sample.[42] Only one of eight plans reported an increase in depression management that met its stated goals, and that plan did not disaggregate the outcome by race.[43] The following year, HealthPartners was the only plan that showed a reduction in racial/ethnic disparities for this measure.[44] It is unclear what consequences plans may have faced, if any, for this apparently unsuccessful PIP.

North Carolina charged its EQRO, Carolina Centers for Excellence, with developing an annual health equity report to report on measures specifically selected to track progress in health equity.[45] Michigan and New York also produce annual health disparities reports to better track health equity outcomes.[46] Michigan's annual report stratifies by race/ethnicity for 13 quality measures.[47] A few other states have taken similar steps to require MCOs to report some performance measures stratified by key demographics like race, ethnicity, language, gender,

age, and disability. Louisiana, Nevada, and Ohio all claim in their quality strategies that they require plans to stratify some performance data by demographics.[48] It is not clear whether this data is publicly available in all cases.

Addressing Health Equity through Core Measures

Since 2012, CMS has encouraged states to report standardized sets of core quality metrics for different Medicaid populations. The Child, Adult, and Behavioral Health core measure sets are reported and reviewed annually and cover a range of measures covering different chronic conditions, preventive care, and experience of care.[49] Significant gaps in the core measures remain. For example, there are few validated quality measures for home and community-based services (HCBS) for people with disabilities. Core measure sets also fall short in that few states report results stratified to show disparities by race, ethnicity, disability, and other key demographics.

The Agency for Healthcare Research and Quality (AHRQ) has published a National Healthcare Quality and Disparities Report annually since 2003. This report documents health disparities at the national level for hundreds of measures. It shows trends over time, though the overarching message is that many disparities are persistent or worsening, even as overall performance results may be slowly improving.[50] AHRQ also has a state level dashboard for disparities, but the data sources vary from state to state, covering Medicare, private insurance, Medicaid, and more targeted health data sources like home health or nursing facility care.[51] This limits cross-state comparisons and can make it difficult to understand which population a given quality measure applies to.

Unfortunately, in Medicaid the reporting of health disparities through the core measure sets continues to be the exception, rather than the rule. None of CMS's national core measure reports includes measure results stratified by race/ethnicity or other key demographics. Those few states, like Minnesota and Michigan, that stratify some core measure results by race and ethnicity rarely post results that allow a finer grained picture of disparities, such as across health plans, or by specific providers. That specificity is key to understanding practices and interventions that may actually improve outcomes, and equity, for low-income beneficiaries. It is hard to know if plan or provider performance is really effective without reporting results stratified by key demographic categories.

Recent efforts to promote data stratification have thus far been tepid, at best. For example, CMS recently proposed a new core measure set to address the quality of home and community-based services (HCBS), which provide crucial supports for people with disabilities living in their communities. Because quality measurement has historically focused more on

acute care settings, there has long been a dearth of validated HCBS measures. On the one hand, the new measure set helps fill that gap, and so will shed light on care quality for people with disabilities. The proposed set also includes a specific domain to address health equity in HCBS. On the other hand, that health equity domain includes only one measure in the proposed set, related to primary language, and called for states to stratify only at least **one** HCBS measure by race/ethnicity. It does not push states to stratify other Adult or Child Core measures by disability, to show potential disparities in access or quality to acute care services for people with disabilities. Setting such a low bar for a recommendation only serves to perpetuate the inadequate status quo.

> ### Health Equity First Steps: Stratifying Data by Race/Ethnicity
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> Measuring health equity means identifying health disparities. To make disparities visible, states must require plans to report standard measures stratified by race/ethnicity and other key demographic data. This can reveal specific populations that should receive extra attention to improve care delivery.
>
> For example, Michigan has produced annual health disparities reports that stratify thirteen measures by race/ethnicity. Without stratification, Michigan HEDIS results would show that 60.6% of pregnant women in Medicaid managed care received recommended post-partum care. Disaggregating the data by race/ethnicity revealed stark disparities, with African American women (54.1%) and Native Americans (57.8%) lagging far behind White women (63.3%) and Asian and Pacific Islanders (71.9%) in post-partum care.[52] These results reveal an urgent need to develop interventions designed to meet the needs of African American and Native American women that would not have been visible without stratification.
>
> Importantly, Michigan's disparities report tracks changes in disparities over time. Six years of reporting shows their stubborn persistence. Rates for African Americans have remained below that of Whites for ten measures since reporting began in 2012, and only a few have seen significant reductions.[53] Few other states have required this level of stratification in quality reporting.

