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Miles to Go:  
*Progress on Addressing Racial  
and Ethnic Health Disparities in  
the Dual Eligible Demonstration  
Projects*

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# Miles to Go: Progress on Addressing Racial and Ethnic Health Disparities in the Dual Eligible Demonstration Projects

## Introduction

It is generally known in health care circles that Medicare-Medicaid enrollees, referred to as dual eligibles, are a vulnerable group with complex medical needs. They experience poorer health outcomes and make greater use of medical and social supports, resulting in very high levels of spending.<sup>1</sup> A lesser discussed fact is that dual eligibles from communities of color experience added barriers when navigating both Medicare and Medicaid to obtain their care. Forty-four percent of the Medicare-Medicaid enrollee populations are from communities of color, compared to 17 percent of the Medicare-only population.<sup>2</sup> An initial look into the numbers of dual Medicare-Medicaid beneficiaries from communities of color is represented in this table:<sup>3</sup>

<b>Medicare-Medicaid Beneficiaries from Communities of Color</b>		
African American	20%	~2,000,000
Latino	15%	~1,500,000
Asian American/Pacific Islander	7%	~700,000
American Indian/Alaska Native	1%	~100,000
Unknown	1%	~100,000

The aggregated numbers in the above table do not provide the full picture of the range of cultural diversity comprising these broad groupings. For example, the Asian American/Pacific Islander category can be broken down into 30 or more subgroups, with some states containing large concentrations of certain populations.<sup>4</sup>

The dual eligible demonstration projects hold the promise of higher-quality, more integrated care for the dually eligible population. A dozen states have received CMS approval for their demonstrations, seven of which have begun enrolling beneficiaries.<sup>5</sup>

While the Affordable Care Act (ACA) includes several provisions that could help reduce racial and ethnic health disparities,<sup>6</sup> the federal government has only required that the dual eligible demonstrations take on two:

1. Providing materials for enrollees<sup>7</sup> – such as enrollment notices and descriptions of benefits – in languages enrollees can understand.
2. Requiring health plans to develop a culturally competent provider network<sup>8</sup> that meets the diversity of the target population.

Besides these two provisions, however, the Medicare Medicaid Coordination Office (MMCO) has left it up

### **Overview of the Dual Eligible Demonstration Projects**

There are approximately 10 million seniors and people with disabilities nationwide enrolled in both Medicare and Medicaid (dual eligibles). To address the fragmented and uncoordinated care that dual eligibles receive, the Medicare Medicaid Coordination Office (MMCO) launched demonstration projects aimed at improving care for dual eligibles, at the same time seeking to reduce the costs that put a strain on Medicare and Medicaid. The MMCO offered two financing models to states interested in pursuing a [demonstration project](#): (1) capitated model and (2) managed fee-for-service model.

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to the states to decide whether to include additional provisions aimed at reducing racial and ethnic health disparities. In early 2013, Community Catalyst published a paper<sup>9</sup> about how to address racial and ethnic health disparities through these demonstration projects and noted a considerable lack of detail in the requirements. Greater detail has emerged since that time, including an express goal noted in all the approved demonstrations of reducing health care disparities. However, details such as ensuring a diverse workforce; having a care delivery process that is responsive to cultural and linguistic needs (e.g. care plan, care coordination, provider-consumer relationships); measuring and monitoring training on topics like cultural competency; providing linguistically accessible services and materials; and instituting quality measures on cultural competency and diverse representation on consumer advisory councils, are still lacking.

The purpose of this paper is to:<sup>10</sup>

- Examine provisions that address racial and ethnic health disparities in approved demonstrations
- Offer recommendations that will improve care for dual eligibles from communities of color
- Highlight roles for consumer advocates in addressing racial and ethnic health disparities for this population

### **Methodology**

This paper examines provisions in documents related to twelve approved demonstration projects: ten in states pursuing the capitated financial model and two in states pursuing the managed fee-for-service financial model.<sup>11</sup>

#### **Capitated**

California  
Illinois  
Massachusetts  
Michigan  
New York  
Ohio  
South Carolina  
Texas  
Virginia  
Washington<sup>12</sup>

#### **Managed Fee-for-Service (MFFS)**

Colorado  
Washington

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The following documents were reviewed:<sup>13</sup>

