Greater Than the Sum:
Using Integrated Care to Reduce Racial and Ethnic Health Disparities among Dual Eligibles

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Background

Nationwide, there are more than 10 million individuals who are eligible for both Medicare and Medicaid (dually eligible).[1] Much has been written about the poor health status and high level of spending associated with this group of low-income seniors and people with disabilities. However, less attention has been paid to the fact that dual eligible beneficiaries are disproportionately from communities of color. More than 36 percent of dual eligibles are from racial or ethnic minority groups, which is between two and four times greater than those enrolled in Medicare alone. Of those dual eligibles, about 20 percent are Black ; 7 percent Latino; 5 percent Asian; and nearly 1 percent Native American or Pacific Islander.[2]

Older adults from communities of color often receive poorer quality of care and face more barriers in seeking preventive care, acute treatment, or chronic disease management, than do white patients. Some examples of these disparities include:

- Black seniors are more likely to be readmitted to the hospital within thirty days for heart attack, congestive heart failure and pneumonia.[3]
- Only 39 percent of Latinos 50 and older report ever having a colonoscopy, compared to 55 percent of the overall population.[4]
- Black and Latino older adults have much lower rates of flu and pneumonia vaccination.[5]
- Among adults with a disability, 55 percent of Latinos and 47 percent of Blacks report fair or poor health, as compared with 37 percent of whites non-Hispanics.[6]
- Black dual eligibles are significantly less likely to fill prescriptions.[7]

The Affordable Care Act (ACA) offers a unique opportunity to address some problems faced by the dual eligible population. The ACA established the Medicare-Medicaid Coordination Office (MMCO), which promotes design of person-centered care models that coordinate primary, acute, behavioral and long-term supports and services for Medicare-Medicaid enrollees. The MMCO has created the Financial Alignment Initiative under which states could use two financial models as the basis for a proposed demonstration project aimed at integrating care for dual eligibles.[8] Twenty-three states are developing these demonstrations. The MMCO has approved four states to move forward; the rest are still under review.

The ACA also includes several provisions that could help reduce racial and ethnic disparities[9] but so far, the federal government has only urged that the dual eligible demonstrations take on two:

1. Providing materials for enrollees – such as enrollment notices and descriptions of benefits – in languages enrollees can understand.[10]
2. Health plans must develop a culturally competent provider network that meets the diversity of the target population.[11]

Besides these two provisions, however, the MMCO has left it up to the states to decide whether to include additional provisions aimed at promoting health equity.[12]

As these demonstrations are being designed, there are opportunities for state and the MMCO to do more to address disparities. The purpose of this issue brief is to:

- Discuss the opportunity the ACA offers to address racial and ethnic health disparities among the dual eligible population.
- Highlight the steps states are planning to take to address racial and ethnic health disparities based on their demonstration project proposals or Memoranda of Understanding.
- Offer recommendations that will advance health equity through the demonstration projects.
- Highlight the role for consumer advocates.

Methodology

We reviewed the 23 active state demonstration project proposals and looked at five factors to measure whether the state proposals offered specific plans to address racial and ethnic health disparities. In some instances, the state is simply applying existing Medicaid policy or practice, to the dual eligible demonstration project but in others, the state is taking on a concrete new step.

We used the following five criteria:

1. **Aligned with the Department of Health and Human Services (HHS) Action Plan:** Did the state indicate that its demonstration project would be aligned with the HHSs Action Plan to Reduce Racial and Ethnic Health Disparities, an effort aimed at promoting integrated approaches, evidence-based programs and best practices to reduce these disparities?[13]

2. **Stakeholder engagement:** Did the state include stakeholders from communities of color in the development of its proposal or indicate plans to include them in the implementation of the demonstration project?

3. **Outreach Materials:** Did the state include plans to provide information about the demonstration in ways that are sensitive to the beneficiary's language and culture?

