CMS Quality 2023 Conference

Building Resilient Communities:

Having an Equitable Foundation for Quality Healthcare

The Path Forward: Improving Data to Advance Health Equity Solutions

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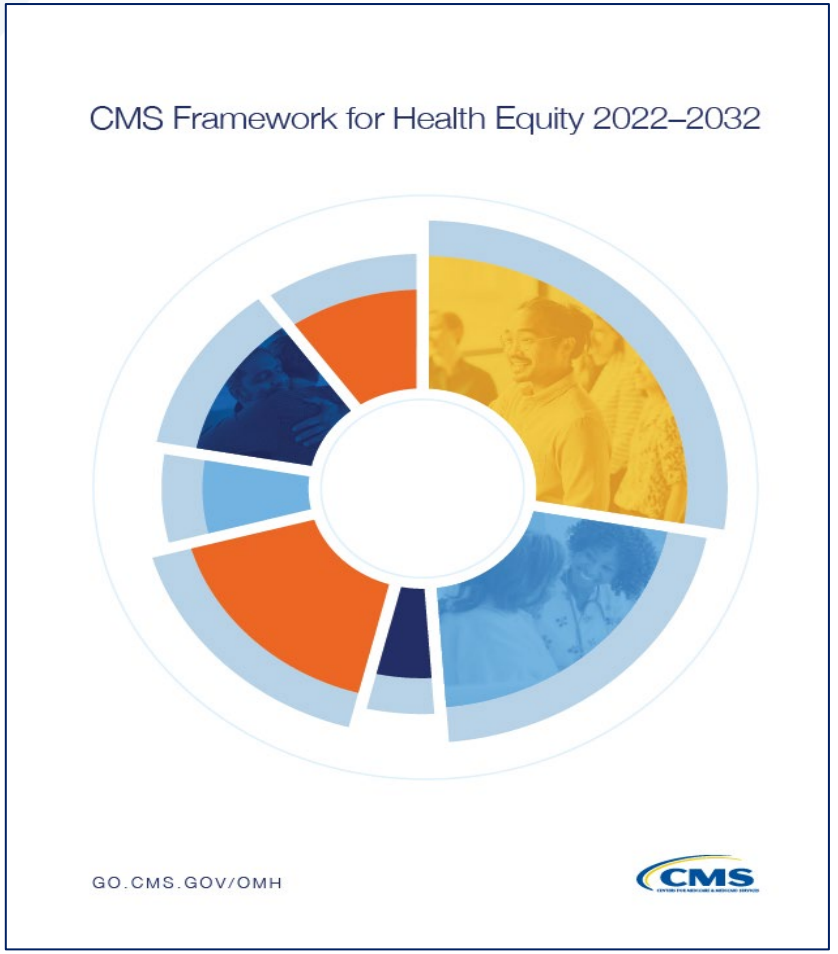
CMS Office of Minority Health Data and Policy Analytics Group

AGENDA (1)

- The Path Forward: Improving Data to Advance Health Equity Solutions
  - Report Overview
  - Health Equity Data: Current State and Challenges
  - Progress to Date
  - Future Actions
- Discussion

CMS Framework for Health Equity

- Allows a framework for CMS to operationalize health equity
- Newly released to expand on the existing CMS Equity Plan to include all CMS programs: Medicare, Marketplace, and Medicaid and CHIP
- Identifies 5 Priority Areas
- Evidence-based
  - CMS' approach to advancing health equity is informed by decades of research and years of dedicated, focused stakeholder input, and evidence review.
  - Gather and synthesize input from health care providers; federal, state, and local partners; tribal nations; individuals and families; researchers; policymakers; and quality improvement and innovation contractors.



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CMS Framework for Health Equity: 5 Priority Areas

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

Priority 2: Assess Causes of Disparities Within CMS Programs, and Address Inequities in Policies and Operations to Close Gaps

Priority 3: Build Capacity of Health Care Organizations and the Workforce to Reduce Health and Health Care Disparities

Priority 4: Advance Language Access, Health Literacy, and the Provision of Culturally Tailored Services

Priority 5: Increase All Forms of Accessibility to Health Care Services & Coverage

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Accurate and Complete Data

Accurate and complete data elements support CMS in its efforts to create evidence-based policies and regulations and to assess how well these policies and regulations align with the needs of the communities and individuals that CMS serves."

From the white paper: *The Path Forward: Improving Data to Advance Health Equity Solutions*

OMH's Data White Paper

- Describes the current state of health equity data collection and consolidation across CMS programs
- Details progress to date
- Defines CMS' future actions to continue the improvement of health equity data and achieve a future vision of health equity data at CMS

Outcomes

CMS & Administration Strategies

CMS Framework for Health Equity
Administrator's Strategic Vision Release
Executive Order 13985

Program Rules & Guidance

Proposed and Final rules for Medicare
Guidance letters to insurers and state Medicaid officials

Stakeholder Feedback

Responses to recent RFIs on health equity indices and other programs; Input from across CMS, ONC, and HRSA

CMS Internal Documents

E.g., memo to the Administrator on current state of health equity data

Intended Outcomes

- CMS has a comprehensive resource that summarizes the current state and future goals for health equity data
- Public and industry have knowledge of CMS' current state
- Public and industry understand CMS' commitment to driving health equity through improved data

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Data Driven Quality Improvement

1. Sociodemographic and SDOH health equity data can help drive quality improvement and improve program/policy evaluation

2. Despite progress, there are gaps in the availability, completeness, and quality of health equity data remain across CMS programs

3. CMS is committed to improving the quality, accuracy, and completeness of data that can enable improvements in health equity

4. Efforts to address these health equity-related data issues are already underway and will be prioritized

Health Equity Data: Current State and Challenges

Completeness, Quality and Accuracy Issues in Enrollee Sociodemographic Data Collection

Sociodemographic Data Type*	Fee-for-Service Medicare**	Medicare Advantage***	Medicaid and CHIP†	Marketplace®‡
Sex	●	●	●	●
Geography	◊	◊	○	◊
Language	○	○	○	○
Disability Status	○	○	○	○
Income	◊	◊	◊	◊
Race/Ethnicity	○	○	○	●
Sexual Orientation and Gender Identity	-	-	-	-

Key:

● Collected aligned to 2011 HHS standards

○ Collected with standards and/or completeness issue(s)

◊ Collected with no major issues, no adopted standard - Not collected

***** The data elements included in this table are the same as those prioritized in Executive Order 13985 and the CMS Framework for Health Equity, and do not encompass all data elements that could be collected or improved.[1,3] This table does not reflect quality and completeness issues in all cases.

****** Data received from SSA and collected via surveys detailed in the sections below.

******* Data collected from Medicare Part C/D enrollment form and various surveys detailed in the sections below, supplemented as needed with SSA data from Fee-for-Service Medicare.

† Data reported from states in the Transformed Medicaid Statistical Information System (T-MSIS).

‡ Data collected from the Marketplace programs using Healthcare.gov platform. Because CMS does not closely regulate data collection on State-Based Exchanges, this table shows data collected on the Federally-Facilitated Exchanges only.

Additional Health Equity Data Challenges

- CMS has **limited authority to collect** all elements (e.g., race) directly, contributing to incomplete data and preventing fully data-driven decisions
- CMS programs collect **limited SDOH data elements** in limited settings (e.g., Innovation Models)
- **Not all elements have widely adopted standards**, though some are in development (e.g., gender)
- Collecting self-reported data in limited settings results in **incomplete sociodemographic data**
- Utilization of some standardized data collection methods (e.g., Z-Codes) remains low
- Lack of disaggregated data can cloud meaningful insights
- Bias in health equity data collection methods challenges CMS's ability to interpret data

Health Equity Data at CMS: Progress to Date

Stakeholder and Advisory Engagement

Launch of the Health Equity Advisory Team (HEAT) through the Innovation Center's Health Care Payment Learning & Action Network (HCPLAN) to help identify and prioritize opportunities to advance health equity through alternative payment models nationwide

Outline of opportunities for state and local health officials to address SDOH under their programs and support officials in designing policies and interventions that can address disparities

Giving CMS and stakeholders the ability to tailor programs and policies in post-acute care settings based on needs and disparities as appropriate

Progress to Date

Collecting new data elements across CMS programs to fill existing gaps (e.g., SDOH data collection in post-acute care settings and via quality payment program participants)

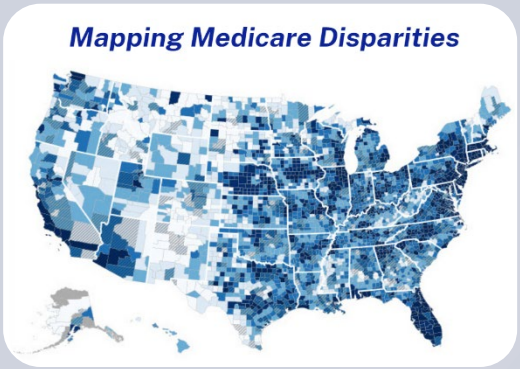
Equipping the industry with new tools and capabilities aligned to health equity goals, such as the Inventory of Resources for Standardized Demographic and Language Data Collection

