TACKLING RACIAL, ETHNIC AND SOCIOECONOMIC INEQUITIES IN MEDICARE ADVANTAGE

Presented by RAM Technologies, Inc.

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INTRODUCTION[1]

Lack of access to safe housing and neighborhoods, sufficient income, healthy food and transportation are an ongoing concern for the health and well-being of seniors. However, recent conversations about ethnic and racial inequity have added new complexity to discussions and efforts to address social determinants of health (SDOH). It's clear these issues cannot be solved without attention to discrimination, language barriers and racial disparities, as these factors underlie the inequity seen in a broad range of SDOH.

The National Academies of Sciences, Engineering and Medicine notes that among the root causes of health inequity are "intrapersonal, interpersonal, institutional and systemic mechanisms that organize the distribution of power and resources differentially across lines of race, gender, class, sexual orientation, gender expression and other dimensions of individual and group identity." The challenges associated with these root causes are difficult for most people to overcome, limiting their ability to actively manage their health and well-being.

Health insurance providers have committed broadly to addressing health inequity, but this work will take time and multi-layered strategies. Medicare Advantage (MA) plans can take a variety of actions to address these problems and offer the care vulnerable groups need in their own language and on their own terms.

MA BENEFICIARIES FACING RACIAL INEQUITY & LANGUAGE BARRIERS:

37%

have incomes below $20,000

22.6%

are older adults with multiple chronic conditions

1 OF 3

high-need older adults report a household income below $20,000

2017 MA BENEFICIARIES BY RACE:

69.5% White

13.8% Hispanic

9.9% Black

4.3% Asian

MA DEMOGRAPHICS AND RELATED CHALLENGES[2-7]

Overall, seniors are a diverse population grappling with numerous challenges to maintaining their health. For example, 9.2% have incomes below the federal poverty level, more than 30% have incomes at less than 200% of the federal poverty level, 7.7% are experiencing food insecurity and 4.7% are homeless.

MA members face particular difficulties, including challenges related to racial equity and language barriers, when it comes to safeguarding their health and accessing high-quality care.

Among this population, 37% have incomes below $20,000, which can create challenges for managing out-of-pocket expenses for care, including deductibles and coinsurance. Meanwhile, 22.6% of older adults with multiple chronic conditions and one of every three high-need older adults report a household income of less than $20,000 a year. High-need older adults are also almost twice as likely to lack a high school degree compared with non-high-need adults, limiting their ability to understand their care plans.

In addition to factoring into income levels and education, the racial and ethnic profiles of Americans, including seniors, is also unfortunately a factor in quality of care.

In 2017, about 69.5% of MA beneficiaries were White, 13.8% were Hispanic, 9.9% were Black and 4.3% were Asians or Pacific Islanders (API). Racial and ethnic disparities are seen in the patient care experience among MA members, with Black and Hispanic beneficiaries reporting worse clinical care than white beneficiaries on many clinical measures, and API beneficiaries report a worse patient experience than white beneficiaries.

Language barriers can also create challenges. Failures in communication between members and providers can have a negative impact on quality of care, patient safety and patient and provider satisfaction. Among Medicare beneficiaries with limited English proficiency, Spanish is spoken at home by 52% while no other language is spoken by more than 5% of the Medicare population with limited English proficiency.

EQUITY-RELATED SDOH AND HEALTH OUTCOMES[8-14]

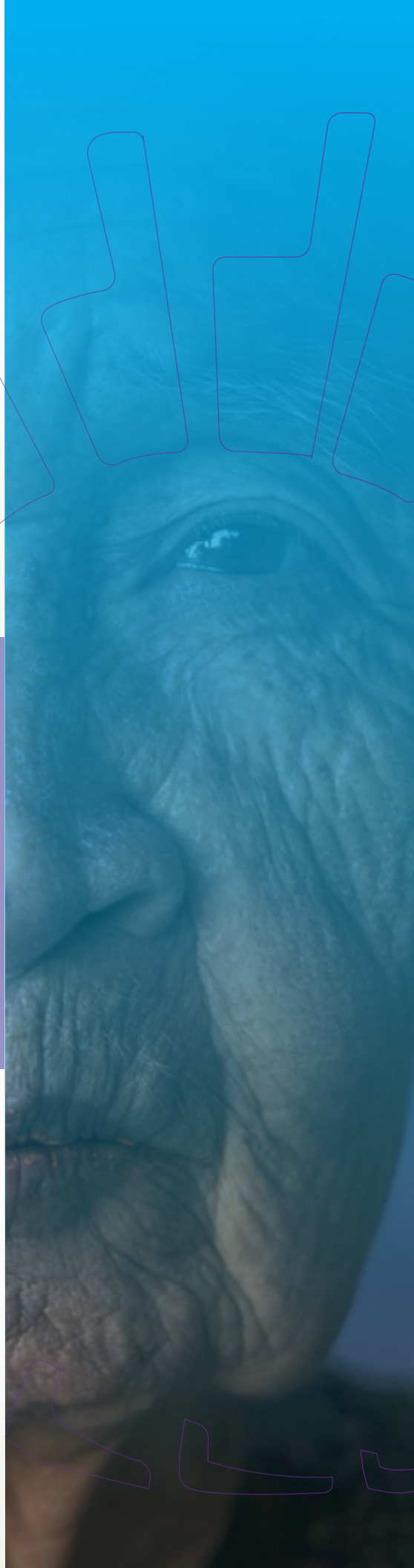
In addition to the impact on the healthcare experience, data from numerous studies show equity-related disparities in SDOH can have a negative impact on health outcomes.

