Advancing Health Equity:
A Recommended Measurement Framework for Accountability in Medicaid

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Contents

Executive Summary

There is growing national interest in adopting a standardized approach to health equity measurement. State Medicaid is at the forefront because it serves populations likely to have low income and low access to health care services, and to experience other negative effects of social risk factors. Almost all states have a form of managed care in place; most include risk-based arrangements that use quality measures to evaluate performance and accountability. This creates an opportunity to align quality and performance strategies with equity-centered approaches to address disparities and close gaps in health care and health outcomes. States have already started down this path, but their approaches have been inconsistent—in part because there has not been a holistic evaluation of which measure concepts and targets are best suited to nuances of accountability and the needs of the Medicaid population.

This report presents a health equity measurement framework that can be used by state Medicaid programs for accountability in health plan managed care contracting. Development drew from the fields of quality measurement, public health and the social sciences. Domains were based on broad review of existing conceptual and quality models. Identification of the final proposed measures followed review of over 300 measure concepts from existing quality programs and the broader literature. Measures were selected based on their relevance, validity, reliability, feasibility, scientific soundness and relationship to outcomes. Stakeholders (e.g., Medicaid agencies, managed care organizations, patient advocates, community-based organizations, clinicians, researchers) were routinely engaged throughout the development process. Their perspectives directly informed the principles that guided development of the framework, selection and structure of domains and selection of associated measures.
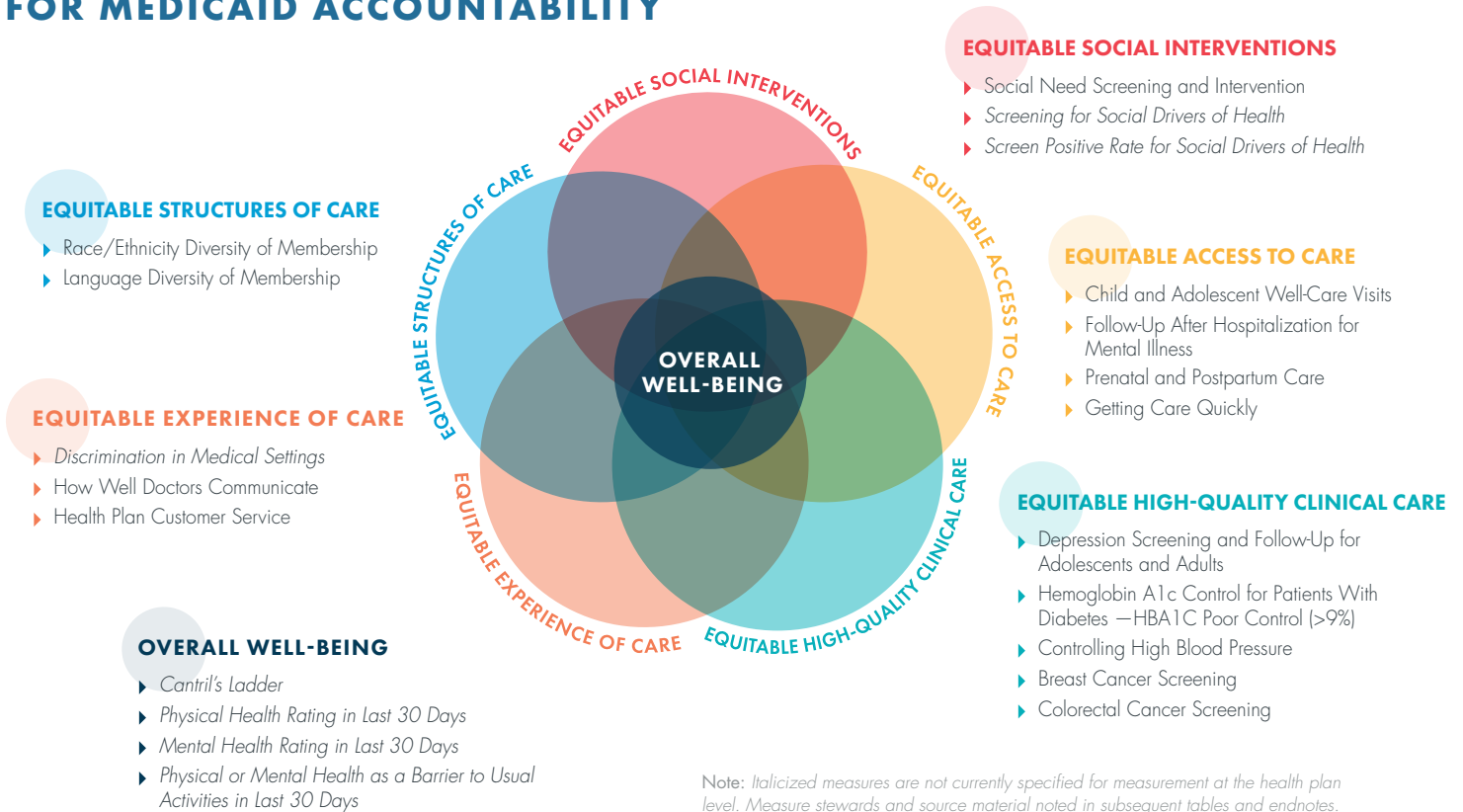
THE FRAMEWORK INCLUDES SIX DOMAINS:

Equitable Social Interventions. Measures of unmet social needs and the interventions and services designed to address them.

Equitable Access to Care. Measures of access to high-value health care services, including the timeliness and convenience of getting care.

Equitable High-Quality Clinical Care. Measures of clinical care process and outcomes, including prevention and management of chronic disease.

Equitable Experiences of Care. Member-reported measures of health care experience.

Equitable Structures of Care. Measures that assess an organization's culture and system of care for meeting the needs of individuals from diverse backgrounds and lived experiences.

Overall Well-Being. Self-reported survey metrics of physical and mental health and overall well-being.

Domains are structured to recognize conceptual and practical overlaps. For example, access to care is a prerequisite for many measures of health outcomes, and social drivers of health can impact both access and overall well-being. Achieving equitable health care and outcomes requires success across domains.

Each domain has a set of associated quality metrics, for a total of 21 across the framework as a whole. Domains and associated measures reflect elements that contribute to or reveal equities and inequities in health care and health outcomes. Many measures are already specified for health-plan level measurement and are used in existing accountability programs. Those that are not reflect concepts central to equity, and can be adapted for use at the health plan level with minimal additional specification. As quality measurement evolves and other new measure concepts are developed, it may be appropriate to update the framework to reflect this evolution.

HEALTH EQUITY MEASUREMENT FRAMEWORK FOR MEDICAID ACCOUNTABILITY

EQUITABLE SOCIAL INTERVENTIONS
- Social Need Screening and Intervention
- *Screening for Social Drivers of Health*
- *Screen Positive Rate for Social Drivers of Health*

EQUITABLE STRUCTURES OF CARE
- Race/Ethnicity Diversity of Membership
- Language Diversity of Membership

EQUITABLE ACCESS TO CARE
- Child and Adolescent Well-Care Visits
- Follow-Up After Hospitalization for Mental Illness
- Prenatal and Postpartum Care
- Getting Care Quickly

EQUITABLE EXPERIENCE OF CARE
- *Discrimination in Medical Settings*
- How Well Doctors Communicate
- Health Plan Customer Service

EQUITABLE HIGH-QUALITY CLINICAL CARE
- Depression Screening and Follow-Up for Adolescents and Adults
- Hemoglobin A1c Control for Patients With Diabetes —HBA1C Poor Control (>9%)
- Controlling High Blood Pressure
- Breast Cancer Screening
- Colorectal Cancer Screening

OVERALL WELL-BEING
- *Cantril's Ladder*
- *Physical Health Rating in Last 30 Days*
- *Mental Health Rating in Last 30 Days*
- *Physical or Mental Health as a Barrier to Usual Activities in Last 30 Days*

(Diagram center: OVERALL WELL-BEING, surrounded by domains: EQUITABLE SOCIAL INTERVENTIONS, EQUITABLE STRUCTURES OF CARE, EQUITABLE ACCESS TO CARE, EQUITABLE EXPERIENCE OF CARE, EQUITABLE HIGH-QUALITY CLINICAL CARE)

Note: *Italicized measures are not currently specified for measurement at the health plan level. Measure stewards and source material noted in subsequent tables and endnotes.*

This framework is part of a larger project to evaluate and develop standard approaches to measuring health equity in Medicaid quality programs. An overview of current health equity quality measure use and application can be found in the December 2021 publication *Evaluating Medicaid's Use of Quality Measurement to Achieve Equity Goals*. The next phase of the project will examine concepts of health equity measure composites and summary scoring to support translation of measurement approaches into accountability evaluations.

The Health Equity Measurement Framework for Medicaid Accountability broadens understanding of how equity and quality intersect, while setting minimum expectations for equitable quality through a common measure set. Although it was designed for implementation in Medicaid, its principles and identified domains could be applied more broadly in the future by adapting the associated measure list to target other populations. In the near term, implementation can help illuminate how well state Medicaid programs and contracted health plans serve Medicaid enrollees by race, ethnicity and other factors, provide data transparency and ultimately help drive improvement in care and outcomes.

Introduction

The COVID-19 pandemic has both highlighted and exacerbated disparities in health care and health outcomes for people with social risk factors (socioeconomic position, race, ethnicity and cultural context, gender, social relationships, residential and community context). These inequities are not new. For example, recent data illustrate that prior to the pandemic, people of color, particularly Black or African American, Hispanic and Native American/Alaska Native people, received lower quality of care and experienced worse outcomes across a broad range of measures related to health and health care.[1] The pandemic intensified these existing inequities; people of color are also at higher risk of COVID-19 infection, hospitalization and death than their White counterparts.[1] This has highlighted the imperative for our health care system to recognize and work to address inequities in care and disparities in outcomes directly.