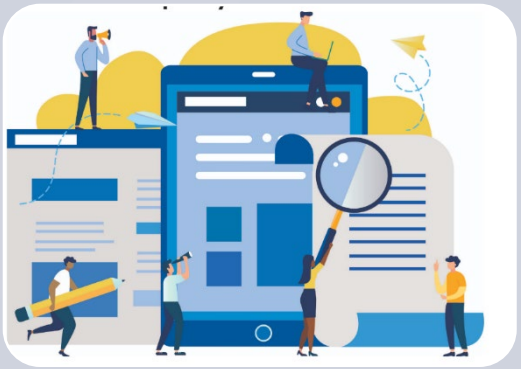
Assessing applications of the Medicare race/ethnicity imputation algorithm to other programs such as Medicaid and CHIP to improve data quality and **exploring options** to obtain self-reported race/ethnicity data

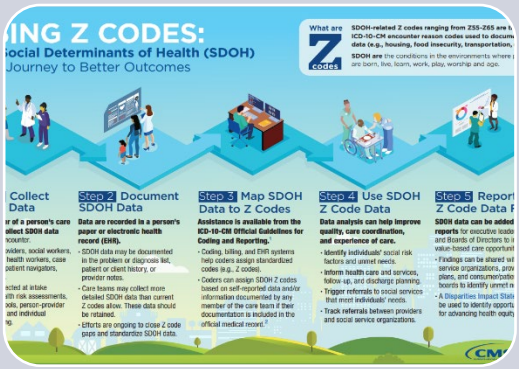
Providing access to **disaggregated data and insights** that the public can use to drive action including annual reports:

- Rural-Urban Disparities in Health Care in Medicare Report
- Dual Eligibility or Eligibility For Low-Income Subsidy National Disparities Stratified Report

Tools and Resources for Community Partners







Mapping Medicare Disparities

- An interactive map to identify areas of disparities between subgroups of Medicare enrollees in health outcomes, utilization and spending.

CMS Health Equity TA Program

- Personalized coaching and resources to help organizations embed health equity into their strategic plan
- Resources on improving care for high-risk populations
- Help developing a language access plan and ensuring effective communication.

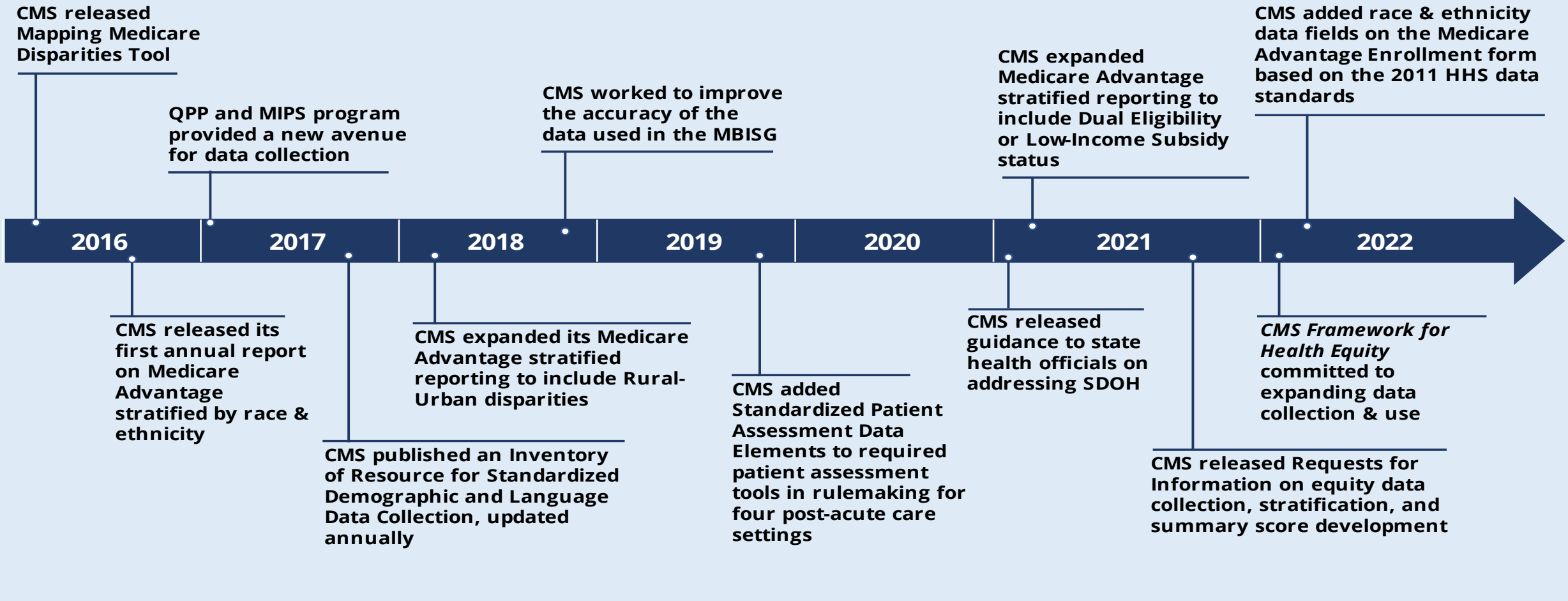
CMS Disparity Impact Statement

- A worksheet tool for all health care stakeholders to achieve health equity for racial and ethnic minorities, people with disabilities, sexual and gender minorities, individuals with limited English proficiency, and rural populations.

Z Codes Journey Map Infographic

- A step-by-step infographic for health care administrators, health care team members, and coding professionals to understand the best practice and importance of gathering and tracking SDOH data.

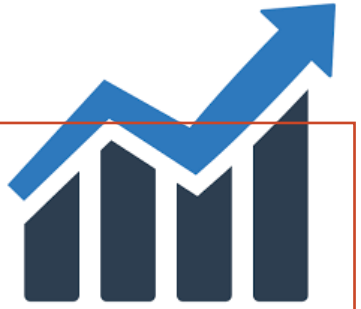
CMS Health Equity Data Highlights



Elements Critical to CMS' Health Equity Data Strategy Success

Working with Partners Across Government and Industry

CMS will continue to collaborate with other federal agencies to receive data, establish standards, and approve program changes to support equity data improvement.

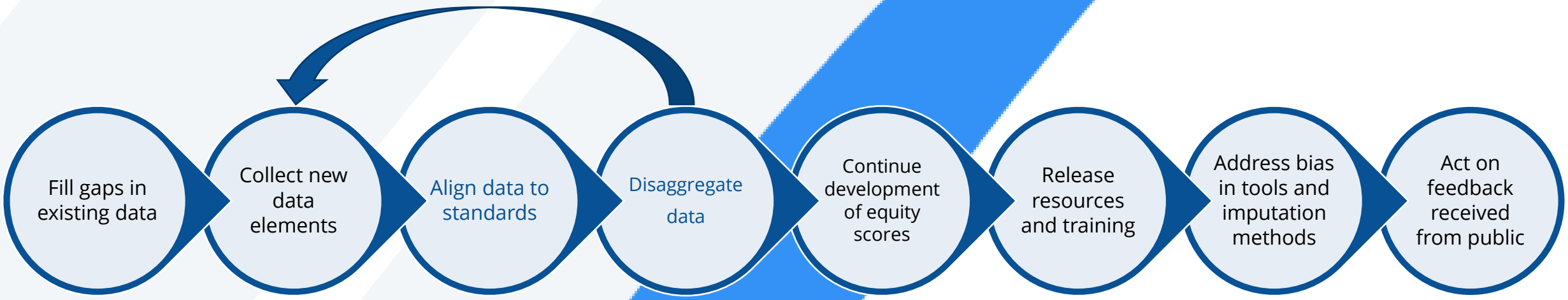


Robust Measurement of Progress

CMS will continuously monitor how CMS data collection, standardization, and use across CMS programs help achieve the following:

- Increase understanding and awareness of disparities and their causes
- Create, test, and implement solutions to advance health equity in CMS programs
- Lead sustainable actions that advance equity in CMS programs

Data Process Flow



Thank you!

CMS OMH Homepage:

go.cms.gov/omh

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Health Equity Summary Score (HESS) and HESS Dashboard:

Overview and Pilot Test Results

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vCMS Office of Minority Health

Health Equity Summary Score (HESS)

Overview of Methodology

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Medicare Advantage Health Equity Summary Score