For example, seniors who are food-insecure have lower nutrient intake — between 9% and 26% lower for important nutrients — have worse health outcomes, and are more likely to have diabetes, be depressed, report difficulty with at least one activity of daily living, have high blood pressure or have congestive heart failure. People with lower socioeconomic status are more likely to have difficulty accessing transportation, which is associated with missed doctor's appointments and reduced access to pharmacies.

Additional data show:

- Race/ethnicity and SDOH have a significant impact on diabetes outcomes.
- Racial disparities have been seen in 30-day readmission rates for MA beneficiaries who underwent one of six specific inpatient surgeries.
- Disparities in control of blood pressure, cholesterol and glucose have not improved nationally for Black MA members, although they were eliminated in the West in 2011.

Discrimination itself can be considered a social determinant of health, as it is a significant stressor. Racism has been linked to disparities in health outcomes for minorities, including low birth weight, high blood pressure and poor health status. Additionally, gender discrimination has been shown to have negative health impacts for women and older adults, and people with disabilities are particularly vulnerable to experiences of discrimination, which has caused health inequities.



THE ROLE OF MA PLANS[2,7,9,15-17]

MA plans are in a strong position to support vulnerable members by addressing racial and ethnic inequities and their negative health effects though a multi-layered approach.

The first layer should consist of supplemental benefits to address general SDOH that can affect all MA members. This can include providing members with nutritious food; transportation to healthcare appointments and trips to the pharmacy; and minor home repairs to increase safety, such as grab bars in the shower.

The second layer should consist of other initiatives that specifically address racial and ethnic disparities.

These efforts can also include training measures for both customer-facing health plan staff and for the plan's healthcare provider network. Cultural training for in-network providers should focus on how to assess the SDOH of minority populations and take them into consideration when designing care plans. Providers should be taught how to incorporate cultural sensitivity and culturally tailored health education into patient care, such as providing written materials in multiple languages or creating messaging that incorporates cultural beliefs. Meanwhile, plans should offer diversity and inclusion training to in-network organizations and should encourage them to diversify their provider networks.

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Connecting members, providers and customer service staff with interpreter services and/or online translation tools, such as Google Translate and MediBabble, can help overcome language barriers between members and providers, as well as between members and the health plan.

Plans can also provide targeted outreach, education and assistance to populations disproportionately affected by conditions such as diabetes, obesity, hypertension and even COVID-19.

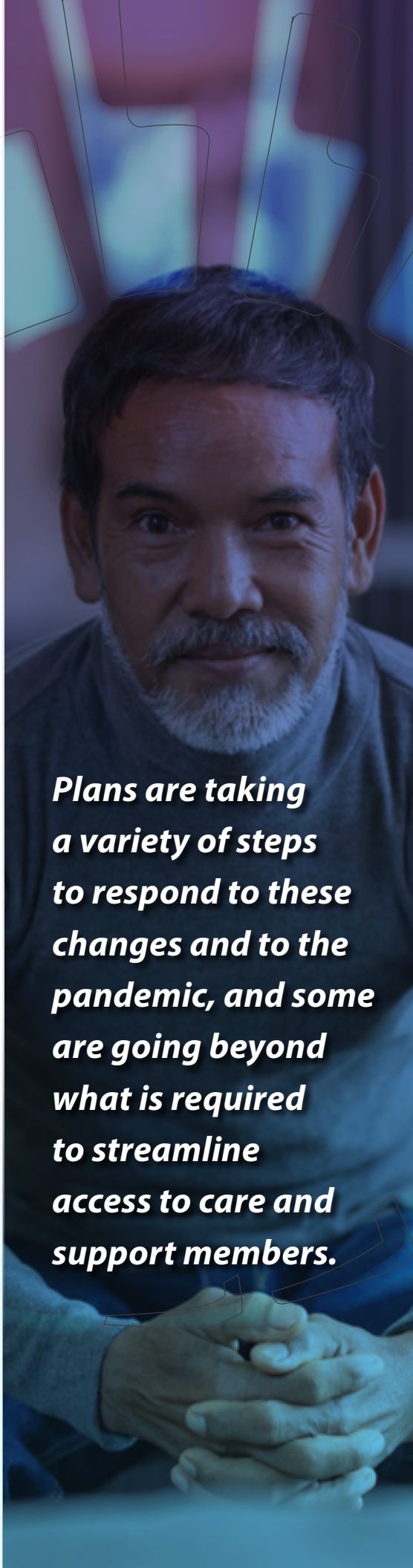
Additionally, plans can employ new care delivery models, such as accountable care, that may bring better results across and within populations. They may also consider partnering with community organizations and local public health workers to deliver new services. Organizations or individuals with established relationships and familiarity with the language and cultural norms in a community can design outreach strategies and program elements that resonate with seniors from racial and ethnic minority groups.

MA plans might find it time-consuming to negotiate contracts with many small and locally based organizations. A potential solution is to work with intermediaries that contract with local organizations on behalf of insurers, although this approach may result in lower payments to social service organizations.

MOVING FORWARD TO ADDRESS INEQUITY

Developing evidence of an ROI for programs addressing racial and socioeconomic inequities will be an important milestone in the process of improving health outcomes for vulnerable seniors. MA plans need to address not just SDOH but the inequities underlying limited access to transportation, education, nutritional food and high-quality healthcare, especially race-based inequity.

Plans have already committed to doing everything in their power to address these issues, both to improve outcomes and because it's the right thing to do. Delivering on these aims, however, may be more challenging. Plans may benefit from partnering with organizations that can help them understand how to incorporate programs that target racial inequities into their existing benefits and then measure results of those efforts. Only by addressing underlying disparities can plans truly improve SDOH and provide optimal care for all their members.



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