State Medicaid programs are at the center of this discussion because they serve populations that are likely to have low income or low access to health care services, and to experience the negative effects of social risk factors or social determinants of health (SDOH). Over 40% of individuals enrolled in Medicaid or in the Children's Health Insurance Program (CHIP) in 2019 had family incomes below 100% of the federal poverty level.[2] They were more likely to be in fair or poor health than people who were uninsured or covered by private insurance. More than half (61.6%) of Medicaid enrollees identify as Black or African American, Hispanic, Asian or another non-White race or ethnicity.[2] Given the intersection of social risk and structural and interpersonal racism, this puts Medicaid agencies at the forefront of both measuring and addressing health equity.

State Medicaid programs are also in a unique position to address health care quality. A majority of states provide insurance coverage to Medicaid enrollees through managed care arrangements. More than two-thirds (69%) of enrollees receive care through comprehensive risk-based managed care organizations (health plans).[3] Quality measures are key elements of accountability in these programs, with payments tied to health plan performance. Integrating health equity into the quality measurement infrastructure creates a clear path to greater transparency and accountability that has the potential to improve care and outcomes for a large population. States have recognized this and have begun to apply such approaches, but implementation has been inconsistent.

To examine disparities, some states stratify quality measures in their current managed care contracts by race, ethnicity or other characteristics. A small but growing number of states are utilizing measures that address social needs and SDOH.[4] But while these steps are important, a more consistent approach is needed to achieve the potential of equity-centered quality measurement and to ensure reliable and harmonious evaluation of performance. A standardized health equity measurement framework can help illuminate how equitably Medicaid plans serve enrollees, and can ultimately help drive improvement of health care and outcomes.

This report presents a health equity measurement framework, with associated domains and measures, that state Medicaid agencies can use to assess equitable health care though quality measurement and reporting. The framework can also be leveraged by other purchasers and for quality improvement purposes. This report describes who will use the framework, and how, and includes an overview and descriptions of the framework's associated domains and measures, as well as a discussion of challenges, barriers and future opportunities.

Intended Audience and Use

INTENDED AUDIENCE

The primary audience of this framework is state Medicaid agencies and the health plans they contract with for managed care. Adopting a standardized approach to health equity quality measurement will allow Medicaid programs to track progress over time, assess performance in and between plans and compare performance to other states and programs. The framework may also inform development of quality improvement programs, helping to focus resources on programs and/or interventions most likely to contribute to improving health equity. For this reason, external quality review organizations and those that assist and facilitate quality improvement and accountability at the state level are also a natural audience.

Although it was developed with a focus on Medicaid use cases, the framework can also be leveraged by other payers, health care organizations and stakeholders across the industry as they consider approaches to measuring and improving health equity. Specifically, the framework's domains represent a holistic approach to equity that can facilitate how quality measurement is conceptualized at the local, system and federal levels. The domains include both upstream and downstream factors, accounting for multiple levels of engagement, intervention and interaction that impact health status and health equity.

HOW THIS FRAMEWORK CAN BE LEVERAGED

The framework is designed for use across states and health plans with a range of analytic and data capabilities. It is meant to be implemented in full (with a few exceptions, discussed below), with a focus on populations and services broadly covered by Medicaid programs nationally. This ensures that different elements of equity are represented and evaluated completely and in context. Allowing plans to "pick and choose" measures to report may disincentivize selecting measures perceived as more difficult, or signal a performance ceiling rather than a minimum floor from which to strive upward. But in certain cases, some flexibility in applying the measure set may be warranted. For example, some states may have carve-outs that make specific data difficult to obtain; some states with managed long-term services and supports (LTSS) programs that offer home and community-based services (HCBS) may benefit from adding or substituting HCBS survey measures specific to their populations.

The framework was developed with an eye to accountability.[5] Specifically, it is a formal evaluation of compliance and performance of health plans contracted to provide managed care services for Medicaid enrollees. This focus shaped selection of the quality measures, particularly with regard to criteria of feasibility and relevance. However, the framework can also be leveraged for quality improvement through routine evaluation of subgroups, root cause analysis and integration into quality improvement initiatives such as Plan-Do-Study-Act cycles.[6] The domains represent the different ways equity intersects with health care services and outcomes, and can be used to evaluate contributing factors, and the measures reflect meaningful targets for evaluation.

Successfully implementing the framework relies heavily, though not entirely, on stratification by groups (e.g., by race and ethnicity), and will require states to invest in collecting and making the necessary demographic data accessible to their managed care organizations. Data from the state lay the foundation for the analysis,

APPROACHES TO SCORING

The framework—and associated domains and measures—does not prescribe how Medicaid programs or health plans should aggregate or score measures for accountability. Future work under this grant will review approaches for creating health equity composites and summary scoring, and will outline criteria for use by states or others to assess those approaches.

quality improvement and accountability on which managed care organizations can build to address disparities. The ongoing update, maintenance and supplementation of the data on equity factors such as demographics sits with managed care organizations to support both quality improvement and achievement of accountability targets.

The field of quality measurement is always evolving. As the nature of equity in health care and outcomes is reevaluated to include the perspective of patients and communities, revisions to existing measures and new measure concepts should be anticipated. As such, the framework is not intended to be static. The concepts and domains are designed to be flexible to support its evolution, and specific examples are noted in the discussion of individual domains.

Principles for Framework Development

This project advances equity as a cross-cutting concept integral to all domains of health care quality. Though this differs from approaches that treat equity as a separate domain or quality target, it aligns with recent discussions on equity's position in health care quality.[7,8] Equity is fundamental to the definition of high-quality health care. Achieving high-quality care is not possible without also achieving equitable care.[7]

While addressing health equity is becoming a priority among state Medicaid programs, states and plans are at varying stages of incorporating equity into health care quality and measurement programs. With that in mind, NCQA, with input from stakeholders and states, identified principles to facilitate development of the framework for this use case.

GUIDING PRINCIPLES

Alignment: Align with health equity conceptual models and measures currently in use, where possible, while acknowledging the benefit of including domains or measure concepts without existing specified measures.

Parsimony: Limit the size and scale of the framework to maintain feasibility and to ensure consistent implementation of the highest-value measures.

Meaningfulness: Balance additional measure burden with a strong evidence base or conceptual justification that the activity being measured will lead to more equitable outcomes.

Utility: Link the framework and measures to broader goals of quality improvement and policy and payment reform, conducive to use in programs.

Equity Beyond Disparities: Integrate factors of equity that go beyond disparities (i.e., differences in subgroups).

Breadth of Focus: Remain open to quality measure concepts that are in development and may not yet be formal measures.

Acknowledge Limitations: Quality measurement as an enterprise cannot address all structural elements necessary for equity (e.g., equitable benefit design, equitable distribution of environmental resources). Our expectations for the framework should account for this, and the framework should not be interpreted as a stand-alone solution, though it may help facilitate structural change.

Frame: Measure selection was framed by racial equity as a focus, but the framework should generalize across systematically underserved groups, including by race, ethnicity, sexual orientation, gender identity, individuals with disabilities and others, recognizing intersections of identity.

Methods

The framework was developed through an iterative process of evidence review and stakeholder engagement, beginning with co-development of the guiding principles described above. These principles informed decision making as we identified, assessed and narrowed domains and associated measures. Represented stakeholders included Medicaid agencies, managed care organizations, patient advocates, community-based organizations, clinicians and researchers, and more. Refer to Appendix 4 for a description of the stakeholder engagement process.

We conducted a targeted literature review of conceptual models from the fields of quality measurement, public health, social sciences and health equity to evaluate options for framework structure and domain concepts. This included review and synthesis of quality models for health equity. We used the National Quality Forum's Domains of Health Equity Measurement framework, developed in 2017 with a specific focus on equitable quality measurement, as a reference during synthesis of findings.[9] Stakeholders were engaged throughout the process to elicit unique domain concepts and scope. Refer to Appendix 2 for a description of the framework development process.

Evaluation of candidate quality measures was concurrent with domain development and was finalized after domains were determined. Over 300 potential candidate measures currently in use or proposed for use to address health equity were inventoried from existing quality programs and the literature. Measures were reviewed against a prespecified set of prioritization criteria (validity, reliability, feasibility, scientific soundness).[10] Stakeholders prioritized policy relevance and relationship to outcomes; for example, measures of upstream care processes or factors that have the potential to prevent negative or inequitable outcomes were preferred over measures of downstream processes. Policy relevance was evaluated by comparison to priorities derived from review of existing state efforts and interviews with Medicaid leadership.[4] These criteria were used to narrow the final set of measures, understanding that the guiding principle of "parsimony" required difficult choices in determining which measures to include or exclude, until the final list was identified. This resulted in a final set of 2–5 measures per domain, for a total of 21 measures. Refer to Appendix 3 for a description of the measure selection process.

A Quality Measurement Framework for Health Equity

The framework is designed to display foundational elements that contribute to, or reflect, equities (and inequities) in health care and outcomes. The six domains are Equitable Social Interventions, Equitable Access to Care, Equitable High-Quality Clinical Care, Equitable Experiences of Care, Equitable Structures of Care and Overall Well-Being (Figure A).

FIGURE 1: Health Equity Measurement Framework for Medicaid Accountability Domains

Each domain is defined in detail in the following sections. Domains are presented in relation to each other, recognizing the conceptual and practical overlaps between concepts, as represented by the overlaps in the diagram. For example, access to care is a prerequisite for many measures of health outcomes and can be impacted by social drivers of health; intervention can also improve overall well-being.

The framework avoids implications of hierarchy, acknowledging that achieving equitable health care and outcomes require success across domains. Domains have 2–5 associated quality measures each, for a total of 21 across the full framework. Selected measures are discussed in the context of their associated domain. Refer to Appendix 1 for a complete list of measures.