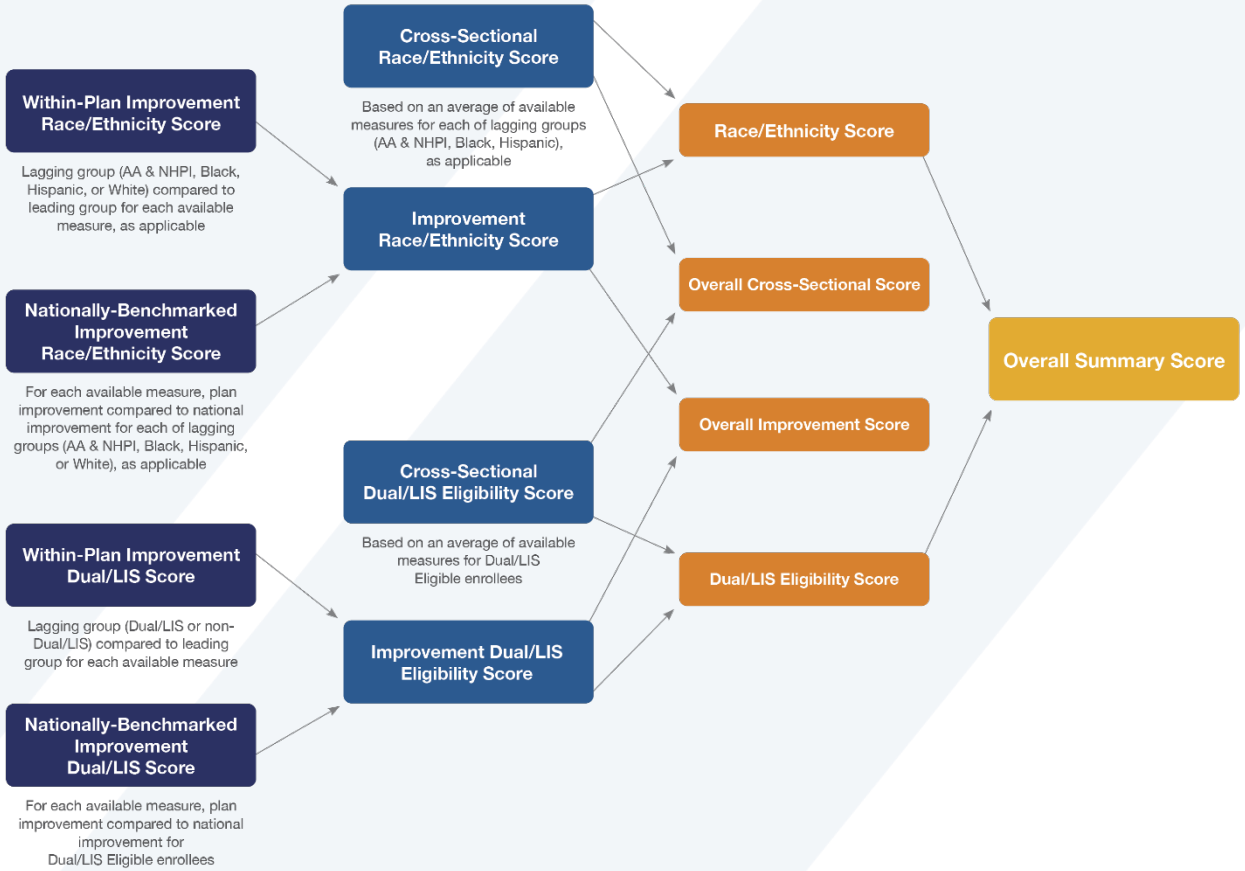

Table 1. MA HESS Component Quality Measures

Patient Experience	Clinical Quality
MA & PDP CAHPS®	HEDIS
Getting Needed Care	Adult BMI Assessment
Getting Appointments and Care Quickly	Breast Cancer Screening
Customer Service	Colorectal Cancer Screening
Doctors Who Communicate Well	Diabetes: Blood Sugar Controlled
Care Coordination	Diabetes: Kidney Disease Monitoring
Getting Needed Prescription Drugs	Diabetes: Retinal Eye Exam
Annual Flu Vaccine	Controlling High Blood Pressure

Table 2. MA HESS Grouping Factors

Race/Ethnicity (i.e., Asian American, Native Hawaiian and Pacific Islander – AA & NHPI, Black, Hispanic, and white)
Dual/LIS eligibility status (i.e., eligible for both Medicare and Medicaid OR eligible for the Low-Income Subsidy).

Medicare Advantage HESS Dashboard

Context, Objectives, and Status Update

Health Equity Summary Score & Dashboard Pilot Test

Context & Objectives

CMS developed the Medicare Advantage Health Equity Summary Score (MA HESS) to provide Medicare Advantage Organizations (MAOs) with a 'snapshot' of information about the **quality of care that MAOs provide to enrollees** who are racial/ethnic minorities or Dual/Low-Income Subsidy (LIS) eligible

The MA HESS is intended to be used **for informational purposes only.** The score and associated data and benchmarks provide MAOs with an understanding of their health equity performance as compared to their peers and to themselves over time

The MA HESS Dashboard was developed to allow MAOs to view their **confidential HESS performance** on demand in the Health Plan Management System (HPMS). It was **pilot tested** between September 30, 2022, and December 30, 2022, to ensure **functionality, usability, and utility** of the information and resources provided

Pilot test results will be used to **inform MA HESS and Dashboard improvements** for future planned iterations

Approach

All MAOs were invited to participate in the pilot test of the HESS Dashboard using their existing HPMS access and to provide feedback via a web-based survey.

Pilot Test Contents:

- Dashboard visuals and underlying data
- FAQ Document, User Guide, and other methodology documentation
- Resources to inform quality improvement

Input Requested:

- Usefulness of the MA HESS to MAOs
- Feedback on the Dashboard utility and functionality
- Input on the ease-of-use and clarity of HESS supporting documentation

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MA HESS Dashboard Pilot Overview & Considerations

Pilot Preparation & Process

Prior to launching the Pilot, we:

- Collaborated with colleagues in the Center for Medicare to build **HESS Dashboard** and **HESS Resource List pages** in the Health Plan Management System (HPMS)
- Prepared **supplementary materials** (e.g., FAQs, user guide, methodology document, memo) and a feedback form
- Briefed other **CMS components** about the HESS Dashboard
- Connected with the **Health Equity Technical Assistance** team to ensure plans could contact us with questions

Pilot Implementation

During the Pilot, we:

- Communicated with plans about the HESS Dashboard pilot via **HPMS memos** sent at the beginning and end of the pilot period
- Made a feedback form available for plans to complete and **supported users** in submitting forms and understanding pilot activities
- **Received feedback from 36 plans, 4 other organizations, and one account manager at CMS**

Additional Considerations

In response to feedback from other CMS components, we:

- Added additional information to the Dashboard on:
  - ✓ Demographic distribution and comparability to other plans
  - ✓ Definitions and interpretation of visuals within the graphics
  - ✓ Known changes to the MA HESS in future years (i.e., adjustment for Public Health Emergency (PHE) data gaps, discontinued measures)

Medicare Advantage HESS Dashboard

Results

MA HESS Dashboard Pilot Survey Results

Overall

- The HESS Dashboard provides **value** to plans and can help **inform their future health equity improvement**
- Supplemental materials were helpful, and there are **opportunities to refine** for bigger impact
- More intensive **supports and training** for using the HESS and developing related action plans were of interest to many users
- Plans too new or small to be scored expressed interest in a **national HESS**

Plan-Reported Strengths

- Overall scores and Key Insights on the HESS Summary page were **beneficial** in guiding plans to **focus areas**
- The Dashboard provides **insight** into how Race/Ethnicity and Dual/LIS status **impact different health care dimensions**
- The plans found the Dashboard **easy to access** and make initial selections

Plan-Reported Opportunities

Documentation:

- **Consolidate** documentation
- Provide both high-level **summaries** and technical **details**

Understandability:

- Add additional **hover text and definitions** to explain scores
- Improve Cross-Sectional performance Section
- Provide **clarity** around expected actions/areas of improvement

Navigability:

- Add ability to **download datasets** for multiple plans in one file
- Maintain **filter settings** across tabs
- Provide a **downloadable Dashboard PDF** (not just Excel)

> *The categories … provide important information to **ensure health equity is at the forefront of a MA Member's experience."***

> *The provided materials were beneficial. Overall, the **Dashboard was very well done**.*

Medicare Advantage HESS Dashboard

Next Steps

Proposed Next Steps for Improving MA HESS Dashboard

Based on feedback received from Plans and other stakeholders, we are exploring implementing the following changes:

1 Revisions to Dashboard

- Conduct **listening sessions** with plans to identify ways to revise/simplify visuals, particularly the Cross-Sectional Performance Section
- Add **additional hovers, definitions**, and other interpretation guidance
- Enhance **navigability** where possible

2 Updates to Documentation

- Place all related documentation into one **easy-to-navigate** location
- Add **technical notes** and a data dictionary
- Provide **additional information** on HESS usage and potential next steps after accessing scores

3 Supplemental Materials

- Several organizations expressed interest in accessing HESS performance data; we are considering developing a **National HESS Performance Report** to summarize performance at a national level
- Continue to post links to **tools and guides** that support MAOs to reduce disparities

4 HESS Training & Technical Assistance (TA)

- Develop a training to provide additional information on **how to use and interpret** the Dashboard
- Provide more **clarity** around potential end-user actions to support **score improvement**
- Deliver **ongoing HESS TA support** as needed

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Mapping Medicare Disparities (MMD) Tool

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Office of Minority Health (OMH)

Centers for Medicare & Medicaid Services (CMS)












AGENDA (2)

- Introduction
- About CMS OMH
- Mapping Medicare Disparities (MMD) Tool
  - Population View
  - Hospital View
- Live Demo
- Questions/Feedback

HHS Offices of Minority Health

- When the Affordable Care Act was introduced, it called for the establishment of six offices of minority health within HHS agencies, including the **CMS Office of Minority Health**.
- These offices joined forces with the HHS Office of Minority Health and the National Institute on Minority Health and Health Disparities to lead and coordinate activities that improve the health of minority populations.

CMS OMH Mission & Vision

Mission

CMS OMH will lead the advancement and integration of health equity in the development, evaluation, and implementation of CMS's policies, programs, and partnerships.