	<b>Evaluation Plans</b>	<b>Three-Way Contracts</b>	<b>MOU<sup>14</sup></b>	<b>Marketing Materials</b>	<b>Readiness Review Tools</b>	<b>State Specific Reporting Requirements</b>
CA	X	X	X	X	X	
CO			X <sup>15</sup>			
IL	X	X	X	X	X	X
MA	X	X	X	X	X	X
MI		X	X	X	X	
NY		X	X	X	X	
OH	X	X	X	X	X	X
SC		X	X	X	X	
TX			X		X	
VA	X	X	X	X	X	X
WA (capitated)	X		X		X	
WA (MFFS)	X		X <sup>16</sup>			

In addition to reviewing the above listed documents, the following Centers for Medicare and Medicaid Services (CMS) documents were also reviewed:

- Enrollment Guidance
- Aggregate Evaluation Plan
- Reporting Requirements

Four factors were used to evaluate how the demonstration will impact communities of color; within each factor, several specific features were examined to see if these are addressed by the demonstrations.

1. Cultural Competency in Care Delivery

- a. Delivery of services in a culturally and linguistically competent manner
- b. Culturally and linguistically competent provider networks
- c. Cultural competence training (includes plan staff, providers, care teams)
- d. Culturally competent care plan
- e. Culturally competent Long-Term Services and Supports (LTSS) providers and coordinators

2. Language Access

- a. Defines threshold or prevalent languages for translation of documents<sup>17</sup>
- b. Enrollees with limited or no proficiency in English provided interpreter services free of charge
- c. Easy to understand materials

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d. Materials developed at 6th grade reading level

3. Quality and Monitoring

- a. Evaluations monitor whether the demonstrations reduce or eliminate racial and ethnic disparities
- b. Quality Improvement Program (QIP) instituted in a culturally competent manner
- c. Enrollee record includes Race, Ethnicity and Language (REL)
- d. Cultural and linguistic competency as a quality measure

4. Consumer Engagement

- a. Consumer Advisory Council must reflect the diversity of the enrollee population

**Findings**

*Cultural Competency in Care Delivery*

State	Delivery of services <sup>18</sup>	Provider networks	Training	Care plan	LTSS providers and coordinators <sup>19</sup>
CA	X	X <sup>20</sup>	X	X <sup>21</sup>	X
CO	X		X	X	X
IL	X	X	X	X	X
MA	X	X	X	X	X
MI	X	X	X	X	X
NY	X <sup>22</sup>	X	X	X	
OH	X	X	X	X	
SC	X	X	X	X	X
TX	X	X	X	X	
VA	X <sup>23</sup>	X	X	X	X
WA	X	X	X	X	
WA(MFFS)	X		X		

- All of the demonstrations state in some fashion that benefits will be delivered in a culturally competent manner.
  - The Washington Managed Fee-for-Service (MFFS) MOU is the only document that provides examples of what it means to deliver services in a culturally competent manner.<sup>24</sup> For example, it requires plans to speak with the beneficiary and their families in their preferred language.
- Those states with signed three-way contracts state that provider networks must be developed with a focus on cultural competency. The readiness review tools imply that network providers will provide services in a linguistically and culturally competent manner.
  - Those states with three-way contracts state that health plans must ensure that all providers require sub-contractors to provide services in a culturally competent manner.

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- Training in cultural competency is noted in all three-way contracts. In other states, training is described in the readiness review tools and/or MOUs.
- All of the states, as a part of assessing readiness of health plans, require care plans to be developed and delivered in a culturally competent manner.

**Standout Provision: Massachusetts’s three-way contract requires these elements as a part of new community-based services:**

- A community health worker who will apply his/her unique linguistic and cultural experience to counsel and help enrollees access services they need
- An appropriate care transition plan across facility and community settings that is a two- way exchange of information about the enrollee; the plan must include culturally and linguistically competent post-discharge education regarding symptoms that may indicate additional health problems or a deteriorating condition

Language Access

State	Translation of documents	Interpreter services	Easy to understand materials <sup>25</sup>	6th grade reading level
CA	X	X	X	X
CO		X	X	
IL	X	X	X	X
MA	X	X	X	X
MI		X	X	X
NY	X	X	X	X
OH	X	X	X	X
SC		X	X	X
TX	X	X	X	
VA	X	X	X	X
WA		X	X	X
WA (MFFS)	X	X	X	

- All of the demonstrations require linguistically accessible materials.
- All demonstrations state that marketing, outreach and enrollee communications must be translated into threshold or prevalent languages. Those states with signed three-way contracts *define* threshold or prevalent languages.
  - Plans in California, Illinois, Massachusetts, Michigan, New York, Ohio, South Carolina and Virginia are required to provide notice of adverse action, complaints and grievances in all threshold or prevalent languages.
- All demonstrations will provide interpreter services to enrollees.