We start our discussion with Equitable Social Interventions and end it in the central domain of Overall Well-Being, which is at the center of the framework to highlight its integrative nature across all domains.

EQUITABLE SOCIAL INTERVENTIONS
EQUITABLE ACCESS TO CARE
EQUITABLE HIGH-QUALITY CLINICAL CARE
EQUITABLE EXPERIENCE OF CARE
EQUITABLE STRUCTURES OF CARE
OVERALL WELL-BEING

EQUITABLE SOCIAL INTERVENTIONS

The Equitable Social Interventions domain includes measures of unmet social needs and the interventions and services designed to address them. Almost 50% of health outcomes are attributable to social determinants of health—the conditions in which people are born, grow, work, live and age.[11] Programs to evaluate and address social risks and unmet social needs have been shown to improve outcomes and are a growing focus for state Medicaid agencies.[4,12] Quality measures are an important tool to evaluate the level of unmet needs in a population, and to ensure that interventions and resources are targeted appropriately and are timely. The three measures recommended for this domain (Table 1) rely primarily on clinical data such as information in electronic health records (EHR) or medical charts, accessed either manually or through electronic clinical data sources.

TABLE 1: Recommended Measures in Equitable Social Interventions

MEASURE	MEASURE STEWARD	DATA SOURCE	ABBREVIATED DESCRIPTION
Social Need Screening and Intervention (HEDIS®)[13]	NCQA	Electronic clinical data systems	The percentage of members who, during the measurement period, were screened at least once for unmet food, housing and transportation needs using prespecified instruments and, if screened positive, received a corresponding intervention.
Screening for Social Drivers of Health[14]	The Physicians Foundation	Clinical data	Percent of beneficiaries 18 years and older screened for food insecurity, housing instability, transportation problems, utility help needs, and interpersonal safety.
Screen Positive Rate for Social Drivers of Health[14]	The Physicians Foundation	Clinical data	Percent of beneficiaries 18 years and older who screen positive for food insecurity, housing instability, transportation problems, utility help needs, or interpersonal safety.

HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).

Social Need Screening and Intervention was released in HEDIS measurement year 2023. It leverages standardized electronic clinical data to report the proportion of members who were screened for an unmet need and received an associated intervention within 30 days if they screened positive. The measure aligns with the work of the Gravity Project, a multi-stakeholder effort to develop standardized approaches to identifying and harmonizing social risk data for exchange in electronic health systems, and allows for the use of a variety of standardized screening tools.[15] It currently assesses three domains of social need, though this may expand to additional domains in the future as electronic data standards expand.

Screening for Social Drivers of Health and *Screen Positive Rate for Social Drivers of Health* are designed to be fielded together to provide a structured evaluation of a population's unmet needs. They leverage the Accountable Health Communities Health-Related Social Needs Screening Tool, which has seen broad implementation through the CMMI innovation program of the same name.[16] In 2022, these measures were recommended for use in the hospital Inpatient Quality Reporting and clinician Merit-based Incentive Payment System (posted on the Measures Under Consideration list as MUC2021-136 and MUC2021-134).[14,17]

CONSIDERATIONS FOR USE

This domain is unique in that the three proposed measures are not wholly distinct; there is overlap in intent. For example, although both *Social Need Screening and Intervention* and *Screening for Social Drivers of Health* include the proportion of the population screened, there are key differences:

- **Populations covered:** *Social Need Screening and Intervention* includes individuals under 18, while the other measures are specified for 18 and older.

- **Evaluated social needs:** All three measures include food, housing and transportation, while *Screening for Social Drivers of Health* and *Screen Positive Rate for Social Drivers of Health* also include domains of utility needs and interpersonal safety.

- **Data sources:** *Social Need Screening and Intervention* is collected via electronic clinical data, while the other two measures rely on chart review.

- **Level of specification:** *Social Need Screening and Intervention* is currently specified for measurement at the health plan level. *Screening for Social Drivers of Health* and *Screen Positive Rate for Social Drivers of Health* have been proposed primarily for the clinician and institutional levels of measurement and may need to be adapted for use in plan-level accountability.

In the current evolving measurement space, all three measures are recommended to ensure a complete and thorough evaluation of unmet social needs and the actions taken to address them. However, as federal and state programs align, states may consider limiting to measures collected in other quality programs, to reduce burden and promote consistency.

Through an accountability lens, state Medicaid programs and health plans can use these measures to assess and advance equity by stratifying performance by race, ethnicity and other sociodemographic characteristics, then evaluating plan differences between and within groups over time to ensure equitable access to key health care services. Through a quality improvement lens, rates of positive screenings can be used to target network investments; for example, by identifying specific regions to expand relationships with community-based organizations to support enrollee needs.

EQUITABLE ACCESS TO CARE

The Equitable Access to Care domain includes measures of access to high-value health care services, including the timeliness and convenience of getting care. The four measures (Table 2) align with national programs and reach across multiple priority areas identified by stakeholders (e.g., behavioral health, maternal and child health). They leverage a mix of administrative data (claims and encounters), hybrid data from the clinical record (e.g., EHR, medical chart) and survey data (member self-reported experience in accessing care).

TABLE 2: Recommended Measures in Equitable Access to Care

MEASURE	MEASURE STEWARD	DATA SOURCE	ABBREVIATED DESCRIPTION
Child and Adolescent Well-Care Visits (HEDIS)[18]	NCQA	Administrative data	The percentage of members 3–21 years of age who had at least one comprehensive well-care visit with a PCP or an OB/GYN practitioner during the measurement year.
Follow-Up After Hospitalization for Mental Illness (HEDIS)[18]	NCQA	Administrative data	The percentage of discharges for members 6 years of age and older who were hospitalized for treatment of selected mental illness or intentional self-harm diagnoses and who had a follow-up visit with a mental health provider.
Prenatal and Postpartum Care (HEDIS)[18]	NCQA	Administrative or hybrid data	Assesses access to prenatal and postpartum care: • *Timeliness of Prenatal Care.* The percentage of deliveries in which women had a prenatal care visit in the first trimester, on or before the enrollment start date or within 42 days of enrollment in the organization. • *Postpartum Care.* The percentage of deliveries in which women had a postpartum visit on or between 7 and 84 days after delivery.
Getting Care Quickly (CAHPS®)[19]	AHRQ	Survey data	The survey asked enrollees how often they got care as soon as needed when sick or injured and got non-urgent appointments as soon as needed. • Respondent got care for illness/ injury as soon as needed. • Respondent got non-urgent appointment as soon as needed.

CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).

Child and Adolescent Well-Care Visits covers an important priority population in Medicaid: Over a third of children in the U.S. were enrolled in Medicaid or in the Children's Health Insurance Program (CHIP) in 2019; that increased to roughly half during the COVID-19 pandemic.[2,20] The measure assesses whether enrollees have access to annual preventive care visits. It is included in the Medicaid Child Core Set; as many health plans already report this measure through the Core Set or other programs, it presents minimal burden for reporting.[21]

Follow-Up After Hospitalization for Mental Illness assesses access and barriers to follow-up care for enrollees hospitalized for mental illness or intentional self-harm. Regular and timely assessment of an individual's needs and treatment response after discharge is critical to ensure optimal outcome and transition back to the community. This measure also aligns with national reporting programs and is included in the Medicaid Adult and Child Core Sets, and in the Medicaid Behavioral Health Core Set, a set of 20 behavioral health measures for voluntary reporting by state Medicaid and CHIP agencies that will be used by CMS to measure and evaluate progress toward improvement of behavioral health in Medicaid and CHIP.[21–23]

Prenatal and Postpartum Care assesses whether enrollees had timely prenatal care while pregnant and timely postpartum care after giving birth. It is included in the Medicaid Adult Core Set.[22] Maternal and child health is a critical area for the Medicaid program:[4] Medicaid paid for close to half of all births in 2018.[24] Medicaid also paid for a greater share of births among Hispanic, Black or African American and American Indian and Alaska Native people, as well as births in rural areas and among those with lower levels of educational attainment.[24]

Getting Care Quickly is a composite measure from the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey, derived from two questions that ask enrollees how often they got care as soon as they needed it when they were sick or injured and for non-urgent appointments.[19] The CAHPS Health Plan Survey is included in both the Medicaid Adult and Child Core Sets and provides valuable insight into patient experiences.

CONSIDERATIONS FOR USE

From an accountability standpoint, these measures can be stratified (by race, ethnicity and other sociodemographic factors) and evaluated for disparities—and for reduction of disparities—between and within groups over time. This suite of access measures can also be used for quality improvement. Plans may consider more detailed subgroup analyses and cross-stratification to look at intersectional disparities and target interventions to groups with the highest level of unmet health needs. Evaluation of administrative processes and structures of care, such as network adequacy, can also be conducted to identify and address specific barriers.[25]

EQUITABLE HIGH-QUALITY CLINICAL CARE

The Equitable High-Quality Clinical Care domain includes measures of clinical care process and outcomes, including prevention and management of chronic disease. The five measures (Table 3) leverage a mix of administrative data (claims and encounters), hybrid data from the clinical record (e.g., EHR, medical chart) and other electronic clinical data. They include general population screening measures for both cancer and depression, and measures of chronic disease management for specific populations.

TABLE 3: Recommended Measures in Equitable High-Quality Clinical Care

MEASURE	MEASURE STEWARD	DATA SOURCE	DESCRIPTION
Depression Screening and Follow-Up for Adolescents and Adults (HEDIS)[18]	NCQA	Electronic clinical data systems	The percentage of members 12 years of age and older who were screened for clinical depression using a standardized instrument and, if screened positive, received follow-up care. Two rates: Screening and Follow-Up.
Hemoglobin A1c Control for Patients With Diabetes—HBA1C Poor Control (>9%) (HEDIS)[18]	NCQA	Administrative or hybrid data	The percentage of members 18–75 years of age with diabetes (types 1 and 2) whose hemoglobin A1c (HbA1c) was at the following levels during the measurement year: HbA1c poor control (>9.0%) indicator.