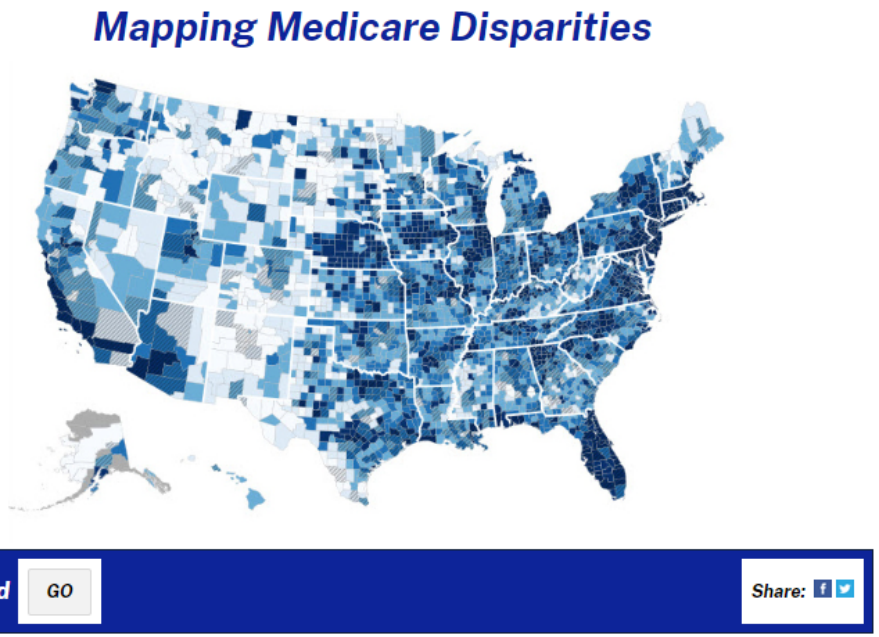
Vision

All those served by CMS have achieved their highest level of health and well-being, and we have eliminated disparities in health care quality and access.

Mapping Medicare Disparities (MMD) Tool

Office of Minority Health MMD Tool homepage

Chronic diseases pose a significant problem in the United States resulting in substantial morbidity, mortality, disability, and cost. The CMS Office of Minority Health has designed an interactive map, the Mapping Medicare Disparities (MMD) Tool, to identify areas of disparities between subgroups of Medicare enrollees (e.g., racial and ethnic groups) in health outcomes, utilization, and spending. It is an excellent starting point to understand and investigate geographic and racial and ethnic differences in health outcomes. This information may be used to inform policy decisions and to target populations and geographies for potential interventions.



How to Use the Tool

- Mapping Medicare Disparities (MMD) Tool – Demonstration by CMS Office of Minority Health
- Mapping Medicare Disparities (MMD) Tool Overview (PDF)
- Quick Start Guide (PDF)
- Frequently Asked Questions (FAQs) (PDF)
- Technical Documentation (PDF)
- MMD – A Tool To Understanding Data

Other Resources

- CMS Geographic Variation Dashboard
- CMS Medicare Chronic Condition Dashboard
- CDC Atlas of Heart Disease and Stroke
- County Health Rankings and Roadmaps

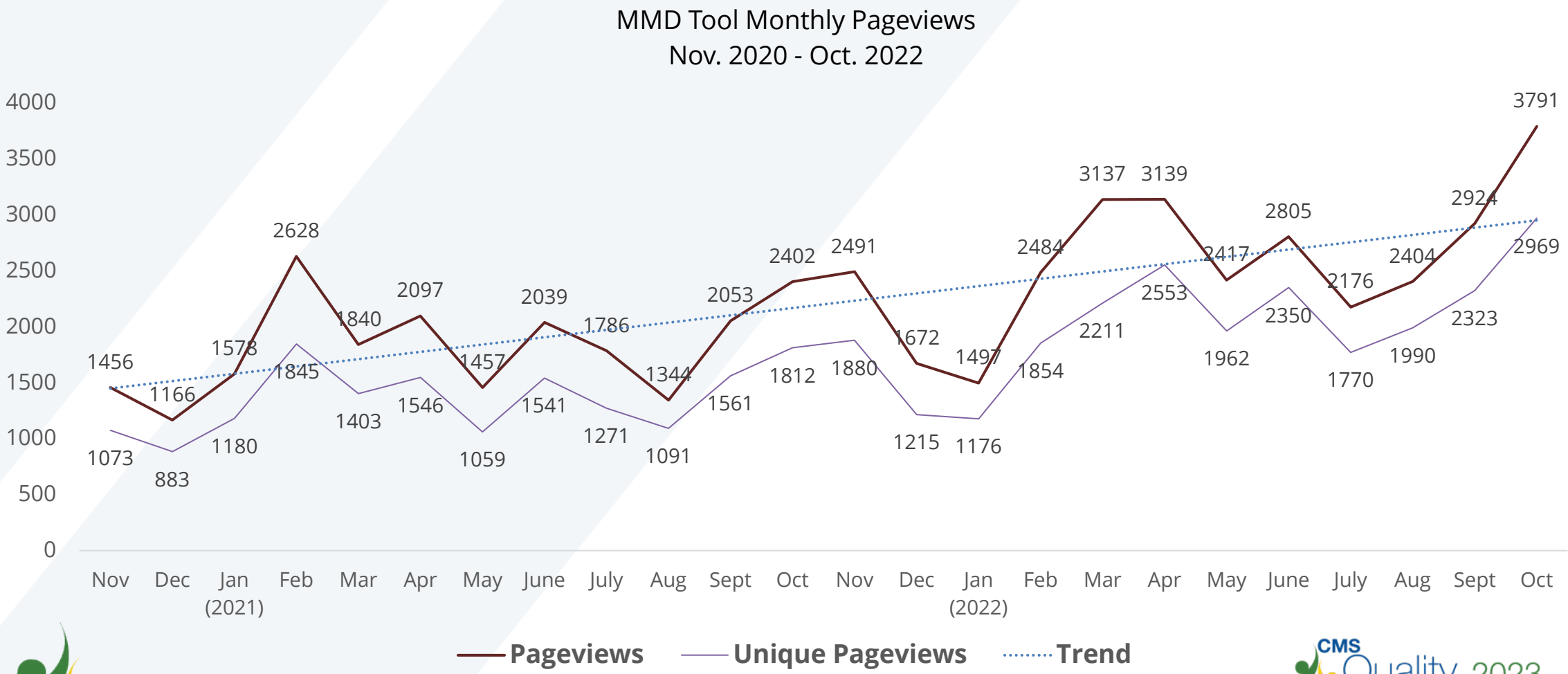
About MMD Tool

- Launched in March 2016 by CMS OMH
- Interactive map that allows users to identify areas of disparities between subgroups of Medicare beneficiaries (e.g., racial and ethnic groups), chronic disease prevalence, health outcomes, spending, and utilization.
- User friendly and visually appealing
- Medicare Fee-for-Service (FFS) data, recently updated with 2021 data
- Downloadable data and maps
- Available in Spanish
- **go.cms.gov/mmd**

Who Should Use the MMD Tool?

- **Providers** can evaluate health disparities of vulnerable populations to prioritize quality improvement efforts
- **Beneficiaries** can compare their health outcomes in their communities to others
- **Researchers, state/local health representatives,** and **Quality Improvement Network/Quality Improvement Organizations** can identify disparities in Medicare to inform the design of targeted interventions
- **Hospital** quality representatives can analyze and compare hospital quality measures and performance scores

MMD Tool Website Page Views



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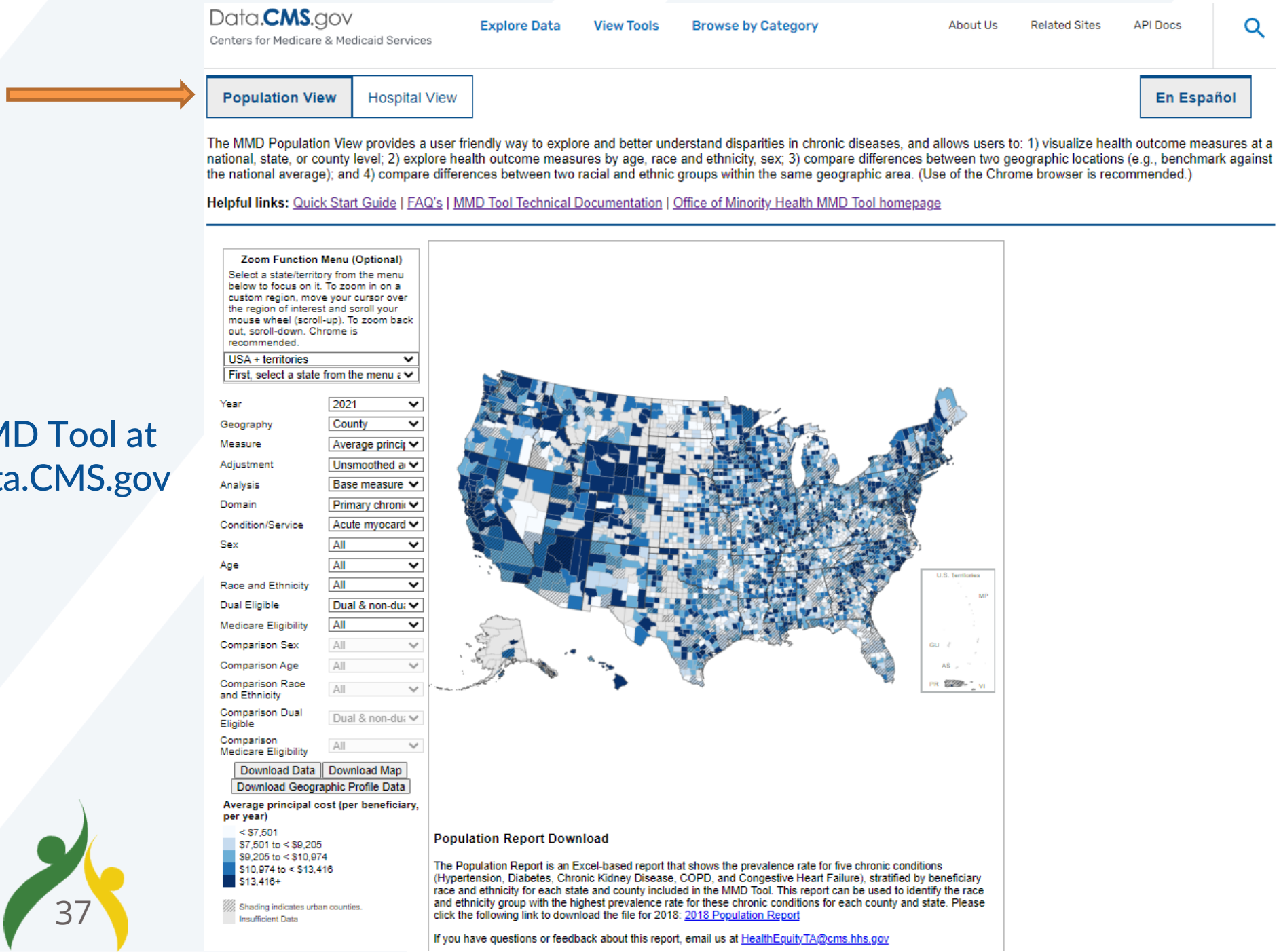
MMD Tool at Data.CMS.gov