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- California, Illinois, Massachusetts, Michigan New York, Ohio, South Carolina and Virginia add that plans must provide information regarding the ability to appeal or file a grievance through an interpreter service, if needed.
- All demonstrations add that customer service representatives must be linguistically and culturally competent and be able to access interpreter services.
- In the two MFFS states, Washington and Colorado, both MOUs say that the state will partner with local organizations serving minority and underserved populations to reach those whose first language is not English.

Quality and Monitoring

State	Evaluations	QIP	Enrollee record	Cultural and linguistic competency as a quality measure
CMS	X <sup>26</sup>			
CA	X	X		
CO				X
IL	X	X		X
MA	X	X	X	X
MI		X	X	
NY		X		
OH	X	X	X	X
SC	X	X		X
TX				
VA	X	X	X	X
WA	X			
WA (MFFS)	X			X

- The CMS Aggregate Evaluation Plan and the state-based evaluation plans indicate that both CMS and the states will measure access to culturally and linguistically competent care and consider it a success measure for the program.
- CMS will measure beneficiary experience through stakeholder interviews, focus groups, demonstration data and interviews with state agency staff. Focus groups will reflect a range of demographic characteristics. The decision to conduct focus groups in languages other than English will be made based on the prevalence of non-English-speaking beneficiaries in the state.
- In order to understand the impact of the demonstration on particular subpopulations, the CMS evaluation will explore whether the demonstrations reduce or eliminate disparities (e.g., by race or ethnicity) in access to care, beneficiary experience, health care utilization,

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expenditures, quality of care, quality of health and to what extent specific features drive these outcomes.

- Demonstrations with signed three-ways contracts require that QIPs be established in a culturally competent manner.
- Massachusetts and Virginia plan reporting requirements include reporting on race, ethnicity and primary language as a part of the enrollee record. In Michigan and Ohio this information is collected as a state-specified quality measure.
- Though more than half of the approved demonstrations include cultural competency as a measure of quality, none include linguistic competency specifically.
  - In the Colorado and Washington MFFS demonstrations, this measure is tied to cultural competency training and used in all three years of the demonstration – the first year as a reporting measure and the last two years as a benchmark.
- New York’s three-way contract requires health plans participating in the demonstration to comply with requirements and recommendations adopted by the Medicaid Redesign Team’s Health Disparities Work Group.<sup>27</sup> The workgroup offered recommendations on a number of topics, such as data collection and metrics to measure disparities, language access and population health.
- Ohio’s three-way contract requires health plans participating in the demonstration to join the Ohio Department of Medicaid’s (ODM) Health Equity Workgroup (HEW). The workgroup will be comprised of the health plans, ODM, the Ohio Commission on Minority Health and the Ohio Department of Health. The workgroup will be responsible for:
  - Determining the data elements (e.g., self-identified race, ethnicity, and language) needed to calculate health disparities
  - Describing the extent of health care disparities among beneficiaries based on the data collected
  - Developing a strategy based on what the measures show

### Consumer Engagement

State	Consumer Advisory Committee
CA	X
CO	X
IL	X
MA	X
MI	X
NY	X
OH	X
SC	X
TX	X
VA	X
WA	X
WA (MFFS)	X

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- Every state using a capitated financing model requires plans to create a consumer advisory committee that reflects the diversity of the enrollee population
  - Some states define the diversity of the population by including community-based groups. For example, Illinois, Michigan and Washington each state that committees will be comprised of representation from faith-based groups, advocacy groups and other community-based organizations.
  - The Illinois three-way contract states that there will be a consumer advisory committee and a community stakeholder committee. Both will provide feedback to the quality assurance team to identify key program issues, such as racial or ethnic disparities, that may impact community groups.
- In the two MFFS states, Colorado and Washington, the CMS and state will require mechanisms that ensure beneficiary input and involvement in planning and process improvement.