MEASURE	MEASURE STEWARD	DATA SOURCE	DESCRIPTION
Controlling High Blood Pressure (HEDIS)[18]	NCQA	Administrative or hybrid data	The percentage of members 18–85 years of age who had a diagnosis of hypertension (HTN) and whose BP was adequately controlled (<140/90 mm Hg) during the measurement year.
Breast Cancer Screening (HEDIS)[18]	NCQA	Administrative data	The percentage of women 50–74 years of age who had a mammogram to screen for breast cancer.
Colorectal Cancer Screening (HEDIS)[18]	NCQA	Administrative data	The percentage of members 45–75 years of age who had appropriate screening for colorectal cancer.

Depression Screening and Follow-Up for Adolescents and Adults covers an important clinical area in assessing behavioral health, and because it is a general population screening measure, looks at upstream factors and includes a large portion of the Medicaid population. Evidence shows that depression exacerbates negative outcomes in other clinical areas, so it is critical to screen, and to provide follow-up care for people who screen positive.[26–28] There are also existing disparities in this area: A 2008 study found that among people with a diagnosed depressive disorder, 63.7% of Latino patients and 58.8% of Black or African American patients had not accessed any mental health treatment in the past year, compared to 40.2% of non-Latino White patients.[29] This measure does require clinical data, which may be challenging for some health systems, but it is included because of its high value and clinical importance. This measure has also been recommended for inclusion in the 2023 Medicaid Child and Adult Core Sets.[30]

Both *Hemoglobin A1c Control for Patients With Diabetes—HBA1C Poor Control (>9%) and the Controlling High Blood Pressure* assess management of populations with two chronic illnesses: diabetes and hypertension. Both measures are considered disparities-sensitive by NQF and are included in the Medicaid Adult Core Set.[9,22] To increase alignment with the Medicaid Core Set and reduce burden for plans, only the HBA1C Poor Control (>9%) indicator is included for Comprehensive Diabetes Care.

Two cancer screening measures are also included: *Breast Cancer Screening and Colorectal Cancer Screening*. These measures include a large portion of the population, are considered disparities-sensitive by NQF and are included in the Medicaid Adult Core Set.[9,22] Cancer screening measures are an important tool for addressing inequities in both incidence and mortality rates for these diseases. For example, between 2010 and 2014, breast cancer mortality for Black or African American women was 41% higher than for White women.[30] Screening may be a contributing factor to this disparity; one study found that mammography use in 2006 was 65% among White women and 59% among Black or African American women, and Black or African American women are more likely than White women to have longer intervals between screening mammograms, which may lead to an increase in later-stage cancer diagnoses.[31] The incidence of colorectal cancer in the non-Hispanic Black and African American populations is 20% higher than in the non-Hispanic White population, and the mortality rate is 40% higher. Differences in screening are estimated to account for almost half this disparity.[32]

CONSIDERATIONS FOR USE

Stratification remains the primary tool for accountability, with more detailed and intersectional subgroup analyses to support quality improvement efforts. Quality improvement may also benefit from root cause analyses to determine underlying barriers and how they might differ between groups, allowing interventions to be targeted to groups with greater disparities in quality of care.

EQUITABLE EXPERIENCE OF CARE

The Equitable Experiences of Care domain includes member-reported measures of health care experience. Three measures are recommended for inclusion (Table 4). One is a survey measure covering experiences of discrimination in health care; two are from the standardized CAHPS survey.

TABLE 4: Recommended Measures in Equitable Experience of Care

MEASURE	MEASURE STEWARD	DATA SOURCE	DESCRIPTION
Discrimination in Medical Settings[33–35]	NA	Survey data	Asks respondents to indicate whether the following events have happened to them in medical settings: • Treated with less courtesy or respect than other people. • Received poorer service than others. • A doctor or nurse acts as if they think you are not smart, as if they are afraid of you, as if they are better than you or that they are not listening to what you were saying. A follow-up question asks respondent to identify what they think is the main reason for these experiences. Response options include: Ancestry or National Origins, Gender, Race, Age, Religion, Height, Weight, Some other Aspect of Physical Appearance, Sexual Orientation, Education or Income Level
How Well Doctors Communicate Composite (CAHPS)[19]	AHRQ	Survey data	This question asks enrollees how often their personal doctor explained things clearly, listened carefully, showed respect and spent enough time with them. • Doctor explained things in a way that was easy to understand. • Doctor listened carefully to enrollee. • Doctor showed respect for what enrollee had to say. • Doctor spent enough time with enrollee.
Health Plan Customer Service (CAHPS)[19]	AHRQ	Survey data	This measure asks enrollees how often customer service staff were helpful and treated them with courtesy and respect. • Customer service gave necessary information/help. • Customer service was courteous and respectful.

Discrimination in Medical Settings, while not currently part of a standardized survey already routinely fielded by plans, represents an important facet of equitable experience of care. Stakeholders strongly supported inclusion of this measure concept, and asking enrollees directly if they experienced discrimination when engaging with the health care system. This measure and set of questions are a modified version of the Everyday Discrimination Scale and were adapted for use in medical settings.[33–35]

How Well Doctors Communicate is a composite from the CAHPS health plan survey, and asks enrollees whether providers explained things clearly, listened carefully, showed respect and spent enough time with them.[19] Stakeholders have noted the importance of centering enrollee voices and member experiences when receiving care and interacting with providers—beyond whether the appropriate test or treatment was given—in assessing equity across populations.

Health Plan Customer Service, a composite measure, comprises two questions asking if the enrollee/customer was given the necessary information and assistance, and if customer service staff was respectful. The CAHPS Health Plan Survey is included in both the Medicaid Adult and Child Core Sets.[21,22]

SUPPLEMENTAL SURVEY ITEMS

Although they are not included in the framework, there are additional survey items that states and plans may find useful for assessing equity for specific populations.

For example, the Consumer Assessment of Healthcare Providers and Systems Home and Community-Based (HCBS CAHPS) Survey is geared specifically to adults receiving long-term services and supports from state Medicaid HCBS programs.[36] This survey includes a Personal Safety and Respect composite that comprises three measures of physical safety, treatment of property and respectful language and interactions with staff,[37] which align with the Equitable Experience of Care domain. The survey also includes a *Transportation to Medical Appointments* composite measure that assesses a component of access—having a way to get to appointments—and accessibility and timeliness of transportation.[37]

The CAHPS Health Literacy Item Sets, supplemental items to the CAHPS Health Plan Survey, also include questions about access and experiences of care. For example, plans can choose to include a question about how often information received from their customer service was easy to understand.[38]

CONSIDERATIONS FOR USE

Methodologic challenges should be considered when implementing these measures. Low survey response rates can present sample size challenges, particularly for smaller sociodemographic groups, which may prevent nuanced analyses. The likelihood of non-response is also not random: Groups facing higher structural barriers may be less likely to respond, which can bias conclusions drawn from results.[39] Experience measures are not collected and returned to health plans routinely, but rather annually or periodically, which can present an obstacle to quality improvement initiatives. These barriers apply both to proposed measures that are part of current standardized surveys (CAHPS) and those that are not.

Discrimination in Medical Settings faces an additional challenge because it is not currently specified with a numerator and denominator to support plan-level accountability. One option to facilitate its use would be to field it as an ad hoc question in tandem and aligned with CAHPS sampling and data collection. States should specify the survey method, including eligible population, to facilitate consistent accountability comparisons.

Barriers aside, patient-reported measures of experience are critical for understanding and addressing inequities in care, and are an outcome of specific importance to enrollees. Through an accountability lens, stratification can be used to assess differences between groups and over time. For quality improvement, states and plans can use performance in this domain to inform workforce training and engagement, conduct root cause analyses and conduct qualitative interviews with enrollees to further understand and improve their experiences of care. Understanding the dynamics of the interactions that inform patient experience survey results, and how experiences can differ between groups, may also point to necessary behavior shifts on the part of providers by uncovering patient perspectives that might not have come to light through other approaches.

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FUTURE CONSIDERATIONS FOR EQUITABLE EXPERIENCE OF CARE

The Equitable Experience of Care domain may benefit from evolution in quality measurement, with more feasible or conceptually aligned measures under development. For example, a perceived discrimination measure was proposed for CMS's CAHPS 2022 field-testing.[40] The question is currently specified for Medicare Advantage, Part D and Prescription Drug Plans, and is worded, "In the last 6 months, did anyone from a clinic, emergency room, or doctor's office where you got care treat you in an unfair or insensitive way because of any of the following things about you?" The response options are "medical history," "disability," "age," "culture or region," "language or accent," "race or ethnicity," "gender or gender identity," "sexual orientation."[40] Field-test results are anticipated in September 2022 and may be disseminated or available afterward. If a measure of perceived discrimination is included in a future version of the CAHPS survey (which plans are already routinely fielding), replacing *Discrimination in Medical Settings* with a standardized CAHPS measure (which we recommend) would reduce measurement burden.

EQUITABLE STRUCTURES OF CARE

The Equitable Structures of Care domain includes measures that assess an organization's culture and system of care for meeting the needs of individuals from diverse backgrounds and lived experiences. The two measures include data collected directly from an organization's enrollees or from enrollment information furnished by the state or other third-party sources.

TABLE 5: Recommended Measures in Equitable Structures of Care

MEASURE	MEASURE STEWARD	DATA SOURCE	MEASURE DESCRIPTION
Race/Ethnicity Diversity of Membership (HEDIS)[18]	NCQA	Member-reported and enrollment data	This measure assesses the count and percentage of members enrolled at any time during the measurement year by race and ethnicity.
Language Diversity of Membership (HEDIS)[18]	NCQA	Member-reported and enrollment data	This measure assesses the count and percentage of members enrolled at any time during the measurement year by spoken language preferred for health care and for written materials.

