



Using Data to Track and Reduce Health Disparities in Medicaid

Why is this important?

- There are almost 40 million non-elderly Medicaid beneficiaries across the United States, and over half are racial and ethnic minorities.¹
- Health disparities among racial and ethnic minorities are well documented. For example, blacks are 10 times more likely than whites to have AIDS; American Indians are two times more likely than whites to have diabetes; Latinos are up to two times more likely than whites to have infection-related cancers. These gaps widen for people below 200 percent of the federal poverty level, or earning \$36,620 for a family of three.²
- Racial and ethnic minorities are less likely to rely on a private physician for care than whites – 62 percent of blacks and 44 percent of Latinos, compared to 77 percent of whites a private physician.³
- Tracking disparities is an essential step in shaping strategies to reduce disparities and measure progress.
- Eliminating racial and ethnic health disparities will improve the health of state residents and result in long-term cost savings in Medicaid.

Keys to success⁴

Obtain reliable data

- Require Medicaid agencies and providers to collect data on race, ethnicity and language preference. Do not make data collection optional. Require everyone to use the same collection methods.
- Expand race and ethnicity categories. To generate a more accurate snapshot of the Medicaid population, state agencies should go beyond collecting data on whites, blacks and Latinos and include at least five racial and ethnicity categories, as well as language preference.
- Support training of data collectors. There is often hesitancy to ask for data from beneficiaries or patients.
- Educate consumers about the role of data collection in improving the quality of health care and patients' overall health. Assure consumers that data collection is legal and that data are kept private.
- Press Medicaid agencies and providers to safeguard privacy of data by securing confidentiality agreements and encrypting data.⁵

Use data to identify disparities

- Use Health Plan Employer Data and Information Set (HEDIS) or similar measures to provide a baseline that may identify disparities across race, ethnicity and language preference. Examples of HEDIS measures, collected by managed care and other health

organizations, include breast cancer screening, child and adult immunization, diabetes care, and cholesterol and high blood pressure treatment. Medicaid agencies can use these existing measures to identify disparities in their programs.

Add to existing quality efforts

- Require Medicaid agencies to include disparities reduction as a specific goal within their existing quality initiatives. Medicaid agencies can write disparities reduction goals into managed care contracts and include financial incentives such as pay-for-performance.
- Require collaboration between Medicaid agencies and managed care organizations to ensure accuracy of racial and ethnic minority data.

Target the efforts

- Encourage innovative ways to statistically capture health disparity trends among smaller populations, such as American Indians and Pacific Islanders.
- Develop programming that targets specific health disparities, such as diabetes and asthma.

What can advocates do?

- *Educate community members about the role of data in improving health, and empower them to use data.* There is ample evidence that fears about privacy and security play a role in whether or not racial and ethnic minorities share health information. Advocates can address those fears and help community members to use the data themselves to ask questions of their caregivers.
- *Press for state and federal laws and regulations that require standardized collection of data and public reporting.*
- *Engage managed care companies in a conversation about health disparities.* Managed care companies are the largest insurer of Medicaid enrollees. They have a financial stake in improving patient health through quality initiatives.
- *Provide analysis about racial and ethnic disparities in your state.* Data regarding racial and ethnic disparities is a powerful tool – especially when presented side by side with Medicaid racial and ethnic enrollee composition.
- *Publicize data and analyses of improvements or setbacks.* This can help motivate change.
- *Urge legislators and/or state Medicaid directors to establish disparities reduction goals.* States that have been successful in this, such as Michigan, have very specific benchmarks for reducing health disparities. These benchmarks are determined by rigorous data analysis targeting the disparities that most need attention.
- *Alert local groups and agencies to grant and funding opportunities to support data collection.* Many foundations fund efforts to expand data collection and analysis on racial and ethnic health disparities as a way to improve community health.

Example 1: New York advocates commission Medicaid data analysis to push for disparity reduction

Using data collected by New York's Medicaid program, state consumer advocates identified racial disparities within care provided by managed care plans. Advocates used these findings to advocate for improvements.

The Community Services Society (CSS), a non-profit consumer advocacy group that serves vulnerable populations in New York City, began this project because of the information gap regarding how racial and ethnic groups were faring in the Medicaid system. The CSS commissioned an analysis of data that New York requires Medicaid managed care plans to collect, but which the state had not used to study racial and ethnic disparities. In 2009, CSS published [*Promoting Equity and Quality in New York's Public Insurance Programs*](#), which found that blacks enrolled in Medicaid managed care plans were less likely to receive recommended preventive care or treatment for chronic diseases than any other racial or ethnic group. For example, blacks had fewer dental visits, mammograms, diabetes and cholesterol tests, and eye exams. In addition, fewer blacks received recommended care to control asthma, blood pressure, cholesterol or blood sugar. CSS noted that the lack of data monitoring by the state is a lost opportunity to identify disparities and track changes over time.