### Recommendations

With a disproportionate number of dual eligibles being from communities of color, it is imperative that CMS, states and delivery systems (health plans and provider groups) make it their priority to reduce racial and ethnic health disparities. As stated earlier, the ACA includes several provisions that could help reduce racial and ethnic health disparities, including nondiscrimination provisions to ensure consumers have access to health care that is culturally and linguistically appropriate.<sup>28</sup> It is vital that CMS and states require delivery systems to adhere by these laws and implement them for the duals demonstrations. In addition to what is in the ACA, we provide the following recommendations for both the capitated and MFFS models. These recommendations are built on a previous set of recommendations.<sup>29</sup> We applaud the greater detail that has been provided since 2013 by states and CMS; however, more is needed in terms of how policies and procedures will be implemented.

#### 1. Cultural Competency in Care Delivery

##### Ensure a Diverse Workforce

Quality care means having a diverse workforce both in terms of diversity of disciplines (e.g., primary care physicians, social workers, nurses, home care workers) as well as diversity of cultures and ethnicities. This should be done at multiple levels – at the delivery system level for those on the Interdisciplinary Care Team, including the care managers and other delivery system staff – as well as reflected in the diversity of the providers under contract with the delivery system. Delivery systems that are culturally competent<sup>30</sup> realize improved health outcomes for their consumers, and earn their respect, understanding and trust.<sup>31</sup>

The following should be required to ensure a diverse workforce:

- An ethnically and racially diverse pool of providers in the network, representative of the community being served and speaking the languages prevalent in the community
- Delivery system participation in initiatives (in partnership with the state) to recruit and develop a more diverse workforce

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- The creation of a network directory that includes the languages spoken by each provider
- The use of community health workers<sup>32</sup> within the care team to bridge the gap for consumers who do not speak English or have limited proficiency and to provide culturally competent care
- A care team on which, at a minimum, the care coordinator speaks the same language as the consumer
- Financial arrangements with network providers that incentivize the delivery of culturally competent services and the use of a diverse direct care workforce to carry out those services

### **Delivering Long-Term Supports and Services in a Culturally Competent Manner**

The dual eligible demonstration projects present for the first time, for many dual eligibles, an opportunity to receive care from a health plan that integrates long-term supports and services (LTSS) with clinical services.<sup>33</sup> The non-medical care settings and services have not traditionally focused on cultural and linguistic competence. However, for dual eligibles – particularly those from communities of color – to live successfully in the community it is critical to have LTSS providers with the training and skills to meet the cultural and linguistic needs of the enrollees.

The following should be required to ensure LTSS are delivered in a culturally competent manner, in addition to the provisions for all providers above:

- Delivery systems allow consumer self-direction and contract with LTSS providers that are diverse and representative of the community being served
- LTSS coordination should be done in a manner that is responsive to the cultural and linguistic needs of enrollees  
Services provided in home and social settings must also be culturally and linguistically competent. For example, ensuring that those interacting with beneficiaries speak the preferred language, understand cultural norms and respect dietary requirements and restrictions.

### **Cultural Competency Training for Staff and Providers**

Quality care for the diverse dual eligible population requires trained delivery system staff and providers that understand and respect different cultures. Cultural competency training is critical to improving the quality of services delivered and should be an ongoing part of staff and provider continuing education.

*Delivery systems should:*

- train staff and providers annually on cultural competency
- develop training modules based on existing levels of understanding demonstrated by staff and providers on cultural competency
- use patient surveys and partner with local organizations to develop training content

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*States and CMS should:*

- require delivery systems to report on trainings conducted and use patient surveys to improve outcomes of those trainings
- conduct onsite monitoring and assessment of how the training is conducted
- conduct assessments of whether the care provided is culturally competent by using secret shoppers or other similar tests

### 2. Language Access

Delivery systems that implement appropriate language access services can reduce barriers and create clearer pathways for dual eligibles to access the appropriate services, improve their health outcomes and increase their satisfaction with the care they receive.<sup>34</sup> The ability to engage in successful patient-provider communications, understand written notices, and communicate needs and preferences are all critical to having a positive care experience.