These measures represent a structural evaluation of a plan's ability to understand and manage the data that describe its members. *Race/Ethnicity Diversity of Membership* represents a count and percentage of members by race and ethnicity; *Language Diversity of Membership* assesses members' preferred spoken language for health care and for written materials. For both measures, it is considered "best practice" to collect data directly from members to ensure that data reflects members' self-identification.

CONSIDERATIONS FOR USE

These measures provide the information needed to evaluate completeness of a health plan's data on race, ethnicity and preferred language of members, as well as the quality of data sources. Specifically, the proportion of a plan's non-missing data (e.g., values other than unknown) and the percentage of non-missing data derived from member self-reporting (the gold standard) vs. other methods, can be compared to a target benchmark. This could include achieving a specific completeness target (alone or in combination with a requirement that a specific proportion of data come from member self-reporting), comparisons to state or national averages or other thresholds, or in-plan improvement over time. For quality improvement, these measures can be used for training and community engagement about the needs of a plan's population as reflected in these data. The measures can also be used to evaluate different approaches and initiatives to improve data collection.

FUTURE CONSIDERATIONS FOR EQUITABLE STRUCTURES OF CARE

The Equitable Structures of Care domain is an important area for assessing and improving equity, but few existing measures assess the ability of an organization's systems or processes to meet the needs of people with diverse lived experiences. Future measure development may benefit this domain as these types of measures become more common. Measures of digital health and telehealth access may be appropriate for this domain, particularly as these care avenues become more common and might be exacerbated and/or impacted by the digital divide. Another area that could benefit from future evolution is measurement of resource and network adequacy, including provider diversity as a component of an equitable network; this concept was raised frequently in stakeholder discussions.

Increased standardization of data collection for elements beyond race and ethnicity, including sexual orientation, gender identity and disability, will allow states and plans to evaluate and act on a broader range of data and inequities. As data infrastructure evolves, it should be designed to support multidirectional exchange. In requesting these data from patients, organizations have a responsibility to ensure data are actively used to improve health care, experiences and outcomes. Relevant data such as language and gender identity, which may be collected as part of the enrollment process, should be accessible at the point of care to inform clinical interactions and decision making.

In the interim, states and plans can consider standards or other improvement activities to set expectations for managing and improving structural elements—capacity, systems, processes—that facilitate provision of equitable care. Some examples of these activities include participating in standards programs such as NCQA's Health Equity Accreditation and Health Equity Accreditation Plus, implementing the National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care or deploying the Communication Climate Assessment Toolkit (C-CAT) at the plan level.[41–43]

OVERALL WELL-BEING

The Overall Well-Being domain integrates the overall benefit and impact of efforts to improve health and quality of life. Its four measures (Table 6) are self-reported survey metrics of physical and mental health and overall well-being.

TABLE 6: Recommended Measures in Overall Well-Being

MEASURE	MEASURE STEWARD	DATA SOURCE	MEASURE DESCRIPTION
Cantril's Ladder[44]	NA	Survey data	This measure is an assessment of well-being, which asks respondents to imagine a ladder with steps numbered from 0 at the bottom to 10 at the top, where the top and bottom of the ladder represent the best and worst possible life. Respondents are asked to indicate where on the ladder they feel they stand now, and where they think they will stand 5 years from now. Respondents are then categorized as follows: Thriving: 7 or higher currently, 8 or higher in 5 years Suffering: 4 or lower currently and in 5 years Struggling: in the middle or inconsistent
Physical health rating in last 30 days (BRFSS™)[45]	CDC	Survey data	Asks respondents to think about their physical health, including physical illness and injury, and for how many days during the past 30 days was their physical health not good.
Mental health rating in last 30 days (BRFSS™)[45]	CDC	Survey data	Asks respondents to think about their mental health, including stress, depression, and problems with emotions, and for how many days during the past 30 days was their mental health not good.
Physical or mental health as a barrier to usual activities in last 30 days (BRFSS™)[45]	CDC	Survey data	Asks respondents to report about how many days during the past 30 days did poor physical or mental health keep them from doing their usual activities, such as self-care, work, or recreation.

Cantril's Ladder asks respondents to assess their overall well-being—going beyond health to consider their life overall—and categorizes respondents as thriving, struggling or suffering. This measure is included in the "Well-Being in the Nation" framework, has been used by large health systems and state agencies, is fielded as part of routine Gallup polls and has been translated and tested in a variety of languages internationally.[46,47] Stakeholders strongly supported inclusion of measures assessing overall well-being, to get an individual's self-assessed, holistic view of their health and overall status.

USE OF SELF-REPORTED MEASURES OF WELL-BEING

While these measures are not currently specified at the health plan level, some plans and health systems are implementing them to assess their populations' health. For example, since 2015 Humana has used the Healthy Days survey questions from the Behavioral Risk Factor Surveillance System to track progress in its Bold Goal communities.[48] Cantril's Ladder is fielded as part of the Gallup World Poll and the Robert Wood Johnson Foundation's Culture of Health Survey, and has also been used by local health systems. For example, the Delaware Division of Substance Abuse and Mental Health rapidly deployed this and other measures at the start of COVID-19, addressing identified social needs and training care managers to use it to stratify and support patients in real time.[47]

Physical health rating in last 30 days, Mental health rating in last 30 days and Physical or mental health as a barrier to usual activities in last 30 days are from the Centers for Disease Control and Prevention's Behavioral Risk Factors Surveillance Survey (BRFSS). Survey questions are asked together as a suite. Respondents indicate the number of days (in the last 30 days) when their physical or mental health was not good, and the number of days when they could not do normal activities due to their health status. Responses are often categorized into "groups" (0, 1–4, 5–13, 14+ days).[49] These measures bridge health care quality and public health because they are commonly used in state public health equity and community health needs assessments.[50–52] Responses have been shown to strongly correlate with chronic illness, morbidity and mortality, with well-documented methods for analysis and trending.[53,54]

CONSIDERATIONS FOR USE

This domain faces similar implementation challenges as those described in Equitable Experience of Care. Proposed measures are not formally specified for use at the health plan level; states will need to define the desired denominators, as well as numerator scoring categories, to facilitate comparisons. Public health literature may help identify scoring cut-points.

The scoring methods used for measures in other domains may not be appropriate for these measures of overall well-being and health status without case-mix or other types of adjustment or stratification. However, the measures still bring critical transparency on the ultimate outcome of health services and care interventions, and present opportunities for corrective action and, potentially, public reporting. For quality improvement purposes, states and plans could use these measures to conduct subgroup analyses and cross-stratification to look at intersectional disparities, conduct root cause analyses and target interventions to specific populations.

💬 Discussion

This framework represents an effort to centralize equity in quality measurement through a set of domains that approach equity from a conceptually holistic perspective, with a parsimonious selection of associated quality measures that can be feasibly implemented into state accountability and incentive programs.

OPPORTUNITIES

A standardized approach to evaluating equity in accountability programs provides a number of advantages. First, it acts a point of alignment and common understanding of equity, and particularly of equity as a central and cross-cutting concept across quality. The framework represents the perspectives of a range of stakeholders and partners, reflecting a shared understanding of the role quality can play in advancing equity. It provides an opportunity to help build momentum and garner consensus across stakeholders, including state and health plan leadership and community members. This consensus-building has been identified as a critical factor for success in state-level initiatives to improve equity in Medicaid.[4]

Although not the first to propose domains of equitable quality measurement, this framework is unique in how it integrates lessons learned and conceptual approaches from different perspectives in the field, including findings from international health equity efforts, as well as lessons learned from public health. Quality measurement can, and should be, informed by broader public health and research efforts to improve equitable population health and outcomes, such as structures and systems of care, experience of bias and discrimination and how interactions with and outcomes of health care influence overall well-being. In the framework, this is reflected in the selection of experience and well-being measures outside existing quality programs and efforts. Quality accountability also requires a unique focus on the locus of control for the entities being measured, where fair responsibility may differ between providers, systems, plans and states. The framework provides a path to translate broader health equity concepts into a format explicitly linked to health care accountability at the health plan level.

Selection of a specific set of recommended measures, as opposed to a portfolio of measures to choose from, reduces variation in how the framework is implemented, and avoids the risk of "cherry-picking" (selecting measures that are easier to perform well on, or that an organization already performs well on). It also helps ensure that equity concepts are consistently represented, with the understanding that system-level challenges leading to inequity cannot be addressed by a single domain. Measures selected for the framework were specifically evaluated to prioritize feasibility and reduce additional measure burden, where possible.

LIMITATIONS

Creation of the framework involved a number of choices. The Medicaid managed care use case significantly influenced selection of quality measures. Because Medicaid populations were prioritized, measures for commercially insured populations, older adults in Medicare or other populations may be under-represented. However, the framework structure and domains were designed for broad application. Given the recent interest in addressing equity by national stakeholders such as the National Association of Insurance Commissioners,[55] and by state regulators such as the California Department of Managed Healthcare,[56] we expect this work to inform policy well beyond Medicaid. The domain definitions and the relationships between them are founded in concepts not specific to one population or payer, with the intent that the framework can be adapted for use in a wide range of populations and programs in the future, with targeted modification (particularly to measures in the Equitable Access and Equitable High-Quality Clinical Care domains).

The goal of this project was not to present a menu of quality measures, but a set of measures that should be implemented together to ensure consistent representation of core equity concepts. For feasibility, the measure list was constrained, resulting in the final set of 21. Some may think 21 is too many, though inclusion of measures from existing programs, such as the Medicaid Core Sets, should mitigate measurement burden. Others may think the selected measures are not enough. Measure selection was based on a thorough evaluation against state Medicaid and public health priorities, as well as on robust stakeholder engagement, but we acknowledge there may be additional processes, outcomes and concepts important for evaluating equity. This framework is intended to function as a minimum approach, not as an upper limit. We encourage users to think about other metrics that may be key to a specific program or population, and to use the framework as a guide for how those metrics can be integrated or evaluated.