However, change may be afoot. Two recent developments show promise that core measures may open up powerful advocacy opportunities. First, in 2020 Congress mandated for the first time that all states begin to report the Behavioral Health and Child Core Measure sets by 2024.[54] Previously, CMS had left core measure reporting at state option. This mandate creates a window where advocacy successes on core measures at the federal level can generate rapid, nationwide changes in how these measures are reported.

Second, the National Committee for Quality Assurance (NCQA), the steward for the most widespread national quality measure set, proposed changes in February that would require health plans to report measures stratified by key demographics within the next three years.[55] NCQA's Healthcare Effectiveness Data and Information Set (HEDIS®) consists of over 90 measures that cover health care services provided to over 190 million people.[56] Health plans in the private commercial market, Medicaid, and Medicare Advantage all report HEDIS measures, and the proposed changes would cross all three product lines.[57] NCQA is also a major health plan accreditor. If it pushes such changes in data reporting, health plans will listen.

NCQA's proposed plan calls for plans to stratify five measures for measure year 2022, expanding to 15 measures by 2024.[58] Plans would, at first, be allowed to collect Race, Ethnicity and Language (R/E/L) data indirectly, such as through census tracts or using surname coding, but would later have to collect the data directly from surveyed enrollees. The preliminary list of measures included Controlling High Blood Pressure, Comprehensive Diabetes Care Blood glucose control, Comprehensive Diabetes Care Eye Exam, Antidepressant Medication Management, Adults' Access to preventive/Ambulatory Health Services, Prenatal and Postpartum Care, two measures of Wellcare Visits, and one on Mental Health Utilization.[59]

In 2021, NCQA is the measure steward for 13 of the 22 child core measures and 13 of 23 adult core measures.[60] If health plans begin to report HEDIS® data to identify racial and ethnic health disparities, overcoming the administrative challenges of stratifying data for quality reporting would get much easier. It would open the door to measuring Medicaid quality at the plan and perhaps even the provider level. The remaining challenge would be to convince states to require public reporting of the results of these measures.

Health Equity and Risk-Based Adjustment of Quality Measures

One ongoing debate in the field of quality measurement involves the use of risk adjustment to interpret results. This relates to health equity because some of the key demographics, like R/E/L and disability, also correlate with other important social determinants of health, like income. When it comes to policymaking, one way to enforce quality is to tie measure results to financial incentives. However, if a provider or a health plan typically treats a population with more health care needs, the health outcomes of that population will likely be worse even if the care provided was of equal quality. Proponents of risk adjustment argue that it prevents penalizing providers simply because they serve more disadvantaged communities.

Financial structures that link payment to outcome measures require careful evaluation weighing whether to apply a risk-adjustment. On the one hand, a provider or plan that serves a generally sicker, older, or lower income population might be more likely to not achieve the outcome goal and end up losing resources. For example, Medicare penalizes hospitals with excess hospital readmissions within 30 days of an inpatient stay (i.e. above the national average). Safety-net hospitals have been more likely to face financial penalties partly because more of their patients have lower incomes, less stable housing, and other social risk factors.[61] Initially, Medicare did not risk-adjust for social factors in hospital readmissions, but in 2016 Congress required HHS to adjust outcomes for the proportion of fully dual eligible (Medicaid + Medicare) beneficiaries a hospital treats.[62] This reduced the penalties safety-net hospitals faced.[63]

On the other hand, adjusting all metrics for expected disparities might simply lower the bar by building in an expectation that plans and providers serving lower income or other disadvantaged groups should have lower outcomes. In short, risk-adjusting performance measures could obscure ongoing health disparities.[64] One way to avoid this would be to emphasize improvement over objective outcomes, or create financial incentive structure otherwise increases resources to plans or providers with higher risk populations.