*Delivery systems should be required to:*

#### **Care Planning**

- Assess language needs for each enrollee, document them and develop plans to meet the needs as part of the care plan

#### **Patient-Provider Communications**

- Utilize bilingual staff whenever possible
- Employ translators from the community who can not only translate, but do so in a culturally competent manner
- Work with or utilize community-based organization or community roles, such as community health workers, to be a bridge for those enrollees who have limited or no English proficiency
- Provide language assistance training to those providing education/assistance to enrollees<sup>35</sup>
- Offer language lines linking to a pool of interpreters when an in-person interpreter is not available

*States and CMS should:*

#### **Accountability in Language Access Services**

- Conduct focus groups and create other mechanisms for feedback where limited English proficiency enrollees can report issues
- Require delivery systems to report on language access services provided
- Use secret shoppers to test availability and competency of interpreters, including the amount of time needed to secure an interpreter, accuracy of translation and cultural appropriateness of translation both for language and medical jargon.
- Assess training and certification of interpreters

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### Simple and Easy-to-Understand Materials

- Test materials before using them through focus groups made up of people with limited or no English proficiency
- Use secret shoppers to test availability of translated materials
- Partner with local community-based organizations to develop materials in languages other than English and to tailor them to the local community so consumers feel welcomed and understood. In addition, work with local community-based organizations to conduct outreach efforts to those consumers whose first language is not English.
- Use plain language to communicate with consumers (e.g. “doctor” instead of “provider”)
- Use visuals when possible to reach out to certain immigrant populations who are dual eligibles<sup>36</sup>

### 3. Quality and Monitoring

Ongoing monitoring, ensuring appropriate quality measures and capturing data related to racial and ethnic health disparities are important elements to the success of the demonstration projects. CMS and states should require delivery systems to:

- Use data to meaningfully address care delivery and assess if they are meeting the needs of enrollees. The MMCO is providing states with data on demographic characteristics, utilization, and spending patterns of Medicare-Medicaid enrollees to better understand and serve these populations.<sup>37</sup> The data included in these reports do provide some breakdown of enrollees by race and ethnicity. Disaggregated data is critical to identify on a state-by-state basis which populations are present and their language and cultural competency needs.
- Collect data on use of services and on grievances and appeals stratified by race, ethnicity and primary language and examine for disparities<sup>38</sup>
- Structure payments to providers to incentivize data collection
- Apply the data to address patient preferences and in care planning
- Submit annual reports that measure outcomes related to health equity such as: percentage of reduction in racial and ethnic health disparities, service change patterns and new initiatives resulting from consumer input, particularly from dual eligibles from communities of color and/or non-English speaking members, and improved communication and educational materials for consumers based on feedback from consumers

The qualitative evaluation that CMS is conducting should be done with dual eligibles from racial and ethnic groups and those who have limited English proficiency to understand their experience with the demonstration. In addition, CMS should examine if there was a reduction in disparities over time.

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Finally, CMS and states should create financial incentives to reward health plans and provider groups that make progress toward the reduction of disparities. This can be done by adding quality withholds under existing measures which delivery systems can be repaid based on progress they have made towards addressing health disparities.

### 4. Consumer Engagement

Ongoing consumer engagement is critical to ensure the success of the dual eligible demonstration projects. While the demonstrations have built-in requirements to engage consumers, there is still a lack of detail that leaves room for skimping on truly engaging consumers beyond just tokenism.

CMS and states must:

- Establish a consumer advisory committee quality withhold measure that is beyond year one of delivery system participation in the demonstration
- Require delivery systems to have representation from communities of color on their community advisory committees<sup>39</sup>
- Require that consumer advisory committees provide feedback to the quality assurance team to identify key program issues, such as racial or ethnic disparities, that may impact communities of color.
- Establish a platform for input from those with limited English proficiency and/or those from specific racial/ethnic groups, for example: host a focus group with those from the Latino community. Focus groups and feedback sessions in the community should be led by bilingual community members or utilize professional interpreters. This is important for CMS and states to do as part of outreach as well as for delivery systems to effectively engage their members.
- Ensure that the Ombudsman's office is trained in cultural competency and has the ability to take complaints from consumers whose first language is not English.

### **Role for Advocates<sup>40</sup>**

Consumer advocates play a pivotal role in ensuring that consumer protections are firmly in place during the design, implementation and oversight of the dual eligible demonstration projects. Each phase represents an opportunity for consumers and their advocates to get involved at the state, health plan and grassroots level.

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## Design Phase<sup>41</sup>

### State Level

- Contribute comments in state-hosted public meetings and make sure that those from communities of color are represented
- Review federal and state guidance on the demonstrations with an eye towards racial and ethnic disparities and provide written comments
- Encourage your state to create a health equity advisory group that includes consumers and advocates, particularly from communities of color to be charged with examining how the demonstration is addressing disparities and provide recommendations.