Conversely, we recognize that variations in Medicaid program design and implementation may create situations where certain measures in the framework may not apply or may not be feasible. Differences in payment, data sharing and carve outs (e.g., in behavioral health) frequently present a barrier to integrated measurement. The goal should be to reduce these programmatic barriers where possible, and case studies of such efforts have shown promise.[57,58] However, in some situations, states may need to modify the measure list for feasibility. In such a case, we recommend that all measure domains be represented, to ensure the framework intent is met.

Throughout this effort, the fundamental limitations of quality measurement must be recognized. While they are an important tool, quality measures alone cannot solve inequitable systems of care. Some concepts highlighted through stakeholder engagement as critical for achieving framework goals—such as community partnerships and collaborations—may not be suited to evaluation through a standardized metric. In such cases, states, plans and communities should look to other methods for accountability. These may include accreditation and quality standards, community engagement and advisory boards or other structural approaches. This is also reflected in the framework's Equitable Structures of Care domain, which highlights how core concepts such as network adequacy can be reimagined, not only as a prerequisite for access, but also as a foundation for building a trusted system of care that can respond to the needs of individuals from diverse backgrounds, with diverse experiences.

Quality measures face technical limitations in their ability to evaluate equity. Access to accurate, complete, person-level demographic data is limited across many states, creating a barrier to evaluation of disparities, both cross-sectionally and over time (though routine collection upon Medicaid enrollment can substantially mitigate this[59]). The lack of standardized approaches to evaluating and collecting individual-level social needs presents a similar barrier to consistent evaluation and a burden to providers or health systems that may be asked to screen in multiple ways. Structured approaches to recording data on social needs and well-being in traditional health care are still evolving and may not be broadly implemented. Survey measures of access and experience may suffer from low response rates; thus, limited sample sizes may struggle to support stratification. These limitations are challenging, but not insurmountable. To reduce burden, state agencies should evaluate available tools for aligning data collection and sharing, and look to adopt innovative approaches as methods advance (e.g., online experience surveys).

LOOKING AHEAD

This process identified a number of areas for future development. There is an opportunity to expand patient-reported measures to incorporate the experiences and needs of diverse groups, in new measure concepts such as those under development to evaluate bias and discrimination, as well as new methods of collecting survey data that reach populations that experience inequities. This may include new approaches to framing questions, to clarify how responses are used, or new methods such as online surveys or text messages.[40]

The proposed framework relies on stratification of quality measures and performance comparisons between groups to evaluate differences and disparities in care. Historical approaches have focused on evaluating populations in isolation; for example, stratifying by race and ethnicity, separately by disability, separately by sexual orientation and gender identity and so on. Intersectionality tells us that neither an individual's identity, nor the oppression they experience, exists in isolation, but rather as an interaction.[60,61] Methodologic and sample size limitations have presented a barrier to more nuanced, cross-group analysis of health care quality. Evaluating new survey sample methods or analytic models that are robust to smaller sample sizes and allow evaluation of quality at the intersection will be important in a move to an equitable system of quality improvement and accountability.

Finally, as this framework and other equity measurement efforts are translated into practice, performance-scoring methods that incentivize reduction in disparities and improvement in equitable processes and outcomes must be implemented. There is currently no consensus on the best analytic methods for this type of accountability,[4,62] but in the interim, we can use traditional methods such as between and within-plan comparison on measure-level performance. Going forward, methods of quantifying inequitable outcomes, such as the index of disparity, or composite metrics that integrate performance across multiple measures and population groups may provide new opportunities. Applied with equitable payment methods that account for the resources needed to address disparities, these methods may open options for new value-based contracting approaches that explicitly centralize equity.

⧗ Conclusion

This framework represents an important step toward building accountability for equity into our health care quality systems. It integrates concepts into common domains and links those domains to quality measures, both in current use in state programs and in validated, structured measures of novel concepts central to equity, such as measures of experience of discrimination and overall well-being. By focusing on Medicaid, the framework prioritizes members of our society who face the greatest individual, structural and systemic challenges to achieving optimal health, and supports state programs that innovate to help them achieve it.

As quality measurement continues to evolve, with equity at the forefront, additional measures will need to be evaluated, and perhaps additional ways of conceptualizing the six domains presented in the framework. The framework is not intended to remain static or to be a "cap" on targets for equity in measurement. Rather, the goal is to provide a guiding model for acting now, and a place to start as states continue their work to improve health equity in Medicaid populations.

✅ Acknowledgements

ADVISORY PANELS

Several NCQA advisory panels gave their time and energy to provide valuable insights throughout the development of this framework: the Health Equity Standards Development Advisory Committee, the HEDIS Health Equity Expert Working Group, the Consumer Advisory Council and the Public Sector Advisory Council. Refer to Appendix 4 for information about these groups.

STATE, PLAN AND CBO INTERVIEWEES

This report would not be possible without the generous time and input from state Medicaid agency staff who participated in interviews and provided valuable insights. Our thanks to participants from California, Georgia, Louisiana, Michigan, North Carolina, Oregon and Pennsylvania Medicaid programs. The report also benefited from the input of Medicaid Managed Care organizations and community-based organizations that work with these plans and with state Medicaid agencies to provide services. Our thanks to the plans and CBOs in Louisiana and Pennsylvania who took the time to speak with us.

- Louisiana United Healthcare Community & State

- AmeriHealth Caritas Louisiana

- Health Partners Plans

- Volunteers of America SELA

ABOUT THE FOUNDATION

The *California Health Care Foundation* is dedicated to advancing meaningful, measurable improvements in the way the health care delivery system provides care to the people of California, particularly those with low incomes and those whose needs are not well served by the status quo. It works to ensure that people have access to the care they need, when they need it, at a price they can afford. *Learn about CHCF's approach to building health equity in California.*

Appendices

APPENDIX 1: COMPLETE MEASURE LIST

The full set of measures, by domain, are listed below. Abbreviated measure descriptions are provided for reference, but do not necessarily represent the formal measure specification—or, in the case of survey questions, the full survey set. Refer to cited sources for additional information.

APPENDIX TABLE 1.1: Final Measures in Equitable Social Interventions

Measuring unmet social needs and the interventions and services designed to address them.

MEASURE TITLE	MEASURE DESCRIPTION	NQF #
Social Need Screening and Intervention (HEDIS)[13]	The percentage of members who, during the measurement period, were screened at least once for unmet food, housing and transportation needs using prespecified instruments and, if screened positive, received a corresponding intervention.	NA
Screening for Social Drivers of Health[14]	Percent of beneficiaries 18 years and older screened for food insecurity, housing instability, transportation problems, utility help needs, and interpersonal safety.	NA
Screen Positive Rate for Social Drivers of Health[14]	Percent of beneficiaries 18 years and older who screen positive for food insecurity, housing instability, transportation problems, utility help needs, or interpersonal safety.	NA

APPENDIX TABLE 1.2: Final Measures in Equitable Access to Care

Measures of access to high-value health care services, including affordability, timeliness and convenience.

MEASURE TITLE	MEASURE DESCRIPTION	NQF #
Child and Adolescent Well-Care Visits (HEDIS)[18]	The percentage of members 3–21 years of age who had at least one comprehensive well-care visit with a PCP or an OB/GYN practitioner during the measurement year.	1516^
Follow-Up After Hospitalization for Mental Illness (HEDIS)[18]	The percentage of discharges for members 6 years of age and older who were hospitalized for treatment of selected mental illness or intentional self-harm diagnoses and who had a follow-up visit with a mental health provider. Two rates are reported: • The percentage of discharges for which the member received follow-up within 30 days after discharge. • The percentage of discharges for which the member received follow-up within 7 days after discharge.	0576
Prenatal and Postpartum Care (HEDIS)[18]	Assesses access to prenatal and postpartum care: • *Timeliness of Prenatal Care.* The percentage of deliveries in which women had a prenatal care visit in the first trimester, on or before the enrollment start date or within 42 days of enrollment in the organization. • *Postpartum Care.* The percentage of deliveries in which women had a postpartum visit on or between 7 and 84 days after delivery.	1517*
Getting Care Quickly (CAHPS)[19]	The survey asked enrollees how often they got care as soon as needed when sick or injured and got non-urgent appointments as soon as needed. • Respondent got care for illness/injury as soon as needed. • Respondent got non-urgent appointment as soon as needed.	0006

^Previously endorsed under "Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life."

*Not currently endorsed.

APPENDIX TABLE 1.3: Final Measures in Equitable High-Quality Clinical Care

Measures of clinical care process and outcomes, including prevention and management of chronic disease.

MEASURE TITLE	MEASURE DESCRIPTION	NQF #
Depression Screening and Follow-Up for Adolescents and Adults (HEDIS)[18]	The percentage of members 12 years of age and older who were screened for clinical depression using a standardized instrument and, if screened positive, received follow-up care. Two rates: Screening & Follow-Up.	0418*/ 0418e*
Hemoglobin A1c Control for Patients With Diabetes—HBA1C Poor Control (>9%) (HEDIS)[18]	The percentage of members 18–75 years of age with diabetes (types 1 and 2) whose hemoglobin A1c (HbA1c) was at the following levels during the measurement year: HbA1c poor control (>9.0%) indicator.	0059
Controlling High Blood Pressure (HEDIS)[18]	The percentage of members 18–85 years of age who had a diagnosis of hypertension (HTN) and whose BP was adequately controlled (<140/90 mm Hg) during the measurement year.	0018
Breast Cancer Screening (HEDIS)[18]	The percentage of women 50–74 years of age who had a mammogram to screen for breast cancer.	2372
Colorectal Cancer Screening (HEDIS)[18]	The percentage of members 50–75 years of age who had appropriate screening for colorectal cancer.	0034

*Not currently endorsed.