4. **Model of Care:** Did the state indicate that plans or providers would be required to provide care in a manner sensitive to the beneficiary's language and culture?

5. **Quality measures:** Did the state propose using quality measures to assess racial and ethnic health disparities, and did it establish specific goals and outcomes to measure progress?

Findings

State	Aligned with HHS Action Plan	Stakeholder Engagement		Outreach Materials	Model of Care	Quality Measures
		Proposal development	Implementation			
Arizona						X
California				X	X	
Colorado				X	X	
Connecticut	X	X		X	X	
Hawaii				X	X	
Idaho						
Iowa	X					
Illinois				X	X	
Massachusetts	X			X	X	X
Michigan					X	
Minnesota	X				X	X
Missouri				X	X	
New York	X			X	X	
North Carolina	X					
Ohio	X	X	X	X	X	X
Oklahoma	X			X	X	
Rhode Island	X			X	X	
South Carolina				X		
Texas					X	
Vermont	X			X	X	
Virginia	X			X	X	
Washington				X	X	
Wisconsin				X	X	

Although federal officials did not identify racial and ethnic health disparities as a focus of the duals demonstrations, each state proposal incorporated at least one of the five factors we focused on. Nearly all the states said they would require plans or providers to provide culturally and linguistically competent care, most said they would ensure materials were translated and some indicated they would use quality measures to assess disparities.

Some states went much further. Ohio, for example, indicated it would coordinate its demonstration project with a Medicaid initiative aimed at reducing racial and ethnic disparities. The state incorporated into its demonstration proposal a work plan developed as part of a National Academy of State Health Policy (NASHP) project to address health disparities among its Medicaid beneficiaries.[14] Some of the relevant action steps included in the work plan are:

- Reviewing managed care contracts with a health equity lens
- Improving eligibility and enrollment systems to foster participation of racially and ethnically diverse populations
- Mandating the reporting of quality indicators by race and ethnicity
- Ensuring health homes and patient centered medical homes provide services in a culturally sensitive manner.

Ohio plans to establish a health equity workgroup in the summer of 2013. The state also plans to conduct outreach to minority providers and provide them with resources that will enhance their ability to set up electronic medical records.[15]

Some states mentioned plans for an important first step toward addressing disparities: increasing data collection on dual eligible individuals by race and ethnicity. For example:

- New York plans to expand collection and analysis of data regarding ethnicity, gender identity, and housing and disability status to better identify and understand health disparities and to promote policies that address these gaps.[16]
- Massachusetts will require integrated care organizations to report data on health and quality of care measures that include demographic information on race and ethnicity.[17]

Other states focused on how they would ensure a limited ability to speak and understand English was not a barrier to receiving information or sharing opinions about how the project is going. For example, New York specified vital materials will be translated into the six most common non-English languages spoken by dual eligibles. In addition, New York will survey all participants annually about how their level of satisfaction, using surveys translated into different languages or telephone interviews with interpreters.[18]

Other states paid particular attention to ensuring a racially and ethnically diverse array of stakeholders would be engaged in helping shape and implement the demonstrations. In Connecticut, 15 percent of participants in state-run consumer focus groups leading up to implementation were Spanish speakers (a good representation of dual eligible Latinos in Connecticut).[19]

Recommendations

Because racial and ethnic minorities make up a disproportionately large part of the dual eligible population, it is incumbent upon all states, the MMCO and plans to take specific actions within the context of the dual eligible demonstration projects to reduce health disparities. We recommend the following steps.

Increase Data Collection on Race and Ethnicity

Data regarding race and ethnicity is usually not collected properly, and in many cases it is not collected at all. But reliable data is essential to identify the types and severity of disparities, causes, and type of interventions needed, and to track results. For the dual eligible demonstrations, ideally states and health plans should be collecting data using national standards and definitions and sharing the data with the federal government to facilitate comparisons.