### Plan/Provider Group Level

- Engage in a dialogue with potential plans or provider groups to learn more about their explicit plans to address racial and ethnic disparities and share your perspective on the role they can play in advancing health equity.
- Work with plans to:
  - build meaningful consumer engagement strategies<sup>42</sup>
  - identify consumers from communities of color who can serve on advisory and governing boards

### Grassroots/Education

- Build a broad-based coalition that includes those that represent diverse communities of color to form a united voice
- Educate dual eligible beneficiaries, especially those from communities of color, about the changes coming and the role they can play in the decision-making process
- Educate providers about the demographics of the population they will serve and how the care system will change

## Implementation and Oversight Phase

### State Level

- Push the state to create tables at which all stakeholders can discuss the reduction of racial and ethnic health disparities within the demonstration project
- Push the state to hold quarterly stakeholder meetings in each region of the state where the duals demonstration is implemented to get feedback on key issues and problems
- Urge state and federal policymakers to put pressure on the health plans and provider groups to address health disparities through reporting requirements and quality measures
- Review and comment on relevant materials and policy guidance
- Promote promising practices from other states

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### Plan Level

- Push the health plans and provider groups serving dual eligibles in the demonstration to provide detailed plans for how they will address racial and ethnic disparities and to publicize both their successes and challenges
- Work with the health plans and/or provider groups serving dual eligible beneficiaries in the demonstration to help them develop meaningful strategies for engaging their members and the broader community in ongoing discussions about ways to reduce health disparities. These strategies may include participation in governance, key advisory committees and focus groups. They should include members representing communities of color, be conducted in a culturally competent manner and be fully accessible to those with disabilities<sup>43</sup>
- Review and comment on relevant materials and policy guidance
- Promote promising practices that have led to successes in other states

### Grassroots Level

- Ensure consumer coalitions focused on the dual eligible demonstration project include individuals and organizations that represent communities of color
- Host community meetings, in partnership with organizations that represent communities of color, to educate dual eligibles of color about the demonstration, what it means for their care, and how to play an active role in the implementation and oversight of the demonstration
- Host community meetings and/or focus groups to understand more about the enrollees' own experiences with the demonstration, particular those from communities of color. This can help inform your advocacy on behalf of consumers to the health plans, state and CMS.
- Work with other consumer advocacy groups to monitor progress on how the state and plan are working to address racial and ethnic health disparities. Report information to state and plans

### Conclusion

The design of the dual eligible demonstration projects has progressed in important ways on addressing racial and ethnic health disparities since Community Catalyst published an earlier paper on this issue. However, there is still much to do in order to both meet the needs of a diverse dual eligible population and to realize the full promise of the ACA. As the demonstration projects are rolled out, there is a real opportunity for CMS, states and delivery systems to push the envelope further and intentionally work towards reducing disparities among dual eligibles from communities of color. Attention to detail in the areas laid out in this paper is necessary and partnership amongst the different stakeholders, particularly consumers and their advocates will be essential to the success of these demonstrations.

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<sup>1</sup> Kaiser Family Foundation, “Faces of Dually Eligible Beneficiaries: Profiles of People with Medicare and Medicaid Coverage,” July 2013. Retrieved: <http://kaiserfamilyfoundation.files.wordpress.com/2013/07/8446-faces-of-dually-eligible-beneficiaries1.pdf>

<sup>2</sup> Centers for Medicare and Medicaid Services, “Medicare-Medicaid Enrollee State Profile The National Summary - 2008” Retrieved: <http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/2008NationalSummary.pdf>

<sup>3</sup> Centers for Medicare and Medicaid Services, “Medicare-Medicaid Enrollee State Profile The National Summary - 2008” See Figures 8 and 9. Retrieved: <http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/2008NationalSummary.pdf>

<sup>4</sup> Diverse Elders Coalition, “Not All Asians Are the Same: Diversity within the AAPI Older Adult Population,” November 2013. Retrieved: <http://www.diverseelders.org/2013/11/13/asian-diversity/>

<sup>5</sup> Medicare-Medicaid Coordination Office website - <http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/FinancialModelstoSupportStatesEffortsinCareCoordination.html>

<sup>6</sup> 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. Retrieved: <http://jointcenter.org/sites/default/files/Patient%20Protection%20and%20Affordable%20Care%20Act.pdf>

<sup>7</sup> Centers for Medicare and Medicaid Services, “Medicare Medicaid Plan Enrollment Guidance”, June 2013. Retrieved: <http://cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/MMPFinalEnrollGuidance.pdf>