APPENDIX TABLE 1.4: Final Measures in Equitable Experience of Care

Member-reported measures of health care experiences.

MEASURE TITLE	MEASURE DESCRIPTION	NQF #
Discrimination in Medical Settings*[33–35]	Asks respondents to indicate whether the following events have happened to them in medical settings: • Treated with less courtesy or respect than other people. • Received poorer service than others. • A doctor or nurse acts as if he or she thinks you are not smart, as if they are afraid of you, as if they are better than you or that they are not listening to what you were saying. A follow-up question asks respondent to identify what they think is the main reason for these experiences. Response options include: Ancestry or National Origins, Gender, Race, Age, Religion, Height, Weight, Some other Aspect of Physical Appearance, Sexual Orientation, Education or Income Level	NA
How Well Doctors Communicate Composite (CAHPS)[19]	This question asks enrollees how often their personal doctor explained things clearly, listened carefully, showed respect, and spent enough time with them. • Doctor explained things in a way that was easy to understand. • Doctor listened carefully to enrollee. • Doctor showed respect for what enrollee had to say. • Doctor spent enough time with enrollee.	0006
Health Plan Customer Service (CAHPS)[19]	This measure asks enrollees how often customer service staff were helpful and treated them with courtesy and respect. • Customer service gave necessary information/help. • Customer service was courteous and respectful.	0006

*Note: Discrimination in Medical Settings and the seven related questions were adapted from the Everyday Discrimination Scale; the follow-up question is from the Everyday Discrimination Scale. The question allows Discrimination in Medical Settings to include members' perceived reason for discrimination, including race and other potential factors.

APPENDIX TABLE 1.5: Final Measures in Equitable Structures of Care

Measures of an equitable culture and system of care that can meet the needs of individuals from diverse backgrounds and lived experiences.

MEASURE TITLE	MEASURE DESCRIPTION	NQF #
Race/Ethnicity Diversity of Membership (HEDIS)[18]	This measure assesses the count and percentage of members enrolled at any time during the measurement year by race and ethnicity.	NA
Language Diversity of Membership (HEDIS)[18]	This measure assesses the count and percentage of members enrolled any time during the measurement year by spoken language preferred for health care and for written materials.	NA

APPENDIX TABLE 1.6: Final Measures in Overall Well-Being

An integrative domain that captures the overall benefit and impact of efforts to improve health and quality of life.

MEASURE TITLE	MEASURE DESCRIPTION	NQF #
Cantril's Ladder[44]	This measure is an assessment of well-being that asks respondents to imagine a ladder with steps numbered from 0 at the bottom to 10 at the top, where the top and bottom of the ladder represent the best and worst possible life. Respondents are asked to indicate where on the ladder they feel they stand now and where they think they will stand 5 years from now. Respondents are then categorized as follows: Thriving: 7 or higher currently, 8 or higher in 5 years Suffering: 4 or lower currently and in 5 years Struggling: In the middle or inconsistent	NA
Physical health rating in last 30 days (BRFSS)[45]	Asks respondents to think about their physical health, including physical illness and injury, and for how many days during the past 30 days their physical health was not good.	NA
Mental health rating in last 30 days (BRFSS)[45]	Asks respondents to think about their mental health, including stress, depression and problems with emotions, and for how many days during the past 30 days their mental health was not good.	NA
Physical or mental health as a barrier to usual activities in last 30 days (BRFSS)[45]	Asks respondents to report about how many days during the past 30 days poor physical or mental health kept them from doing their usual activities, such as self-care, work or recreation	NA

APPENDIX 2: FRAMEWORK DEVELOPMENT

LITERATURE REVIEW

The literature review was centered on the following research question: "What equity measurement frameworks currently exist, and what are their core components?" NCQA reviewed current equity measurement frameworks and conceptual models in the literature. We identified 47 sources for review, including peer-reviewed literature, white papers, reports and issue briefs from nonacademic settings.

APPENDIX TABLE 2.1: Literature Review Analysis Questions

Is this a formal framework?

What perspective is the framework from (e.g., state, population, federal, system)?

Is a conceptual model cited as the foundation of framework/approach?

Was the framework limited to a specific population or sub-population?

What domains of focus were identified?

What are the number of domains?

Is there a particular figure depicting the framework and if so, which one?

How was framework developed/justified?

How is framework structured (e.g., unidirectional flow, multidirectional flow, hierarchy, cycle)?

Were specific metrics or measurement targets identified? If by domain, include domain.

What is the number of total measures or metrics linked to the framework?

What outcomes are the frameworks designed to improve?

Is the framework currently in use for quality improvement?

Is an approach to evaluate the framework defined?

Has the framework been used in practice for quality improvement or evaluation?

APPENDIX TABLE 2.2: Literature Review Breakdown

LITERATURE REVIEW BREAKDOWN			
Literature Type	Full Text Review	Excluded for Relevance	Final Relevant Articles
Peer reviewed	32	5	27
Gray literature	13	0	13
Other	2	0	2
Total	47	5	42

FRAMEWORK CONCEPTUAL MODELS

NCQA reviewed multiple conceptual models as a part of the literature review process. These models—categorical, cycle, flow/causal, hierarchy, relational—appeared repeatedly.

- In categorical models, domains do not overlap and are unrelated (Example: The Disability and Wellbeing Monitoring Framework).[63]

- In cycle models, domains are related in a circular pattern (Example: A Roadmap for Promoting Health Equity and Eliminating Disparities: The Four I's for Health Equity).[9]

- In flow models, there is a causal relationship between domains (Example: The Health Equity Measurement Framework: A Comprehensive Model to Measure Social Inequities in Health).[64]

- In hierarchical models, domains build on each other or utilize a "top down" approach (Example: Issues in Developing Multidimensional Indices of State-Level Health Inequalities).[65]

- Relational models hinge on the importance of how domains contribute to one another and/or overlap (Example: A More Practical Guide to Incorporating Health Equity Domains in Implementation Determinant Frameworks).[66]

The team used a relational model for the framework because it acknowledges the intersectional nature of health and how some health services can overlap.

Conceptual Approach: NCQA used the Modified Socio-Ecologic Model as a reference during framework development. The Social Ecological Model shows interactions among individual, relationship, community and societal factors that affect health. The National Quality Forum (NQF) modified this model to acknowledge that government, communities, organizations and providers need to intervene on behalf of public health. Multi-level stakeholder interventions can lead to better health outcomes, particularly for people experiencing adverse social conditions.

The Modified Socio-Ecologic Model is useful in identifying health plans' role in achieving health equity. NCQA decided to place health plans at the organization level to show that plans are an important intermediary that is influenced by and influences the domains around it. This is in line with stakeholder feedback that all approaches to equity must utilize a multi-level strategy, and conceptually supports inclusion of measurement concepts, with shared responsibility between the health plan and other parts of the health care environment.

Index Model: The NQF's "Domains of Health Equity Measurement" was used as an index (reference) model because it was created for and is used in the quality space.[9]

**APPENDIX FIGURE 2.A: National Quality Forum
"Domains of Health Equity Measurement"**
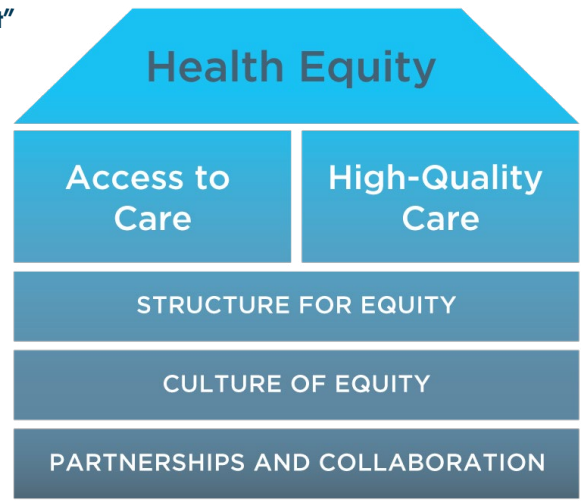
Reproduced from: A Roadmap for Promoting Health Equity and Eliminating Disparities: The Four I's for Health Equity. National Quality Forum. 2017[9]

DOMAIN FORMATION

NCQA reviewed 16 current health equity frameworks to extract domains and themes representing U.S. and international viewpoints and specific clinical areas (e.g., behavioral health), as well as health in general.[44,63,67–80] More than 90 potential domains were extracted from the set of frameworks, and evaluated and grouped thematically. Themes were then compared to the NQF framework; there were some similarities, such as access to care, high-quality care and structure. The NQF framework had to be adapted because other important themes (e.g., social determinants of health) emerged and guiding principles for the project applied (Appendix Table 2.3). Categorically, Experience of Care and Overall Well-Being domains were added, Structure for Equity and Culture of Equity were merged for parsimony and Partnerships and Collaborations was removed because it is more suited to structural metrics than to quality accountability.