The National Quality Forum recommends measures-specific evaluation to decide whether risk-adjustment is appropriate. Not all measures need risk adjustment, and in some cases, poor quality data on social risk factors could introduce bias and uncertainty into a risk adjustment model.[65] CMS has created a useful background resource that delves into the various criteria necessary for effective risk adjustment.[66] As data stratification becomes more common, responsible risk adjustment will play a magnified role in quality improvement programs.

Conclusion

The COVID-19 epidemic, which has had a profoundly disparate impact on communities of color and lower-income individuals, has shone a spotlight on major shortcomings in quality data reporting related to health equity. The long-lasting effects of the epidemic will likely worsen health and health care disparities in the coming years unless government and the industry take major steps to prioritize initiatives to reduce disparities.

The first step in designing interventions is adequately describing the problem. Reporting quality measures stratified by key demographics helps identify specific health disparities, and so represents one critical tool that HHS and states should immediately prioritize across Medicaid quality reporting.

But identifying the problem means nothing without planning and action. The Medicaid external quality review offers one tool for states to leverage more federal resources to engage in this type of equity work. Beyond demanding data stratification in quality reporting, advocates can push their state to use EQR to conduct direct tests of network adequacy and accessibility, require and then audit the quality of performance improvement projects targeted at reducing health disparities, and hold health plans accountable to annual EQR recommendations for improvement.

CMS must also urgently push states to incorporate health equity more thoughtfully and fundamentally into their quality strategies. Establishing clear goals, designing thoughtful interventions informed by input from community-based stakeholders, and directing enough Medicaid resources to improve access to care and health outcomes for individuals from disadvantaged backgrounds is what will actually help to build more health equity into our health care system.

ENDNOTES

[1] 42 U.S.C. § 300kk (codifying ACA § 4302(a)).

[2] CMS, *CMS Quality Strategy 2016*, 5 (2016), http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityInitiativesGenInfo/Downloads/CMS-Quality-Strategy.pdf.

[3] 42 U.S.C. § 300kk (codifying ACA § 4302(a)). The ACA § 4302 language is also due for updating. For example, current advocacy typically includes age, sexual orientation, and gender identity on any list of key demographic data to collect, but it was not part of the ACA.

[4] 42 C.F.R. § 438.340.

[5] 42 C.F.R. § 438(b).

[6] Equity also appeared five times referring to the Mental Health Parity and Addiction Equity Act, and twice referring to equity in the form of capital resources.

[7] 42 C.F.R. § 438.340(b)(6). *See also*, 81 Fed. Reg. 27680, 27696-7 (2016).

[8] Colorado 2019 Quality Strategy, 12 (2019), www.colorado.gov/pacific/sites/default/files/2019%20State%20of%20Colorado%20Quality%20Strategy%20June19.pdf.

[9] State Quality Strategies, Medicaid.gov, https://www.medicaid.gov/medicaid/quality-of-care/medicaid-managed-care-quality/state-quality-strategies/index.html, (last visited May 19, 2021). Wayback Machine capture (Sept 25, 2017): https://web.archive.org/web/20170925141423/https://www.medicaid.gov/medicaid/quality-of-care/medicaid-managed-care/state-quality-strategy/index.html.

[10] The 2016 final rule asserted that states would not be held out of compliance with this change until July 1, 2018.

[11] *Id* at 16.

[12] Del. Health and Soc. Servs., *Quality Strategy 2018* (2018), https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/de/Diamond-State-Health-Plan/de-dshp-quality-strategy-2018.pdf.

[13] Neb. Dept. Health and Human Servs., Div. of Medicaid and Long-Term Care, *Quality Strategy for Heritage Health and the Dental Benefit Program 2020*, 7 (2020), https://dhhs.ne.gov/Documents/NE%20Quality%20Strategy.pdf.

[14] Olga F. Jarrin et al., *Validity of Race and Ethnicity Codes in Medicare Administrative Data Compared with Gold-standard Self-reported Race Collected During Routine Home Health Care Visits*, 58 MEDICAL CARE e1 (2020).

[15] Patricia P. Martin, *Why Researchers Now Rely on Surveys for Race Data on OASDI and SSI Programs: A Comparison of Four Major Surveys*, 2016–01, RESEARCH AND STATISTICS NOTE (2016), https://www.ssa.gov/policy/docs/rsnotes/rsn2016-01.html.