<sup>8</sup> Centers for Medicare and Medicaid Services, “Medicare-Medicaid Capitated Financial Alignment Demonstration MMP Readiness Review”, December 2012. Retrieved: [https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/MMP\\_ReadinessReview\\_Presentation.pdf](https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/MMP_ReadinessReview_Presentation.pdf)

<sup>9</sup> Community Catalyst, “Greater than the Sum,” April 2013. Retrieved: <http://www.communitycatalyst.org/doc-store/publications/greater-than-the-sum.pdf>

<sup>10</sup> We understand that there are other areas of focus in terms of health disparities for this population. For purposes of this paper the focus is on racial and ethnic health disparities among the dual eligible population.

<sup>11</sup> Centers for Medicare and Medicaid Services, “State Medicaid Directors Letter”, July 2011. Retrieved: [http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/Financial\\_Models\\_Supporting\\_Integrated\\_Care\\_SMD.pdf](http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/Financial_Models_Supporting_Integrated_Care_SMD.pdf)

<sup>12</sup> Washington State is pursuing both capitated and managed fee-for-service models. The capitated model will be in two counties only, King and Snohomish. The managed fee-for-service model, using health homes approach, is statewide.

<sup>13</sup> All documents can be found on MMCO website: <http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/FinancialModelstoSupportStatesEffortsinCareCoordination.html>

<sup>14</sup> MOU: Memorandum of Understanding

<sup>15</sup> For the Colorado MFFS demonstration, research also included review of the Final Demonstration Agreement.

<sup>16</sup> For the Washington MFFS demonstration, research also included review of the Final Demonstration Agreement.

<sup>17</sup> Federal law requires that all vital materials be translated into prevalent languages – see CMS’s Strategic Language Access Plan – available at: <http://www.cms.gov/About-CMS/Agency-Information/OEOCRInfo/Downloads/CMS-LAP-Updated-2014-508.pdf>. Community Catalyst position on translation and language access is available at: [http://www.communitycatalyst.org/doc-store/publications/Health\\_Equity\\_through\\_Exchanges.pdf](http://www.communitycatalyst.org/doc-store/publications/Health_Equity_through_Exchanges.pdf)

<sup>18</sup> California three-way contract explicitly calls for culturally competent behavioral health care; Texas states in its MOU; Illinois and Virginia call for this in their readiness review tools

<sup>19</sup> Only Massachusetts and Michigan have an LTSS Coordinator role; the other states, except for Colorado, state that the LTSS provider network must be culturally competent. Colorado MOU states in the LTSS definition that LTSS services must be culturally competent.

<sup>20</sup> California in particular breaks down linguistic, cultural, ethnic, racial, religious, age, gender and then lists a broad category of other unique needs which it identifies by example as homelessness, disability or other special populations

<sup>21</sup> Not explicitly in the three-way contract however implied since the care team would be trained in cultural competency

<sup>22</sup> New York’s three way contract language on covered services is particularly interesting, the contract says, “Nutrition services includes the assessment of nutritional needs and food patterns...these services may include the assessment of

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nutritional status and food preferences, planning for provision of appropriate dietary intake within the Participant's home environment and cultural considerations"

<sup>23</sup> Virginia's language is particularly interesting; the three-way contract says "the Contractor must demonstrate linguistic competency in its dealing, both written and verbal, with Enrollees and must understand that linguistic differences between the provider and the Enrollee cannot be permitted to present barriers to access and quality health care and demonstrate the ability to provide quality health care across a variety of cultures."

<sup>24</sup> See Washington MFFS MOU page 63

<sup>25</sup> This includes enrollment, marketing and outreach materials. California, Illinois, Massachusetts, New York, Ohio, South Carolina and Virginia three-way contracts require that pharmacy and provider directories include the cultural and linguistic capabilities of all network providers.