The HHS Office of Minority Health (OMH) has released standards to more consistently measure race, ethnicity, sex, primary language, and disability status, as required by Section 4302 of the ACA. The law requires that, once established, these data collection standards be used, to the extent practicable, in all national population health surveys.[20] It also requires all federally funded programs and activities to collect data on disparities.

States should:

- Follow the standards created by the HHS when pursuing data collection.[21]
- Require the plans or provider groups collect data from all the dual eligible beneficiaries they serve. The state should then analyze this data to understand and address disparities.

Create Clear Communication Pathways

To have a patient-centered approach, individuals must be able to express their needs and understand their health plan options, understand how to access health care services, and receive disease treatment and prevention services. This requires interpreters, translation of documents and robust networks of multilingual providers who can provide culturally competent care.

The federal Centers for Medicare and Medicaid Services (CMS) have developed a Strategic Language Access Plan that aims to provide timely access to language assistance services for people with limited English proficiency in Medicaid and Medicare. We recommend states follow the CMS plan to ensure effective communication with beneficiaries.[22]

In addition, we recommend:

- States and plans/provider groups translate all materials into languages spoken by the lesser of 5 percent or 500 people in each demonstration service area.
- States and plans/provider groups offer 24/7 toll-free numbers which provide information available in the languages spoken by more of 5 percent of beneficiaries.
- Plans/provider groups offer services that align with National Standards on Culturally and Linguistically Appropriate Services.[23]
- States provide rigorous oversight of the accessibility and quality of language assistance services and require improvements as needed.

- Plans/provider groups increase the racial and cultural diversity of the workforce in contact with beneficiaries.

Require Ongoing Consumer Engagement

Creating structures for the ongoing collection of meaningful feedback from dual eligibles, their families and the advocates that represent them is critical to the success of the demonstrations. It is an important means for identifying promising practices to expand and problems to correct.

States should:

- Involve people from communities of color in state-level bodies charged with the implementation, evaluation and monitoring of the demonstrations
- Require plans and provider groups serving dual eligibles to have ongoing, meaningful consumer input into their operations, with particular emphasis on including limited English proficiency individuals and beneficiaries from racial and ethnic minority communities[24]

Set Goals to Reduce Health Disparities and Measure Progress toward Goals

To ensure demonstration projects focus on reducing health disparities, states should set goals and regularly track progress. Building on key disparity measures included in the HHS Action Plan,[25] states should select quality measures with a specific focus on metrics related to disparities to detect fluctuations over time among populations (race/ethnicity, language, gender, etc.)[26] and should measure across the following settings:

- Practitioner performance (e.g. rate of screening for high blood pressure)
- Facility-specific performance (e.g. risk-adjusted mortality for hospital X)
- Condition management *(*e.g. prevalence of Diabetes complications)
- Cultural competency (e.g. education and management regarding medications)
- Consumer surveys (e.g. satisfaction with most recent visit)

States should also:

- Provide cultural competency training to health plans and provider groups
- Require health plans and provider groups to meet specific benchmarks toward the project's health disparities reduction goals and publicize progress or lack thereof
- Create financial incentives to reward health plans and provider groups that make progress toward the reduction of disparities

Partner with other Organizations and Departments focused on Health Disparities

Health disparities cannot be addressed by improving health care alone—social and economic factors such as education, socioeconomic status, and access to food and transportation are underlying problems that affect health. While the duals demonstrations themselves cannot take on work to change these broader factors, states can partner with agencies and organizations—at both the state and federal levels—that are working to address these issues.

States should develop joint initiatives to address the root causes of health disparities. States could also seek federal support through the Community Transformation Grant Program and other ACA initiatives overseen by agencies focused on health, housing and education.

In addition to the above recommendations specific to the needs of dual eligibles from communities of color, we recommend several priorities for the demonstration projects. While these recommendations are applicable to all dual eligibles, they will have a particularly positive impact on beneficiaries from communities of color.