[16] *Id.*

[17] CMS, Transformed Medicaid Statistical Information System (T-MSIS), https://www.medicaid.gov/medicaid/data-systems/macbis/transformed-medicaid-statistical-information-system-t-msis/index.html (last visited Apr. 27, 2021).

[18] SHADAC, *Race/Ethnicity Data in CMS Medicaid (T-MSIS) Analytic Files Updated February 2020 -- Features 2018 Data*, State Health Access Data Assistance Center News (2021),

https://www.shadac.org/news/raceethnicity-data-cms-medicaid-t-msis-analytic-files-updated-february-2020-%E2%80%93-features-2018.

[19] SHADAC, *Race/Ethnicity Data in CMS Medicaid (T-MSIS) Analytic Files Updated February 2020 -- Features 2018 Data*, State Health Access Data Assistance Center News (2021), https://www.shadac.org/news/raceethnicity-data-cms-medicaid-t-msis-analytic-files-updated-february-2020-%E2%80%93-features-2018.

[20] The four states with "unusable" data in 2018 were MS, NE, TN, and RI. CMS, DQ Atlas, 2018 Race and Ethnicity (last visited Apr. 1, 2021), https://www.medicaid.gov/dq-atlas/landing/topics/single/map?topic=g3m16&tafVersionId=16.

[21] CMS, DQ Data Atlas, 2016 Race and Ethnicity (last visited Apr. 1, 2021), https://www.medicaid.gov/dq-atlas/landing/topics/single/map?topic=g3m16&tafVersionId=7.

[22] U.S. Govt. Accountability Off., Medicaid: Additional CMS Data and Oversight Needed to Help Ensure Children Receive Recommended Screenings (Aug. 2019), https://www.gao.gov/products/gao-19-481.

[23] CMS, DQ Atlas Resources, https://www.medicaid.gov/dq-atlas/landing/resources (Last visited Apr. 27, 2021).

[24] *Id.*

[25] CMS, Early and Periodic Screening, Diagnostic, and Treatment FY 2019 data, https://www.medicaid.gov/medicaid/benefits/downloads/fy-2019-data.zip (last visited Apr. 27, 2021).

[26] Megan M. Reprecht et al., *Evidence of Social and Structural COVID-19 Disparities by Sexual Orientation, Gender Identity, and Race/Ethnicity in an Urban Environment* 80 J. Urban Health 27 (2021), https://link.springer.com/article/10.1007/s11524-020-00497-9; H. Stephen Kaye, *New Analysis of COVID-19 Mortality Risk for Californians with Disabilities Receiving IHSS or DDS services, with Appendix of Demographic Data* (2021), https://dredf.org/2021/02/01/new-analysis-of-covid-19-mortality-risk-for-californians-with-disabilities-under-age-65/.

[27] In a review of 44 state applications, Oregon was the only state we identified that includes a range of gender identity options on its Medicaid application. Ore. Dept. Health Services, *Application for Oregon Health Plan Benefits*, 6 (Last visited May 10, 2021), https://sharedsystems.dhsoha.state.or.us/DHSForms/Served/he7210.pdf. Providers and states may also want to identify potential health disparities for intersex individuals. For more information on data collection for intersex individuals, see *Intersex Data Collection: Your Guide to Question Design*, InterACT (Last visited May 12, 2021), https://interactadvocates.org/intersex-data-collection/.

[28] Medicare and Medicaid Programs; Electronic Health Record Incentive Program – Stage 3 and Modifications to Meaningful Use in 2015 Through 2017, 80 Fed. Reg. 62762, 62859 (Oct. 16, 2015). *See also*, NASTAD, *Modernizing Programs to Collect Sexual Orientation and Gender Identity Data* (June 8, 2017), https://www.nastad.org/sites/default/files/sogi.issue_.brief_.final_.pdf.

[29] 42 C.F.R. § 438.340(b)(6).

[30] David Machledt, Nat'l Health Law Program, *Faces of the Medicaid Expansion: Filling Gaps in Coverage* (May 2021), https://healthlaw.org/resource/the-faces-of-medicaid-expansion-filling-gaps-in-coverage/.

[31] 42 C.F.R. § 438.358.

[32] *Id.*

[33] 42 C.F.R. § 438.370. The enhanced matching rate is only available for EQR related to managed care organizations.