Population View (1 of 2)

The MMD Population View allows for geographical comparisons between:

County, State & national averages	• Compare the disease prevalence, cost, or utilization across every county, state and territory in the U.S. Compare trends across years.
Geographic regions	• Compare the disease prevalence, cost, or utilization across different counties within a state or territory or between urban and rural counties within a state.
Groups within the same geographic area	• Compare disease prevalence, cost, or utilization between different sex, age, racial/ethnic groups, or between dual eligibility within a specific county or state/territory.
State, County Profile View	• View specific state and county data including median household income and employment, federal poverty level, and language literacy rates, etc.

Population View (2 of 2)

The MMD Population View allows for geographical comparisons between:

Population Health Measures

- Average principal cost
- Average total cost
- Average total cost (risk-adjusted)
- Emergency department visit rate
- Hospitalization
- Mortality
- Prevalence
- Prevention quality indicator (PQI)
- Preventive Services
- Readmissions

Inpatient Measures

- Admission Type
- Discharge Destination
- Inpatient Days
- Medicare Reimbursement
- Patient Safety Indicator (PSI)

Key quality, utilization, cost metrics

Over 60 conditions

- Acute myocardial infarction
- Alzheimer's Disease, Related Disorders, or Senile Dementia
- Asthma
- Atrial fibrillation
- Cancer, Colorectal, Breast, Prostate, Lung
- Cancer - Colorectal
- Cancer - Breast
- Cancer - Lung
- Cancer - Prostate
- Chronic kidney disease
- Chronic obstructive pulmonary disease
- Depression
- Diabetes
- Heart failure
- Hyperlipidemia
- Hypertension
- Ischemic heart disease

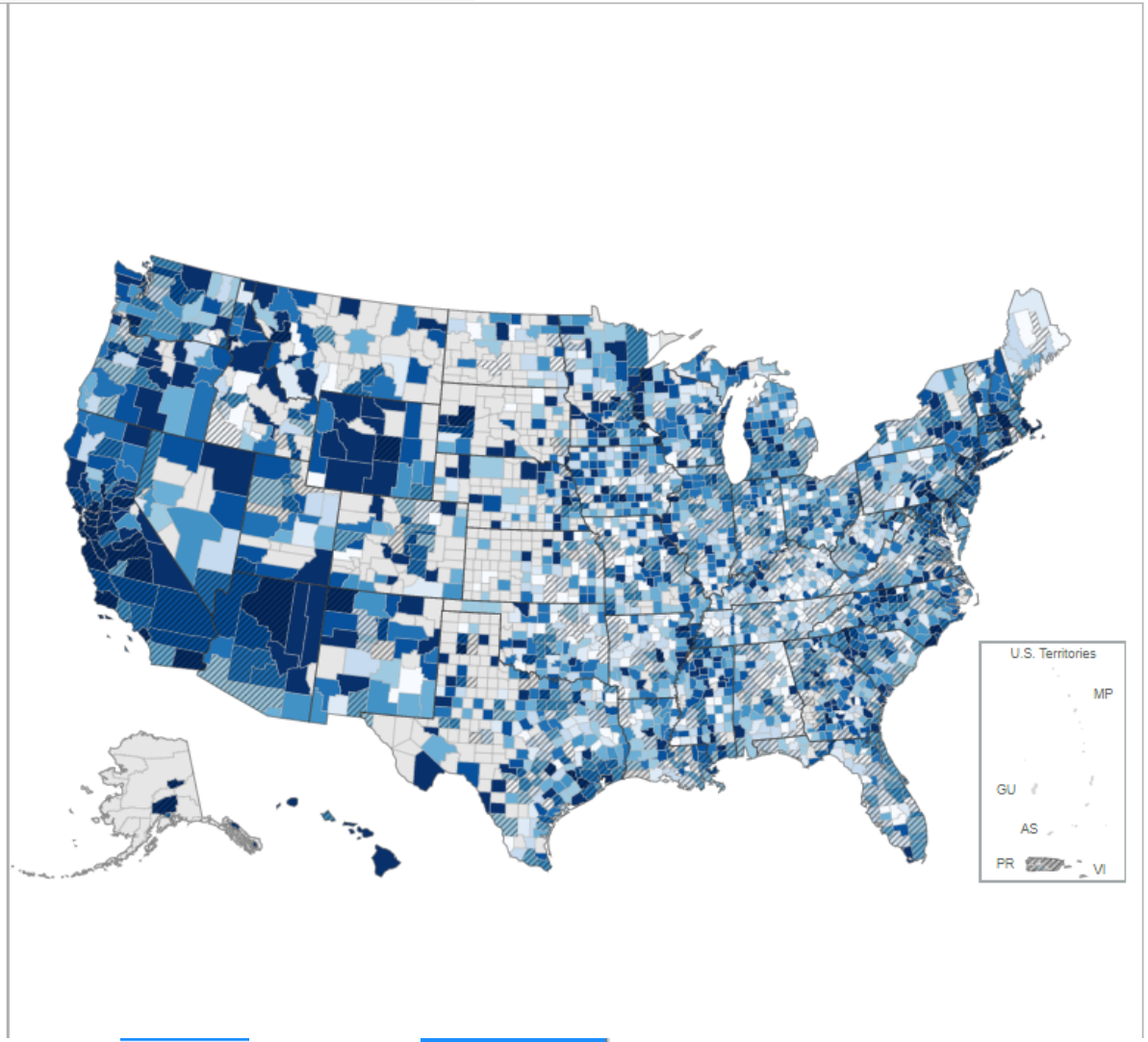
Zoom Function Menu (Optional)

Select a state/territory from the menu below to focus on it. To zoom in on a custom region, move your cursor over the region of interest and scroll your mouse wheel (scroll-up). To zoom back out, scroll-down. Chrome is recommended.

USA + territories

First, select a state from the menu a

Year	2019
Geography	County
Measure	Average princip
Adjustment	Unsmoothed ac
Analysis	Base measure
Domain	Primary chronic
Condition/Service	Acute myocardi
Sex	All
Age	All
Race and Ethnicity	All
Dual Eligible	Dual & non-dua
Medicare Eligibility	All
Comparison Sex	All
Comparison Age	All
Comparison Race and Ethnicity	All
Comparison Dual Eligible	Dual & non-dua
Comparison Medicare Eligibility	All



All | Male | Female

<65 | 65-74 | 75-84 | 85+

Black | Other | Asian/Pacific islander | Hispanic | American Indian/Alaska native

Dual & non-dual | Medicare only | Dual only

Population View
Primary Chronic Conditions

- Acute Myocardial Infarction
- Alzheimer's Disease, Related Disorders, or Senile Dementia
- Asthma
- Atrial Fibrillation
- Cancer (breast, colorectal, lung, and/or prostate)
- Chronic Kidney Disease
- Chronic Obstructive Pulmonary Disease (COPD)
- Depression
- Diabetes
- Heart Failure
- Hyperlipidemia (high cholesterol)
- Hypertension
- Ischemic Heart Disease
- Obesity
- Osteoporosis
- Rheumatoid Arthritis / Osteoarthritis
- Schizophrenia/Other Psychotic Disorders
- Stroke / Transient Ischemic Attack
- End Stage Renal Disease (ESRD)
- Disability (reason for Medicare eligibility)