<sup>26</sup> Centers for Medicare and Medicaid Services, "Measurement, Monitoring, and Evaluation of State Demonstrations to Integrate Care for Dual Eligible Individuals Aggregate Evaluation Plan." December 2013, see pages: ES-23, 76, 93, 94. Retrieved: <http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/EvalPlanFullReport.pdf>

<sup>27</sup> New York State Department of Health, "Medicaid Redesign Team, Health Disparities Workgroup Final Recommendations", October 2011. Retrieved:

[https://www.health.ny.gov/health\\_care/medicaid/redesign/docs/health\\_disparities\\_report.pdf](https://www.health.ny.gov/health_care/medicaid/redesign/docs/health_disparities_report.pdf)

<sup>28</sup> ACA §§ 1557. <http://www.hhs.gov/ocr/civilrights/understanding/section1557/>

<sup>29</sup> Community Catalyst, "Greater than the Sum," April 2013. Retrieved: <http://www.communitycatalyst.org/doc-store/publications/greater-than-the-sum.pdf>

<sup>30</sup> Recommendation from the Diverse Elders Coalition: In addition to race and ethnicity, competency includes LGBT cultural competency training for all staff members to ensure clients feel welcome and safe in seeking healthcare and assistance. Negative interactions for a client or his or her family member with any staff member can quickly reduce communication and openness and ultimately harm the client's health. Doctors, nurses and staff with knowledge of LGBT health concerns that clients can connect with is a plus.

<sup>31</sup> Health Research & Educational Trust, "Becoming a culturally competent health care organization." June 2013. Retrieved: [www.hpoe.org](http://www.hpoe.org). Another resource: 2006 Diversity Research Forum, "Exploring Diversity in the Physician Workforce: Benefits, Challenges, and Future Directions", Summer 2007. Retrieved:

<https://members.aamc.org/eweb/upload/The%20Diversity%20Research%20Forum%20Exploring07.pdf>

<sup>32</sup> <https://www.statereforum.org/weekly-insight/community-health-workers-in-a-reformed-healthcare-system>

<sup>33</sup> The Kaiser Commission on Medicaid and the Uninsured, "Long-Term Services and Supports in the Financial Alignment Demonstrations for Dual Eligible Beneficiaries," November 2013. Retrieved:

<http://kaiserfamilyfoundation.files.wordpress.com/2013/11/8519-long-term-services-and-supports-in-the-financial-alignment-demonstrations.pdf>

<sup>34</sup> Office of Minority Health, U.S. Department of Health and Human Services: Executive Summary: A Patient-Centered Guide to Implementing Language Access Services in Healthcare Organizations, September 2005. Retrieved:

<http://minorityhealth.hhs.gov/Assets/pdf/Checked/HC-LSIG.pdf>

<sup>35</sup> See National Standards on Culturally and Linguistically Appropriate Services at:

<http://minorityhealth.hhs.gov/templates/browse.aspx?lvl=2&lvlid=15>

<sup>36</sup> Recommendation from the Diverse Elders Coalition: Culturally appropriate translation is not always enough due to low levels of health literacy, especially among immigrant populations. Visuals, such as charts and infographics and audio outreach can be better for some populations. CMS' Coverage to Care Roadmap has videos in English and Spanish and is an example of an approach to make the health care process more accessible:

<http://www.diverseelders.org/2014/08/26/new-health-coverage-now-what/>

<sup>37</sup> Centers for Medicare and Medicaid Services, "Analytic Reports and Data Resources." Retrieved:

<https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Analytics.html>

<sup>38</sup> We recommend data collection of the following as well: disability status, sexual orientation, and gender identity.

<sup>39</sup> See Community Catalyst's toolkit on Meaningful Consumer Engagement, which includes a Checklist on Diversity, Incentives and Barriers to help delivery systems build models for consumer engagement that reflect the diversity of the Medicare-Medicaid enrollee population, incentivize consumers to actively critique and collaborate with delivery systems, and eliminate barriers to participation. Retrieved:

<http://www.communitycatalyst.org/resources/tools/meaningful-consumer-engagement/consumer-engagement-checklist-for-diversity-incentives-barriers>

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<sup>40</sup> This section builds on the Role for Advocates fact sheet release in 2013. Available at:

[http://www.communitycatalyst.org/doc-store/publications/greater-than-the-sum\\_advocate-role.pdf](http://www.communitycatalyst.org/doc-store/publications/greater-than-the-sum_advocate-role.pdf)

<sup>41</sup> There are still a limited number of states that are in the design phase as of this publication. See MMCO website:

<http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/FinancialModelstoSupportStatesEffortsinCareCoordination.html>

<sup>42</sup> See Community Catalyst's toolkit on Meaningful Consumer Engagement, available at

<http://www.communitycatalyst.org/resources/tools/meaningful-consumer-engagement>

<sup>43</sup> See Community Catalyst's toolkit on Meaningful Consumer Engagement, available at

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