[34] HSAG and Cal. Dept. Health Care Servs. Managed Care Quality & Monitoring Division, *2019 Health Disparities Report*, (Dec. 2020), https://www.dhcs.ca.gov/dataandstats/reports/Pages/MgdCareQualPerfDisp.aspx.

[35] HSAG and Cal. Dept. Health Care Servs., 2018 Health Disparities Report (Feb. 2020), https://www.dhcs.ca.gov/Documents/CA2018-19-Health-Disparities-Report.pdf.

[36] Cal. Dept. Health Care Servs., *Medi-Cal Managed Care Quality Strategy Report*, 20 (July 2018).

[37] The eight health priorities areas are: Breast and Cervical Cancer, Diabetes, Heart Disease and Stroke, HIV/AIDs and STIs, Immunizations, Infant Mortality, Teen Pregnancy, Unintentional Injury and Violence. Minn. Department of Health Ctr. for Health Equity, *Eliminating Health Disparities Initiative: Report to the Legislature*, 9-11 (Mar. 2019), https://www.health.state.mn.us/communities/equity/reports/legislativerpt2019.pdf; Minn. Dept. of Health, Health Equity Reports and Publications: Advancing Health Equity (Last visited Feb. 26, 2020), https://www.health.state.mn.us/communities/equity/reports/index.html.

[38] Minn. Department of Health, *Advancing Health Equity in Minnesota: Report to the Legislature* (Feb. 2014), https://www.health.state.mn.us/communities/equity/reports/ahe_leg_report_020114.pdf.

[39] Jess Donovan, Minn. Dept. Human Services and Minn. Comm. Measurement, *2019 Health Care Disparities Report for Minnesota Health Care Programs* (May 2020), https://mn.gov/dhs/partners-and-providers/news-initiatives-reports-workgroups/minnesota-health-care-programs/.

[40] Only limited comparisons can be made with prior reports. Only two measures, Childhood Immunization Status and Breast Cancer Screening, overlap with the measures reported in 2017. Those show no change or even slight worsening of disparities, though the report cautions against year-over-year comparisons due to occasional changes in measure specifications. *See* Kevan Edwards et al, Minn. Dept. Human Services and Minn. Comm. Measurement, *2017 Health Care Disparities Report for Minnesota Health Care Programs*, 60-64 (2018), https://www.leg.mn.gov/docs/2018/mandated/180473.pdf.

[41] Island Peer Review Org. ["IPRO"], *Minnesota EQR Technical Report 2017*, 15 (Apr. 2019), https://edocs.dhs.state.mn.us/lfserver/Public/DHS-6888E-ENG. Blue Plus showed an increasing disparity of 8 percentage points over 3 years. Hennepin Health showed an increase of 14.3 percentage points over the same period.

[42] *Id.* at 18, 31, 43, 55, 66, 75, and 89.

[43] *Id.* at 89.

[44] IPRO, *Minnesota EQR Technical Report 2018*, 20, 32, 45, 56, 76, 92, 105 (Apr. 2020), https://edocs.dhs.state.mn.us/lfserver/Public/DHS-6888F-ENG.

[45] N.C. Dept. Health and Human Servs., *North Carolina's Medicaid Managed Care Quality Strategy*, 60 (Apr. 5, 2021), https://files.nc.gov/ncdma/DRAFT_Quality-Strategy-public-comment_2021-04-05.pdf.

[46] See, e.g., NY Dept. of Health, *2017 Health Care Disparities in New York State: A Report on Health Care Disparities for Government Sponsored Insurance Programs* (2017), https://www.health.ny.gov/health_care/managed_care/reports/docs/demographic_variation/demographic_variation_2017.pdf.

[47] Mich. Dept. Health & Human Servs., *Medicaid Health Equity Project Year 8 Report*, 18 (Jan. 2021), https://www.michigan.gov/documents/mdhhs/2018_Medicaid_Health_Equity_Report_All-Plan_Final_717143_7.pdf.

[48] For links to quality strategies, see table in the Appendix.

[49] For a deeper dive into the core measure sets, see Finding and Analyzing Medicaid Quality Measures, another paper in this series. *See also*, CMS, Adult and Child Health Care Quality Measures (Last visited Apr. 29, 2021), https://www.medicaid.gov/medicaid/quality-of-care/performance-measurement/adult-and-child-health-care-quality-measures/index.html.