Population View
Chronic and Potentially Disabling Measures

Measure	Prevalence Rates, Costs, and Hospitalization Rates [1]	
Other Disabling Condition	**Congenital and Developmental Conditions** [2] ADHD, Conduct Disorders, and Hyperkinetic Syndrome Autism Spectrum Disorders Cerebral Palsy Cystic Fibrosis and Other Metabolic Developmental Disorders Intellectual Disabilities and Related Conditions Learning Disabilities **Liver Conditions** [2] Liver Disease, Cirrhosis and Other Liver Conditions Viral Hepatitis (General) **Mental Health and Substance Use Conditions** [2] Anxiety Disorders Bipolar Disorder Depressive Disorders Post-Traumatic Stress Disorder (PTSD) Personality Disorders Schizophrenia Tobacco Use Opioid Use Disorder (OUD): Overarching OUD Indicator, Diagnosis- and Procedure-code-based OUD Indicator, Hospitalization and Emergency Room Visits-based OUD Indicator, and Utilization of Medication-Assisted Therapy based OUD Indicator	**Mobility Limitations and Chronic Pain Conditions** [2] Fibromyalgia, Chronic Pain and Fatigue Multiple Sclerosis and Transverse Myelitis Mobility Impairments Muscular Dystrophy **Neurological Conditions** [2] Epilepsy Migraine and Chronic Headache Spina Bifida and Other Congenital Anomalies of the Nervous System Spinal Cord Injury Traumatic Brain Injury and Nonpsychotic Mental Disorders due to Brain Damage **Other Chronic or Disabling Conditions** [2] Human Immunodeficiency Virus and/or Acquired Immunodeficiency Syndrome (HIV/AIDS) Leukemias and Lymphomas Peripheral Vascular Disease (PVD) Pressure and Chronic Ulcers Sensory - Blindness and Visual Impairment Sensory - Deafness and Hearing Impairment **Other Developmental Delays**

Population View
Preventive Service Measures

Preventive Service Measures

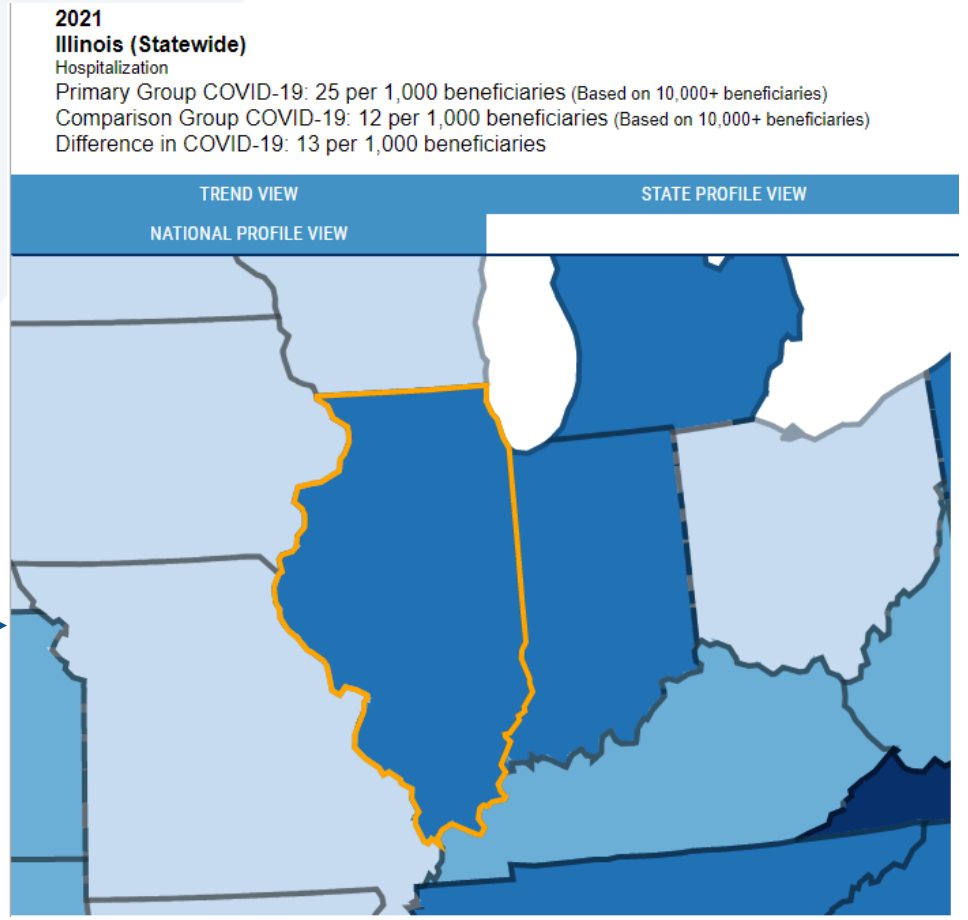
Alcohol Misuse Screening and Counseling	Glaucoma Screening	Medical Nutrition Therapy (MNT) Services
Annual Wellness Visit	Hepatitis B Vaccine	Pneumococcal Vaccine
Bone Mass Measurement	Hepatitis C Screening	Prostate Cancer Screening
Cardiovascular Disease Screening	HIV Screening	Screening for Cervical Cancer with Human Papillomavirus (HPV) Tests
Colorectal Cancer Screening	Influenza Virus Vaccine	Screening for Sexually Transmitted Infections (STIs) and High Intensity Behavioral Counseling (HIBC) to Prevent STIs
Counseling to Prevent Tobacco Use	Initial Preventive Physical Examination (IPPE)	Screening Mammography
Depression Screening	Intensive Behavioral Therapy (IBT) for Cardiovascular Disease (CVD)	Screening Pap Test
Diabetes Screening	Intensive Behavioral Therapy (IBT) for Obesity	Screening Pelvic Examination
Diabetes Self-Management Training (DSMT)	Lung Cancer Screening Counseling and Annual Screening for Lung Cancer With Low Dose Computed Tomography (LDCT)	Ultrasound Screening for Abdominal Aortic Aneurysm (AAA)

Population View
COVID-19

COVID-19 prevalence and hospitalization, 2020 - 2021

COVID-19 hospitalization rate among duals was more than twice as high as Medicare only beneficiaries' in Illinois in 2021.

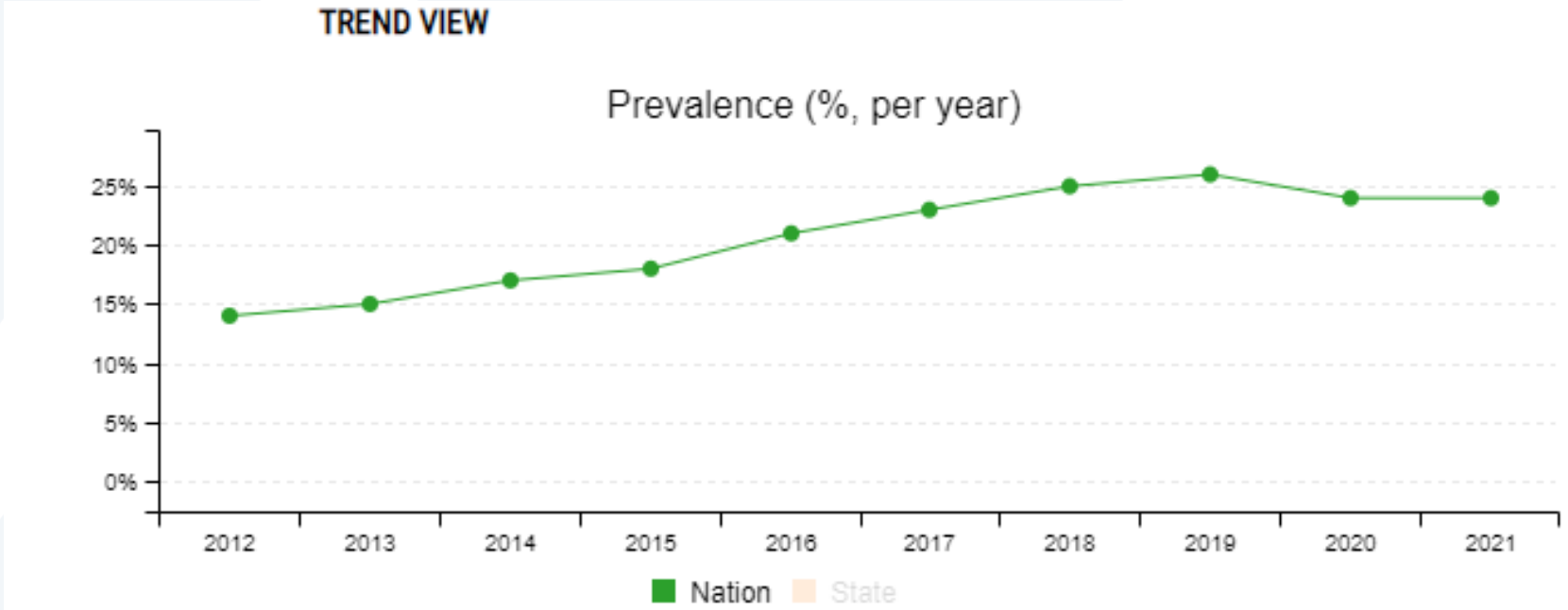
COVID-19 hospitalization, Illinois, 2021
Dual only: 25 per 1000 beneficiaries
Medicare only: 12 per 1000 beneficiaries