The report also provided a series of policy solutions, including requiring managed care organizations to reduce disparities, and targeting chronic illnesses such as diabetes, heart disease and asthma for disparities reduction. The report suggested that managed care organizations adopt safeguards to deter doctors from focusing these efforts on healthier patients to make their performance look better. The report also suggested rotating quality improvement measures to keep doctors from "teaching to the test."

Following their report, CSS met with the commissioner and other advocates to pursue a legislative response. Unfortunately, the New York political climate forced CSS to place their work on hold. They are looking to other advocacy groups to help them identify next steps.

Example 2: Pilot program in Michigan uses data to structure disparities reduction around diabetes

In 2006, the Michigan Medicaid agency, in collaboration with three Medicaid managed care organizations, launched a pilot program to track and reduce racial and ethnic health disparities. This pilot was a part of a six-state data tracking initiative⁶ to reduce health disparities, funded by the federal Health Resources and Services Administration (HRSA) and the Commonwealth Fund. The Michigan pilot focused on diabetes management because initial analyses by the state, funders, and Medicaid managed care plans revealed disparities in diabetes care for blacks. The three plans were chosen because they served a high volume of black patients.

The first step was to determine how patients were doing in the current environment. By pairing their HEDIS data with the Medicaid agency's patient enrollment data, the participating managed care plans were better able to understand the magnitude and breadth of health disparities inside their Medicaid network.

From the baseline established by the data review, the managed care plan generated a set of goals to reduce disparities within diabetes management. Though the plans had differing goals, the general menu of interventions was similar. Patients received information about diabetes in their preferred language, instruction on how to care for themselves, coordinated visits to appropriate doctors and caregivers, and reminders, including at home, about the need to follow recommended testing procedures. In medical terms, these interventions included disease management, culturally sensitive educational materials, case management and home health coordination. The plans worked toward improving care for individuals with diabetes in general and blacks specifically.

All the plans met their goals or exceeded them. On average, black patients in the plans increased their testing of blood sugar and cholesterol levels, leading to better management of their chronic illness.

Additional Resources

- Center for Health Care Strategies offers a tool kit with guidance on how to reduce health disparities in Medicaid through data collection. http://www.chcs.org/usr_doc/Using_Date_to_Reduce_Health_Disparities.pdf
- Robert Wood Johnson Foundation outlines the legality of data collection (2006). <http://www.rwjf.org/files/publications/other/RaceEthnicDisparitiesData06222006.pdf>
- Minnesota published an in-depth handbook on racial and ethnic disparities data collection. It includes data use, collection, measurement, confidentiality concerns, and reporting. http://mncm.org/site/assets/resources/Handbook_on_the_Collection_of_6-30-09_FINAL.pdf

¹ <http://www.statehealthfacts.org/profileind.jsp?cat=3&sub=42&rgn=1>

² Holly Mead, Lara Cartwright-Smith, Karen Jones, Christal Ramos, Kristy Woods, and Bruce Siegel. Racial and Ethnic Disparities in U.S. Health Care: A Chartbook. Commonwealth Fund. March 2008. http://www.commonwealthfund.org/~media/Files/Publications/Chartbook/2008/Mar/Racial%20and%20Ethnic%20Disparities%20in%20U%20S%20Health%20Care%20A%20Chartbook/Mead_raceethnicdisparities_chartbook_1111%20pdf.pdf. Federal poverty level is for 48 states and DC (Alaska and Hawaii have slightly higher figure).

³ Eliminating Racial/Ethnic Disparities in Health Care: What are the Options? Kaiser Family Foundation. October 2008. <http://www.kff.org/minorityhealth/upload/7830.pdf>

⁴ Karen LLanos and Lindsay Palmer. Using Data on Race and Ethnicity to Improve Health Care Quality for Medicaid Beneficiaries. Center for Health Care. June 2006. http://www.chcs.org/usr_doc/Using_Date_to_Reduce_Health_Disparities.pdf

⁵ Agency for Health Care Research and Quality (AHRQ), Regional Coalition Collaboration Guide. April 2008. <http://www.ahrq.gov/qual/value/collabguide9.htm>

⁶ David R. Nerenz and Debra Darling. Addressing Racial and Ethnic Disparities in the Context of Medicaid Managed Care: A Six-State Demonstration Project. Health Resources and Services Administration. November 2004. <http://www.hrsa.gov/reimbursement/disparities/default.htm>