[50] Agency for Healthcare Quality and Research, *2019 National Healthcare Quality and Disparities Report* (Dec. 2020), https://www.ahrq.gov/research/findings/nhqrdr/nhqdr19/index.html.

[51] Agency for Healthcare Research and Quality, National Healthcare Quality and Disparities Reports State View (Last visited Apr, 29, 2020), https://nhqrnet.ahrq.gov/inhqrdr/state/select.

[52] Mich. Dept. Health & Human Servs., *Medicaid Health Equity Project Year 7 Report*, 18 (Sept. 2018), https://www.michigan.gov/documents/mdhhs/2017_Medicaid_Health_Equity_Report_645736_7.pdf.

[53] *Id.* at 8.

[54] *See* Bipartisan Budget Act of 2018 ["BBA"], Pub. L. No. 115-123, tit. I, § 50102 (2018); Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act of 2018 ["SUPPORT Act"], Pub. L. No. 115-271, tit. V, § 5001 (2018) (codified at 42 U.S.C. 1320b-9b).

[55] Eric Musser, Measuring for Equity: The Medicaid Quality Network, NCQA Blog (Sept. 1, 2020), https://blog.ncqa.org/measuring-for-equity-the-medicaid-quality-network/.

[56] NCQA, HEDIS Measures and Technical Resources, https://www.ncqa.org/hedis/measures/ (last visited Mar. 15, 2021).

[57] NCQA, *Proposed Changes to Existing Measures for HEDIS MY 2022: Introduction of Race and Ethnicity Stratification Into Select HEDIS Measures* (Feb. 2021), https://www.ncqa.org/wp-content/uploads/2021/02/02.-Health-Equity.pdf.

[58] *Id.* at 2.

[59] *Id.* at 4.

[60] CMS, *2021 Core Set of Children's Health Care Quality Measures for Medicaid and CHIP*, (last visited Mar. 15, 2021), https://www.medicaid.gov/medicaid/quality-of-care/downloads/2021-child-core-set.pdf; CMS, *2021 Core Set of Adult Health Care Quality Measures for Medicaid and CHIP*, (last visited Mar. 15, 2021), https://www.medicaid.gov/medicaid/quality-of-care/downloads/2021-adult-core-set.pdf.

[61] Karen E. Joynt Maddox et al., *Adjusting for Social Risk Factors Impacts Performance and Penalties in the Hospital Readmissions Reduction Program* 54 HEALTH SERVS. RES. 327 (2019).

[62] CMS, *Risk Adjustment in Quality Measurement*, 2 (Sept. 2020), https://www.cms.gov/files/document/blueprint-risk-adjustment.pdf.

[63] Karen E. Joynt Maddox et al., *Adjusting for Social Risk Factors Impacts Performance and Penalties in the Hospital Readmissions Reduction Program* 54 HEALTH SERVS. RES. 327 (2019).

[64] CMS, *Risk Adjustment in Quality Measurement*, 2 (Sept. 2020), https://www.cms.gov/files/document/blueprint-risk-adjustment.pdf.

[65] *Id.*

[66] *Id.*

Appendix: State Quality Strategies

State	Links to State Quality Strategy & Equity-Related Quality Data
Alabama	Quality Strategy (2019) and quality measure performance data.
Alaska	Alaska has proposed a limited shift to managed care. Draft Quality Strategy (2019)
Arizona	Draft Quality Strategy (2018).
Arkansas	Department of Health Strategic Plan (2020)(not Medicaid specific). Though Arkansas covers low-income adults in a Section 1115 managed care premium assistance program, there is no Medicaid-specific quality strategy available on its website. The Medicaid site does have a Data and Reports page.
California	Quality Strategy (2018).
Colorado	Quality Strategy (2020).
Connecticut	No quality strategy because the state has no managed care.
Delaware	Quality Strategy (2015) on the state's quality page. 2018 Draft Quality Strategy does not appear to have been finalized.
District of Columbia	Quality Strategy (2020) and MCO Report Card: https://dhcf.dc.gov/managed-care-quality-strategy
Florida	Draft Quality Strategy (2020) available on Medicaid quality homepage. The 2017 Quality Strategy remains available.
Georgia	Quality Strategy (2021).
Hawaii	Quality Strategy (2020).
Idaho	Quality Strategy (2018).
Illinois	Quality Strategy (2021) and Health Plan Report Cards: https://www.illinois.gov/hfs/info/reports/Pages/default.aspx.
Indiana	CHIP & Medicaid reports as well as Quality Strategy (2021) available at: https://www.in.gov/fssa/ompp/5533.htm.
Iowa	Quality Strategy (2018).
Kansas	Quality Strategy (2018).
Kentucky	Draft Quality Strategy (2019).
Louisiana	Quality Strategy (2019).
Maine	No quality strategy because the state does not have managed care.
Maryland	Quality Strategy (2015) (current quality strategy not available).
Massachusetts	Quality Strategy (2018) available on the Medicaid Managed Care Reports page.
Michigan	Quality Strategy (2020).