Screen shot from MMD Tool

Population View – Example of trend view

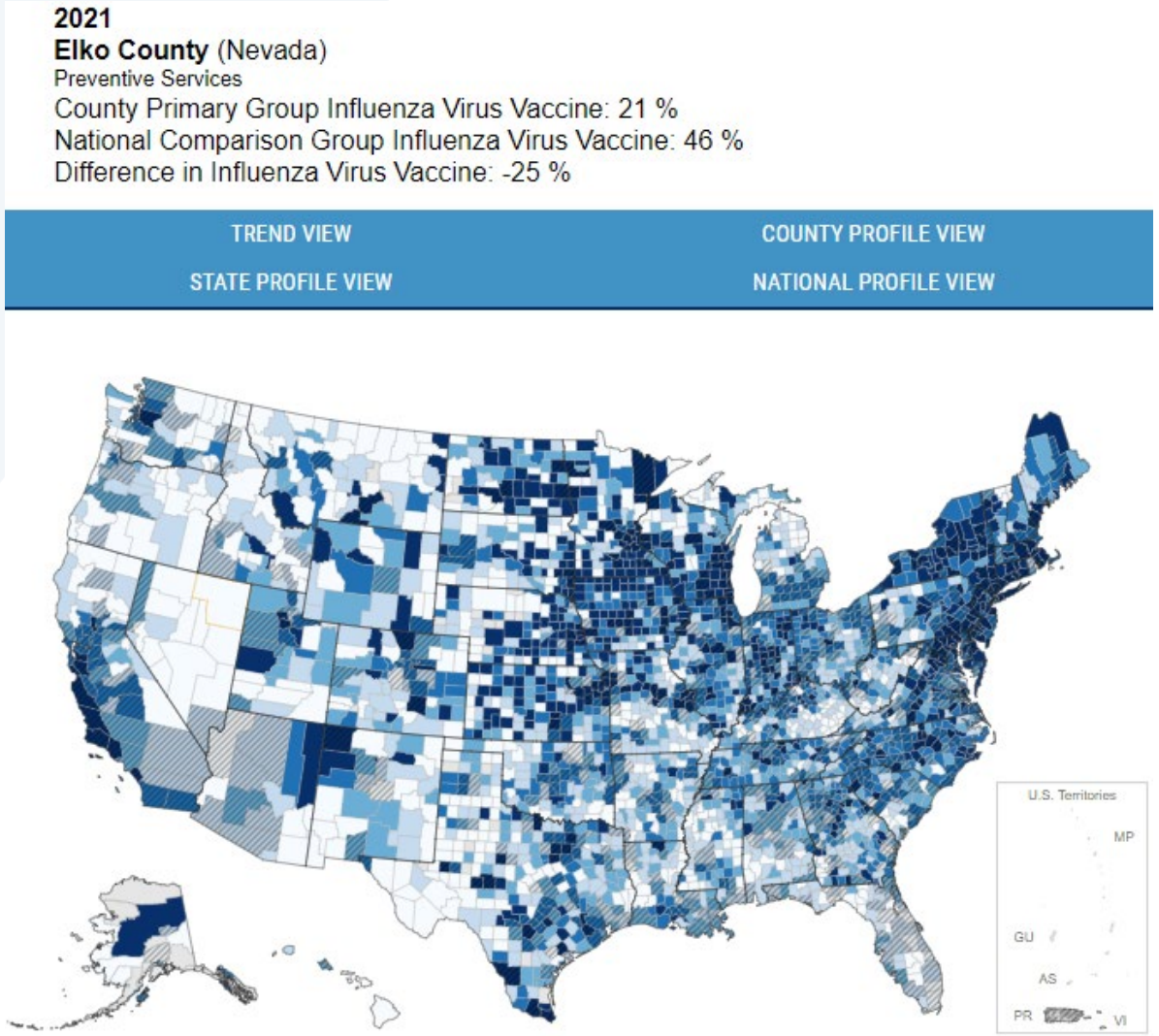
Trends of national obesity prevalence rate among duals, 2012-2021



Screen shot from MMD Tool

Population View – Example of county and national rate comparison

Flu vaccination rate among duals, comparing national average rate among Medicare FFS beneficiaries, 2021.
(Light color areas have lower rate of flu vaccination rate)



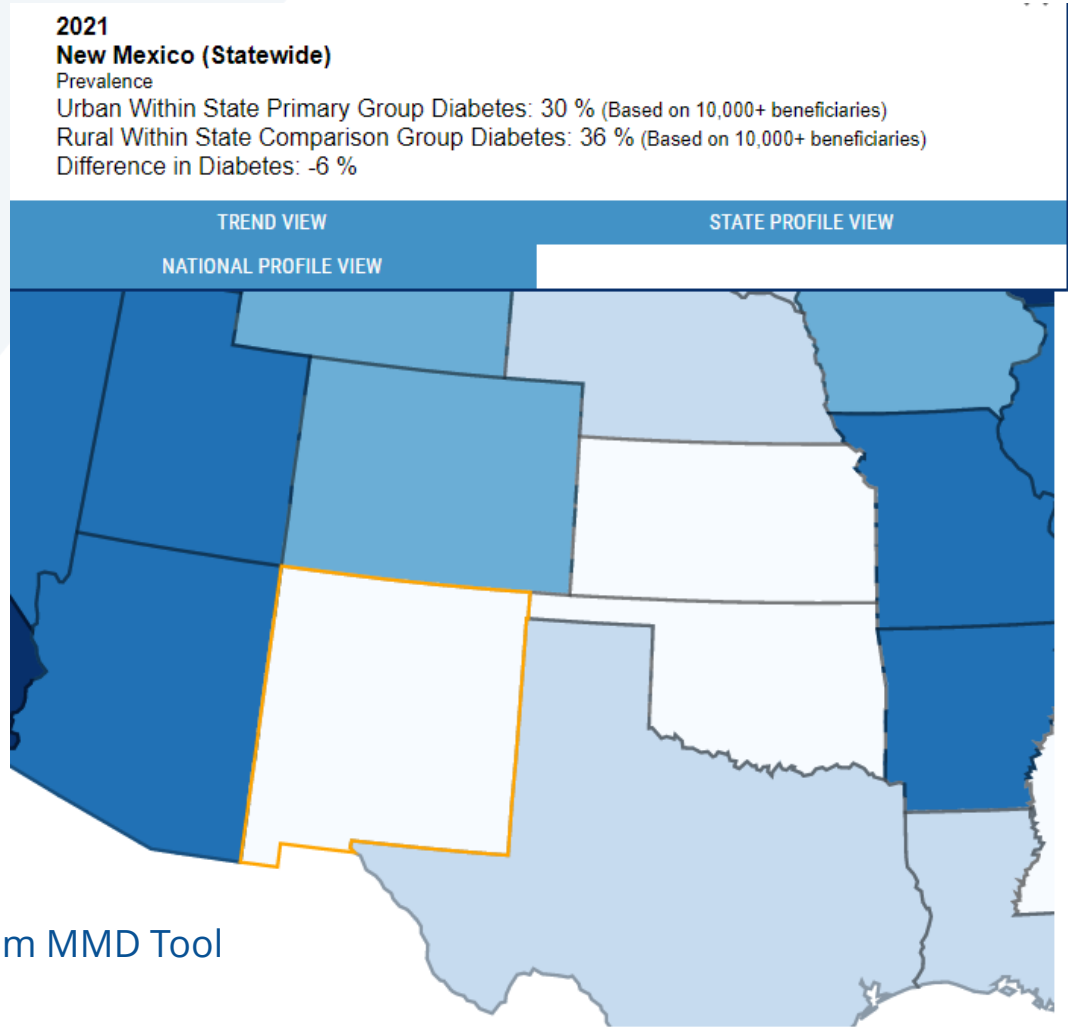
Screen shot from MMD Tool

Population View – Example of Comparison

Rural vs. Urban disparities among Hispanic beneficiaries: Diabetes Prevalence, 2021

*The prevalence of diabetes among Hispanic beneficiaries in **rural** counties is 6% higher than Hispanic beneficiaries in **urban** counties in New Mexico in 2021.*

Hispanic, Urban, prevalence: 30%
Hispanic, Rural, prevalence: 36%



Screen shot from MMD Tool

MMD Tool – Hospital View

Population View | Hospital View

The MMD Hospital View provides a user friendly way to compare hospitals on quality of care (e.g., readmissions and unplanned hospital visits, safety and patient experience) and cost of care (e.g., Medicare spending). Users can visually analyze a hospital's metrics and performance scores and compare with other hospitals based on: geography (e.g., county, state, and national), hospital type (e.g., acute care and critical access), hospital ownership (e.g., government, physician, proprietary, tribal, and voluntary), and/or hospital size (i.e., number of beds). (Use of the Chrome browser is recommended.)

Helpful links: Quick Start Guide | FAQ's | MMD Tool Technical Documentation | Office of Minority Health MMD Tool homepage

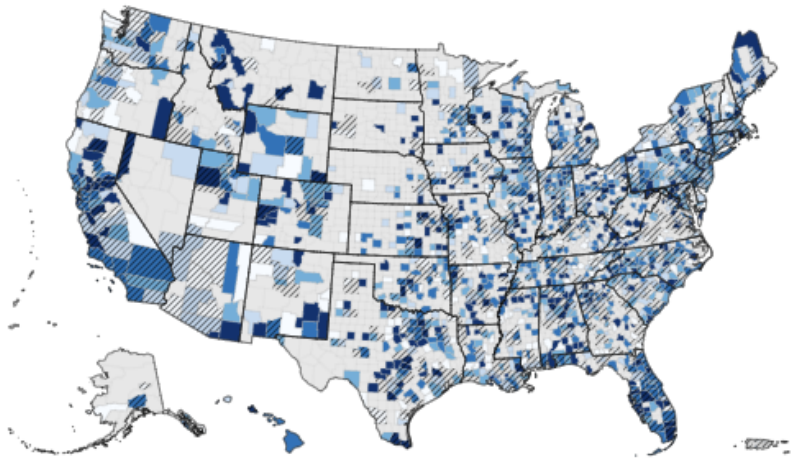
Hospital and Measure Selection

State/Territory: Please Select One
County: Please Select One
Hospital: Please Select One
Domain: Effective Care
Subdomain: Effective Care
Measure: Severe Sepsis and Septic Shoc
Map Display: County/State: County
Geographic Comparison Group: Nation
Hospital Type Comparison Group: All
Hospital Size Comparison Group: All

Download Hospital Subdomain Data
Download Map | Download Chart

Geographic Selection

Select a state and county to see hospital locations. Then hover over to view hospital name, click to visualize selected subdomain in chart below.