Provide Patient-Centered Care Coordination

While care coordination is a foundational element of the dual eligible demonstration projects, it is extremely important for beneficiaries from communities of color. Creating patient-centered care coordination requires plans and providers to build the provision of services around the beneficiary and requires them to include beneficiaries in the decision making process around their care, including managing their own health.

States should:

- Use quality measures that examine important care coordination issues such as transitions of care. One example is the Care Transitions Measure, a survey administered to caregivers and patients that is available in different languages[27]
- Require plans and provider groups to conduct a comprehensive health assessment to identify the specific needs of the beneficiary
- Require plans and provider groups to provide patient education, empowerment and self-management programs. These include:
    - Evidence-based programs such as the Stanford Chronic-Disease Self-Management Program or the Diabetes Self-Management Program.[28]
    - Programs that support caregivers and give them tools to provide better care and support to beneficiaries.[29]
    - Care transition interventions for patients to learn self-management skills to ensure their needs are met during transitions from one setting to another.[30]

Expand Support Services

Long-term services and support (LTSS) are critical for many dual eligibles but make a real difference in the lives of those from communities of color. States should require health plans to maintain robust levels of LTSS. In addition, to ensure proper coordination of LTSS, an LTSS coordinator should be part of the beneficiary care team. The LTSS coordinator can serve as a liaison to other members of the care team.[31]

Furthermore, the demonstration is an opportunity for states to expand services that dual eligibles, especially those from communities of color, have difficulty accessing. For example, in Massachusetts, the state proposed an expansion of covered services to include:

- Dental and vision benefits
- Behavioral diversionary services
- Extensive community support services, especially peer supports, self-directed Personal Care Assistant (PCA) services, home care and recovery support
- Training, repairs and modification of durable medical equipment

Conclusion

The dual eligible demonstration projects create an opportunity to reduce existing health disparities among the disproportionately large number of dual eligibles from communities of color. However, without focused attention from all stakeholders—provider, plans, policymakers and advocates—to the issue, the opportunity will be squandered.

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[1] Medicare-Medicaid Coordination Office , Data Analysis Brief: Medicare-Medicaid Dual Enrollment from 2006 through 2011, February 2013, available at https://www.cms.gov/medicare-medicaid-coordination/medicare-and-medicaid-coordination/medicare-medicaid-coordination-office/downloads/dual_enrollment_2006-2011_final_document.pdf.

[2] Id. at Attachment A: Figures 2.2a & 2.2b.

[3] JAMA "Thirty-Day Readmission Rates for Medicare Beneficiaries by Race and Site of Care", February 2011, available at http://jama.jamanetwork.com/article.aspx?articleid=645647#qundefined

[4] AHRQ "2011 National Healthcare Quality & Disparities Reports; Data Tables Appendix," available at http://www.ahrq.gov/qual/qrdr11/1_cancer/T1_3_2_2b.htm

[5]CDC Office of Minority Health and Health Disparities. "Health Disparities Affecting Minorities," available at http://www.cdc.gov/minorityhealth/brochures/OMHD.pdf

[6] CDC "Disability and Health, Data and Statistics", available at http://www.cdc.gov/ncbddd/disabilityandhealth/data.html

[7] Schore et al, "Racial Disparities in Prescription Drug Use Among Dually Eligible Beneficiaries", Health Care Financing Review/Winter 2003-2004/ Volume 25, Number2

[8] See Financial Alignment Initiative, available at http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialModelstoSupportStatesEffortsinCareCoordination.html.

[9] See Joint Center for Political and Economic Studies, Patient Protection and Affordable Care Act of 2010: Advancing Health Equity for Racially and Ethnically Diverse Populations, July 2010, available at http://www.jointcenter.org/research/patient-protection-and-affordable-care-act-of-2010-advancing-health-equity-for-racially-and.