State	Links to State Quality Strategy & Equity-Related Quality Data
Minnesota	Quality Strategy (2020). Quality Strategy details a Health Care Disparities report (through 2011).
Mississippi	Quality Strategy (2018) on state Medicaid managed care page.
Missouri	Quality Strategy (2018).
Montana	No quality strategy because the state has no managed care.
Nebraska	Quality Strategy (2020).
Nevada	Quality Strategy (2019) (found through search function).
New Hampshire	Quality Strategy (2020) and other resources: https://medicaidquality.nh.gov/standard-reports.
New Jersey	MLTSS Quality Strategy (2014) is posted on the state FamilyCare Comprehensive Demonstration page. Updated quality strategy not readily available on the state Medicaid website.
New Mexico	Quality Strategy (2019), currently in effect, is on state Medicaid quality strategy page. A 2021 Draft Strategy is also available.
New York	Quality Strategy (2014?). No clear date listed, and more recent updates not readily available on state website. Health Disparities reports from 2015-2017 (also under "quality Review Reports" tab)
North Carolina	Quality Strategy (2019) is available on the state quality strategy/ management page. A 2021 draft quality strategy is posted for comment.
North Dakota	Draft Quality Strategy (2021) is posted on state Medicaid publications page.
Ohio	Quality Strategy (2018) accompanies a consolidated Medicaid quality webpage.
Oklahoma	Quality strategy (2018) and other quality reports under "Reports" tab: http://www.okhca.org/research.aspx?id=87.
Oregon	Oregon's managed care 1115 program has an Accountability Plan (2017) posted on the Quality Improvement Program page. Each Coordinated Care Organization (CCO) also has its own quality strategy. Oregon also has a health equity measurement committee and an Office for Equity & Inclusion. Published data on performance measures disaggregated by race, a 2017 report on how OR CCOs can promote health equity. See also: Using a Health Equity Lens in the Transformation and Quality Strategy (TQS).

State	Links to State Quality Strategy & Equity-Related Quality Data
Pennsylvania	Quality Strategy (2017) is available on the state Community HealthChoices Providers Publications page. A 2020 update went out for comment in fall of 2020, but a final version does not appear to have been posted. Other quality resources available on the Physical HealthChoices Provider Publications page.
Rhode Island	Draft Quality Strategy (2019). An older 2014 Quality Strategy is posted on the state's Medicaid Reports to Government Partners page.
South Carolina	Quality Strategy (2019) posted on the SCDHHS Quality Initiatives page.
South Dakota	No quality strategy because the state has no managed care.
Tennessee	Quality Strategy (2019) available under Additional TennCare Reports.
Texas	Quality Strategy (2018) is posted on the state Quality Strategy page. An updated Quality Strategy (2021) has been submitted.
Utah	Quality Strategy (2020) posted under Resources on state managed care page.
Vermont	Quality Strategy (2020).
Virginia	Quality Strategy (2020) is available on the DMAS More Information page.
Washington	Draft Quality Strategy (2020) and updates available on Apple Health quality strategy page.
West Virginia	Quality Strategy (2019). Quality Strategy for Children and Youth Program (2019).
Wisconsin	Quality Strategy (2021).
Wyoming	Draft Quality Strategy (2020 – focused on 1915(b) waiver for targeted case management for children).