APPENDIX TABLE 2.3: Example of Domain and Associated Subdomains (Overall Well-Being)

EXAMPLE DOMAIN	EXAMPLE SUBDOMAINS FROM LITERATURE
Overall Well-Being	Differences in perception of well-being
	Well-being of people
	People's perception of their well-being
	General health
	Subjective health and well-being
	Healthy people

APPENDIX 3: MEASURE SELECTION PROCESS
APPENDIX FIGURE 3.A: Measure Selection Process
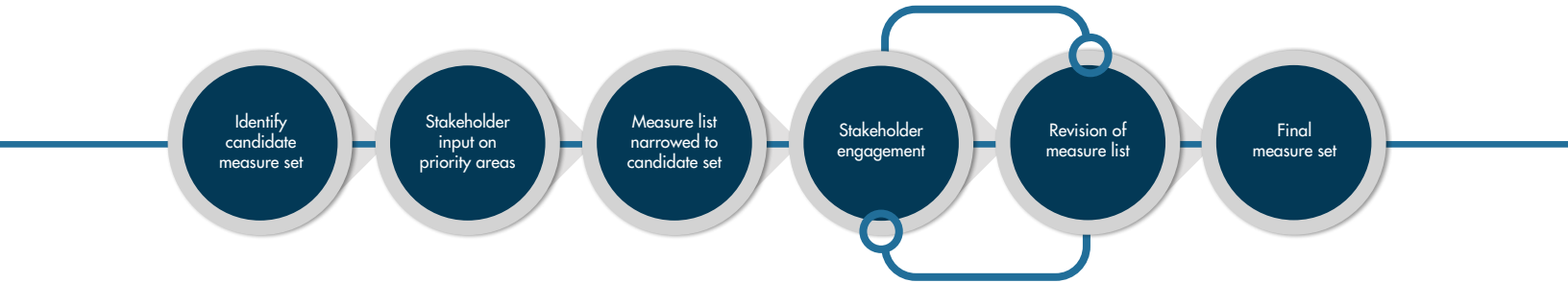
NCQA began measure selection from those identified in *Evaluating Medicaid's Use of Quality Measurement to Achieve Equity Goals* (white paper, Appendix 2 inventory[4]). This inventory of measures was compiled by NCQA during the first phase of the project. The list was supplemented by measures in the framework from domain-focused literature review, with a targeted search for measurement areas with gaps in the initial review. To prioritize a preliminary set of measures for review, measures were evaluated against standard evaluation criteria of reliability, scientific soundness, feasibility and validity, with the following specific elements included with validity:[10]

- **Relevance:** Use in existing programs (e.g., Medicaid Core Set), proximity to constructs of interest, priority areas as identified by stakeholders.

- **Relationship to Outcomes:** Where in trajectory of care the measure captures, with prioritization of upstream care processes or preventive factors.

When multiple measures that targeted the same process or outcome were identified, feasibility was used to prioritize selection. Based on stakeholder feedback, measures of upstream factors (prevention, screening) were prioritized, with the goal of incentivizing early intervention to improve equity of outcomes. Last, the measures were reviewed as a full set for representation of different populations and inclusion of key equity constructs identified through prior reviews (stakeholder or literature).

A description of the measure selection process for each domain follows.

MEASURE SELECTION SUMMARY BY DOMAIN

Equitable Social Interventions: NCQA included measures related to unmet social needs from all relevant sources reviewed, including the Inventory of Equity Measures and Use in State Programs, the Well-Being in the Nation Measurement Framework, the AHRQ National Healthcare Quality and Disparities Report and metrics derived from the literature (Changing the Conversation: Applying a Health Equity Framework to Maternal Mortality Reviews, Using Community Based Participatory Research to Develop Research).[4,44,71,75,81] The project team omitted developmental or research measures from the Healthy People 2030 "Violence Prevention," "Housing and Homes," "Transportation" and "Social Determinants of Health" domains.[82–85] After identifying alignment with the programs and criteria stated above, 107 candidate measures were identified. This list was reduced to 11 measures, which were evaluated through iterative stakeholder engagement. A final list of 3 measures was selected, based on stakeholder feedback and final review against evaluation criteria.

Equitable Access to Care: NCQA included measures related to affordability, timeliness and convenience from all relevant frameworks reviewed, including the NQF Disparities measures compendium's "Equitable Access to Care" domain (NQF Disparities Compendium), the AHRQ 2021 National Healthcare Quality and Disparities Report (AHRQ 2021 National Healthcare Quality and Disparities Report), the Institute of Medicine's Core Metrics for Health and Health Care Progress (Institute of Medicine's Core Metrics for Health and Health Care Progress) and the Well-Being in the Nation Measurement Framework (Well-Being in the Nation Measurement Framework).[44,75,77,86] From the Healthy People 2030 "Health Care Access and Quality" domain (Healthy People 2030 "Health Care Access and Quality"), NCQA excluded developmental or research measures.[87] After identifying alignment with the programs and criteria stated above, 97 candidate measures were identified. This list was reduced to 12 candidate measures, which were evaluated through iterative stakeholder engagement. A final list of 4 measures was selected, based on stakeholder feedback and final review against evaluation criteria.

Equitable High-Quality Clinical Care: Due to the large number of potential measures in this domain, NCQA did not include all relevant measures from the literature review and instead prioritized including measures from *Evaluating Medicaid's Use of Quality Measurement to Achieve Equity Goals* (white paper, Appendix 2 inventory).[4] After identifying alignment with the programs and criteria stated above, 44 candidate measures were identified. This list was reduced to 12 candidate measures, which were evaluated through iterative stakeholder engagement. A final list of 5 measures was selected, based on stakeholder feedback and final review against evaluation criteria.

Equitable Experiences of Care: NCQA included member-reported measures from all relevant sources reviewed, including the NQF Disparities measures compendium's "Culture of Equity" domain, the Well-Being in the Nation Measurement Framework, the AHRQ CAHPS Health Plan Survey and National Healthcare Quality and Disparities Report, as well as metrics derived from the literature.[19,44,75,77,86] From the Healthy People 2030 "Health Communication" domain, the project team excluded developmental or research measures.[88] After identifying alignment with the programs and criteria stated above, 76 measures were identified. The list was reduced to 8 candidate measures, which were evaluated through iterative stakeholder engagement. A final list of 3 measures was selected, based on stakeholder feedback and final review against evaluation criteria.

Equitable Structures of Care: NCQA included measures related to equitable culture and systems from all relevant frameworks reviewed, including the NQF Disparities measures compendium's "Structure for Equity" and "Culture of Equity" domains and the Well-Being in the Nation Measurement Framework.[44,86] From the Healthy People 2030 "Public Health Infrastructure" domain, NCQA excluded developmental or research measures, or any measures that were more appropriate for other domains (Healthy People 2030 "Public Health Infrastructure").[89] After identifying alignment with the programs and criteria stated above, 70 candidate measures were identified. This list was reduced to 10 candidate measures, which were evaluated through iterative stakeholder engagement. A final list of 2 measures was selected, based on stakeholder feedback and final review against evaluation criteria.

Overall Well-Being: NCQA included measures related to improving health and quality of life from all relevant sources reviewed, including the Well-Being in the Nation Measurement Framework, the Institute of Medicine's Core Metrics for Health and Health Care Progress, the AHRQ CAHPS Health Plan Survey, the Medicare Health Outcomes Survey, the Centers for Disease Control and Prevention's Behavioral Risk Factor Surveillance System and metrics derived from the literature.[44,45,77,90,91] After identifying alignment with the programs and criteria stated above, 29 candidate measures were identified. This list was reduced to 8 candidate measures, which were evaluated through iterative stakeholder engagement. A final list of 4 measures was selected, based on stakeholder feedback and final review against evaluation criteria.

APPENDIX 4: STAKEHOLDER ENGAGEMENT PROCESS
Appendix Figure 4.A: Stakeholder Engagement Process

| Identify priority areas and desirable framework attributes - Stakeholder advisory groups | → | Draft framework | → | Evaluate proposed domains and sample measures - States | → | Iterate on final measure list - Stakeholder advisory groups - Health plans - CBO |

NCQA began the stakeholder engagement process by meeting with stakeholder advisory groups, which provided direction for the framework. The proposed domains and measures framework, incorporating that input, was then presented to state Medicaid organizations as key partners in its administration, and then to health plans, community-based organizations and stakeholder advisory panels for additional feedback.

State Medicaid Organizations
NCQA spoke with the following state Medicaid organizations to hear their perspective as key partners with health plans in administering the framework:

* Louisiana.
* Pennsylvania.

Health Plans and Community Based Organizations
NCQA spoke with the following health plans and CBOs as administrators and/or key partners in implementing the framework.

* Louisiana United Healthcare Community & State: A health care organization that covers people who qualify for both Medicaid and Medicare in Louisiana.

* AmeriHealth Caritas Louisiana: A health plan that provides care to people covered by publicly funded programs, including Medicaid and the Louisiana Children's Health Insurance Program.

* Health Partners Plans: A not-for-profit health maintenance organization that provides health care to people covered by Medicaid, Medicare and the Children's Health Insurance Program in counties in Pennsylvania.

* Volunteers of America SELA: A nonprofit organization that provides affordable housing and other assistance services primarily to low-income people throughout southeastern Louisiana.

Stakeholder Advisory Groups
The HEDIS Health Equity Expert Workgroup (EWG): The EWG helps NCQA identify a path to support advancement of health equity in quality measurement, including holistic inclusion of social determinants of health in HEDIS measures. NCQA sought feedback from this panel because of its health equity expertise in the quality space.

The Health Equity Standards Development Advisory Committee (HESDAC): The HESDAC funded by a grant from The California Endowment, comprises expert representatives from health plans and community-based organizations. It functions as a learning collaborative to support continued and future health equity work in California and nationwide. NCQA sought feedback from this panel because its membership includes health plans and community-based organizations.

The Consumer Advisory Council (CAC): The CAC serves as a conduit between NCQA and health care consumers and advocates. CAC members provide NCQA with ongoing input and advice for NCQA programs, products and services; identify consumer concerns and issues for NCQA's focus; and promote understanding of NCQA's mission and programs among consumers and consumer advocates. NCQA sought feedback from this panel because its members provide a consumer point of view that is often ignored in the quality sphere.

The Public Sector Advisory Council (PSAC): The PSAC helps ensure that NCQA's Accreditation, public reporting and oversight services remain relevant and coordinated with regulatory and purchasing initiatives in the public sector. NCQA sought feedback from this panel because its focus is on accreditation and oversight, and because it works with state and federal regulators.

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