[10] CMS, Additional Guidance on the Medicare Plan Selection Process for Organizations Interested in Offering Capitated Financial Alignment Demonstration Plans in 2013, March 2012, available at https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/MarchGuidanceDocumentforFinancialAlignmentDemo.pdf

[11] Centers for Medicare and Medicaid Services. "Medicare-Medicaid Capitated Financial Alignment Demonstration MMP Readiness Review," December 17, 2012. https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/MMP_ReadinessReview_Presentation.pdf

[12] The MMCO is providing states with data on demographic characteristics, utilization, and spending patterns of Medicare-Medicaid enrollees to better understand this population. The data included in these reports have breakdown of race and ethnicity. See Medicare-Medicaid Coordination Office's Analytic Reports and Data Resources available at: https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Analytics.html.

[13] HHS "Action Plan to Reduce Racial and Ethnic Minorities", April 2012, available at http://www.minorityhealth.hhs.gov/npa/files/Plans/HHS/HHS_Plan_complete.pdf

[14] Ohio Department of Job and Family Services Office of Ohio Health Plans, State Demonstration to Integrate Care for Medicaid-Medicare Enrollees Proposal to the Center for Medicare and Medicaid Innovation, April 2012, at Appendix L, available at http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/OhioProposal.pdf

[15] Harry Saxe, Ohio Department of Job and Family Services, and Angela Dawson, Ohio Commission on Minority Health, New Opportunity to Address Racial and Ethnic Health Disparities for Medicare and Medicaid Beneficiaries, Conference Call, March 5, 2013.

[16] New York State Department of Health's Demonstration to Integrate Care for Dual Eligible Individuals, May 2012, at 68, available at http://www.health.ny.gov/facilities/long_term_care/docs/2012-05-25_final_proposal.pdf.

[17] Commonwealth of Massachusetts, Proposal to the Center for Medicare and Medicaid Innovation, State Demonstration to Integrate Care for Dual Eligible Individuals, February 2012, at 38, available at http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/MassachusettsProposal.pdf.

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[20] HHS Office of Minority Health, Final Data Collection Standards for Race, Ethnicity, Primary Language, Sex and Disability Status Required by Section 4302 of the Affordable Care Act, available at http://minorityhealth.hhs.gov/templates/browse.aspx?lvl=2&lvlid=208.
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[23] See National Standards on Culturally and Linguistically Appropriate Services at http://minorityhealth.hhs.gov/templates/browse.aspx?lvl=2&lvlid=15.
[24] See Community Catalyst, Best Practices for Meaningful Consumer Input in New Health Care Delivery Models, September 2012, available at http://www.communitycatalyst.org/doc_store/publications/meaningfulconsumerinput_healthcaredeliverymodels.pdf.
[25] HHS "Action Plan to Reduce Racial and Ethnic Minorities", April 2012, at 44, available at http://www.minorityhealth.hhs.gov/npa/files/Plans/HHS/HHS_Plan_complete.pdf.
[26] Weissman et al, Commissioned Paper: Healthcare Disparities Measurement, October 2011, available at http://www.qualityforum.org/Publications/2012/02/Commissioned_Paper__Healthcare_Disparities_Measurement.aspx.
[27] Information about the Care Transitions Measure is available at http://www.caretransitions.org/ctm_main.asp.
[28] See descriptions of Stanford Self-Management programs at http://patienteducation.stanford.edu/programs/.
[29] See, e.g., tools and resources from the Family Caregiver Alliance, available at http://www.caretransitions.org/caregiver_resources.asp.
[30] See, e.g., resources for patients and family caregivers from The Care Transitions Program, available at http://www.caretransitions.org/caregiver_resources.asp.
[31] See Community Catalyst, Dual Eligible Demonstration Projects: Top Ten Priorities for Consumer Advocates, March 2012, available at: http://www.communitycatalyst.org/doc_store/publications/Top_Ten_Duals_Projects_Guide_Advocates.pdf