Urban Counties

Severe Sepsis and Septic Shock

0.00% - 45.00% | 45.00% - 55.00% | 55.00% - 62.00% | 62.00% - 71.00% | 71.00% - 100.00%

Hospital View

About the Hospital View of the Tool:

- Launched on September 7, 2018 as a new addition to the MMD Tool
- Interactive, web-based tool
- Provides over 50 quality measures at the hospital-level
- Allows for the analysis and comparison of individual hospital's metrics and performance scores to other hospitals based on geography (e.g. county, state, and national), hospital type (e.g. acute care and critical access), and/or hospital size (i.e. number of beds)

Hospital View Measures

- **Effective Care**
- **Hospital value based purchasing** (HVBP)
- **Inpatient psychiatric facility quality reporting** (IPFQR)
- **Medicare spending**
  - Value of care
- **Patient experience**
  - Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey
- **Prospective payment system** (PPS)
  - Oncology care
  - Exempt Cancer Hospital Quality Reporting (PCHQR)
- **Readmissions**
  - Unplanned hospital visits
  - Readmissions
- **Safety**
  - Patient safety indicators (PSI)
  - Mortality
  - Healthcare associated infections (HAIs)
  - Hip/Knee Complications

Readmissions: Inova Fair Oaks Hospital, VA

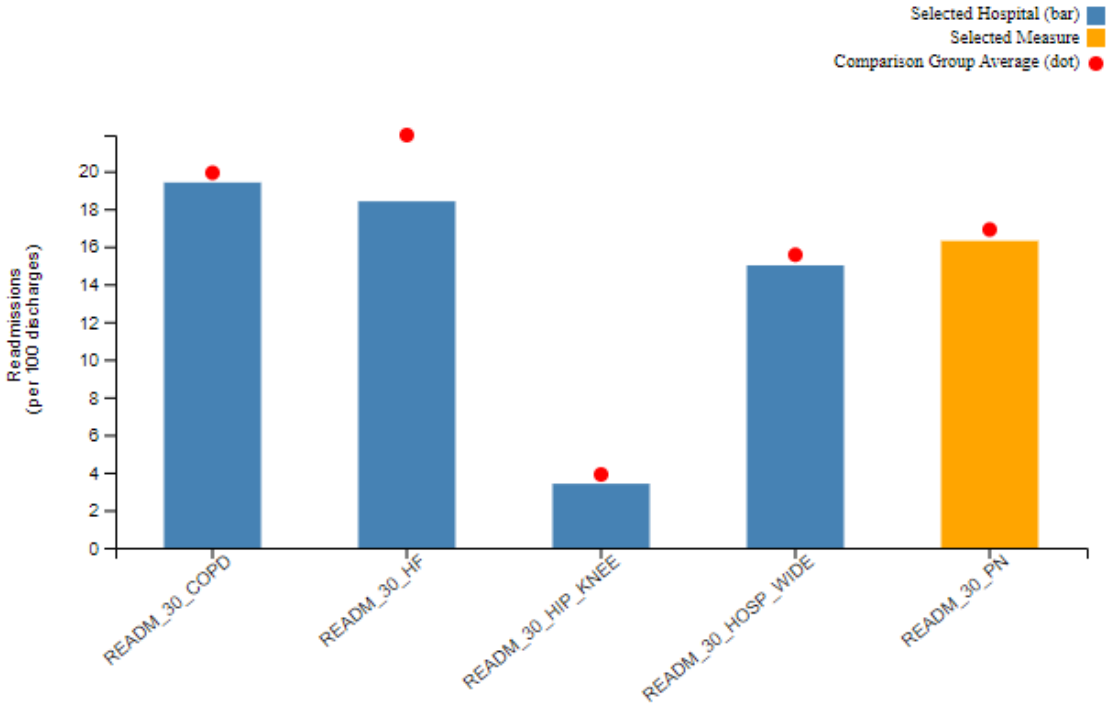
Hospital Information

Address	3600 Joseph Siewick Drive, Fairfax
County	Fairfax
Hospital	Inova Fair Oaks Hospital
Hospital Size	182 Beds
Ownership	Voluntary non-profit - Other
Provider #	490101
State	VA
Type	Acute Care Hospitals
ZIP Code	22033

Inova Fair Oaks Hospital had a Pneumonia 30-day readmission rate of 16.30% versus the national average of 16.90%.

Readmissions: Readmissions

Subdomain/Measure Date Range: 07/01/2017 - 12/01/2019



Measure Key

Details on "Readmissions" measures @ Medicare.gov

READM_30_AMI	Acute Myocardial Infarction (AMI) 30-Day Readmission Rate
READM_30_CABG	Coronary Artery Bypass Grafting (CABG) 30-Day Readmission Rate
READM_30_COPD	Chronic Obstructive Pulmonary Disease (COPD) 30-Day Readmission Rate
READM_30_HF	Heart Failure (HF) 30-Day Readmission Rate
READM_30_HIP_KNEE	Hip/Knee Replacement 30-Day Readmission Rate
READM_30_HOSP_WIDE	Hospital 30-Day Readmission Rate (hospital-wide)
READM_30_PN	Pneumonia (PN) 30-Day Readmission Rate

MMD Tool data use

MMD Tool data and maps used for CMS chronic conditions data snapshots

https://www.cms.gov/about-cms/agency-information/omh/research-and-data/health-care-disparities-data/data-snapshots

The **Mapping Medicare Disparities Tool** developed by Centers for Medicare & Medicaid Services (CMS) shows that 25% of people with Medicare fee-for-service (FFS) had a diagnosis of CKD in 2020.[3] The prevalence of CKD has increased over time, from 15% in 2012 to 25% in 2020 as shown in Figure 1, and varied by age, sex, race and ethnicity, eligibility for Medicare and Medicaid, and geographic areas. Figure 2 shows the age standardized prevalence of CKD among people with FFS by race and ethnicity in 2020. CKD was highest among Black/African American (36%), followed by American Indian/Alaska Native (32%), Hispanic (29%), and Asian/Pacific Islander (26%). Whites (24%) with FFS had the lowest percentages of CKD.

The rate of Medicare FFS enrollees with CKD also varied by geographic areas as shown in Figure 3. Puerto Rico (33%), Florida (30%), Guam (30%), Alabama (28%), Georgia (28%), Louisiana (27%), Tennessee (27%), Texas (27%) and West Virginia (27%) had a higher prevalence rate, and Montana (16%), Wyoming (16%), Alaska (17%), Vermont (17%), New Hampshire (19%), Colorado (20%), Idaho (20%) and Oregon (20%) had a lower prevalence rate.

Figure 4 shows geographic differences in CKD prevalence among minority racial and ethnic groups with FFS.

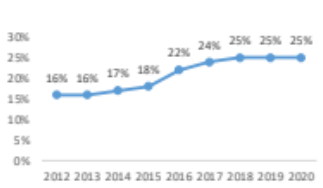


Figure 1. Prevalence of CKD among People with FFS by year

Figure 2. Age Standardized Prevalence of CKD among People with FFS by Race/Ethnicity, 2020

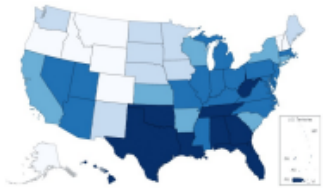


Figure 3. Prevalence of CKD among People with FFS by State/Territory, 2020

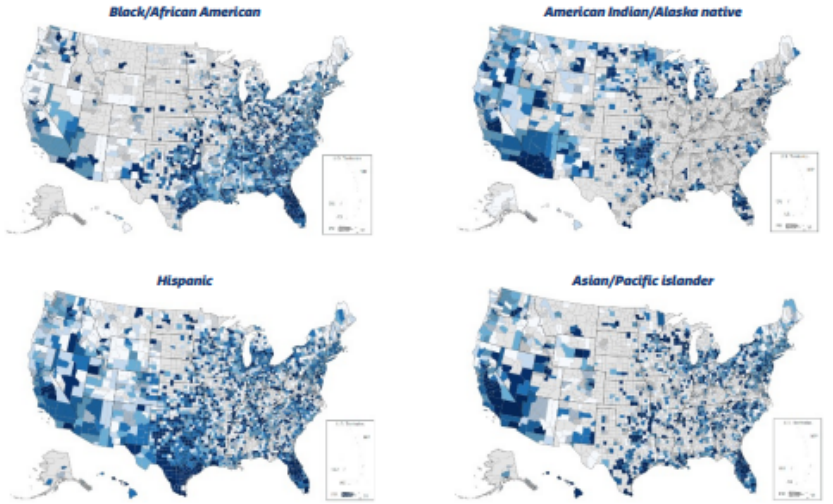


Figure 4. CKD Prevalence Maps for Minority Race/Ethnicity by County among People with FFS, 2020

Data SNAPSHOT March 2022

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Live Demo
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Thank You!

CMS OMH Homepage:

go.cms.gov/omh

If you have any questions, feedback, or suggested enhancements to the MMD Tool, please email us at

HealthEquityTA@cms.hhs.gov