



CONVENING REPORT

Addressing Health Disparities in Medicare

BY BETTER MEDICARE ALLIANCE
DECEMBER 2019

BETTER MEDICARE
ALLIANCE

Planning Committee

Congresswoman Allyson Y. Schwartz, Better Medicare Alliance
Daniel E. Dawes, Morehouse School of Medicine
Kermit Payne, 1Joshua Group, LLC
James Michel, Better Medicare Alliance

Convening Participants

Courtney Baldrige, National Association of Area Agencies on Aging
Congresswoman Karen Bass, U.S. House of Representatives
Tammy Kaye Boyd, Black Women's Health Imperative
Danielle Casanova, American Medical Group Association
Blair Childs, Premier, Inc.
Gaurov Dayal, ChenMed
Melanie Egorin, U.S. House of Representatives, Committee on Ways and Means
Millicent Gorham, National Black Nurses Association
Carrie Graham, U.S. House of Representatives
Angela Hagan, Humana
Lauren Hall, Consumer Action
Sara Houston, Doane University
Marjorie Innocent, National Association for the Advancement of Colored People (NAACP)
Congresswoman Robin Kelly, U.S. House of Representatives
Oliver Kim, Asian & Pacific Islander American Health Forum
Dan Lowenstein, Visiting Nurse Service of New York
Niva Lubin-Johnson, National Medical Association
Aletha Maybank, American Medical Association
William McDade, Accreditation Council for Graduate Medical Education
Carrie Monks, Humana
Jennifer Nading, Trinity Health
Leila Nowroozi, Aetna / CVS Health
Gary Puckrein, National Minority Quality Forum
James Ricciuti, JR Policy & Business Strategies
Charmaine Ruddock, Institute for Family Health / Bronx Health REACH
Pamela Schweitzer, Previously of HHS, CMS, and IHS
Brenda Ann Sulick, SCAN Health Plan
Danielle Turnipseed, Solera Health
Aelaf Worku, CareMore Health Systems

Special Acknowledgements

To Daniel E. Dawes, Morehouse School of Medicine, 1Joshua Group, Nelson J. Dunlap, Health Equity Leadership and Exchange Network, Jeremiah McCoy, Better Medicare Alliance, and to each of the participants listed above for their active engagement in this timely and important convening.

Table of Contents

Overview & Purpose of Convening 1

Background 2

Understanding Health Disparities in Medicare 3

Tools in Medicare Advantage to Address Health Inequities 7

Summary of Presentations 10

Summary of Roundtable Discussions 11

Recommendations for Action 14

Conclusion 15



Overview & Purpose of Convening

The Better Medicare Alliance (BMA) is a national coalition of more than 400,000 beneficiaries over 140 ally organizations that share a commitment to improving health care for seniors through a strong Medicare Advantage program. At BMA, we believe that seniors deserve value-driven, affordable, quality health care available in Medicare Advantage. Medicare Advantage is addressing the needs of today's beneficiaries by working to improve health outcomes and lower costs by advancing the adoption of person-centered, value-based care.

On April 29, 2019, BMA convened a meeting of national experts and health care stakeholders in Washington, D.C., to discuss issues related to racial, ethnic, and gender disparities in health care. At the convening, more than 30 experts – representing health plans, providers, consumers, academic researchers and patient advocates – participated in a facilitated, high-level discussion of the opportunities and challenges in addressing health disparities, with a particular focus on Medicare Advantage. The convening had three primary goals:

1. To engage participants in a thoughtful, in-depth discussion of the issues surrounding racial and ethnic health disparities in Medicare Advantage; The roadblocks facing both payers and providers in creating innovative models
2. To identify key barriers to furthering health equity; and
3. To align on potential policy solutions to effectively address those barriers.

Attendees heard from experts through a series of presentations and panel discussions and participated in breakout groups to share their unique perspectives. This report provides background and history on the issue, summarizes key discussion points from the convening, and proposes a call to action for policymakers to address and reduce disparities in the Medicare program.

Background

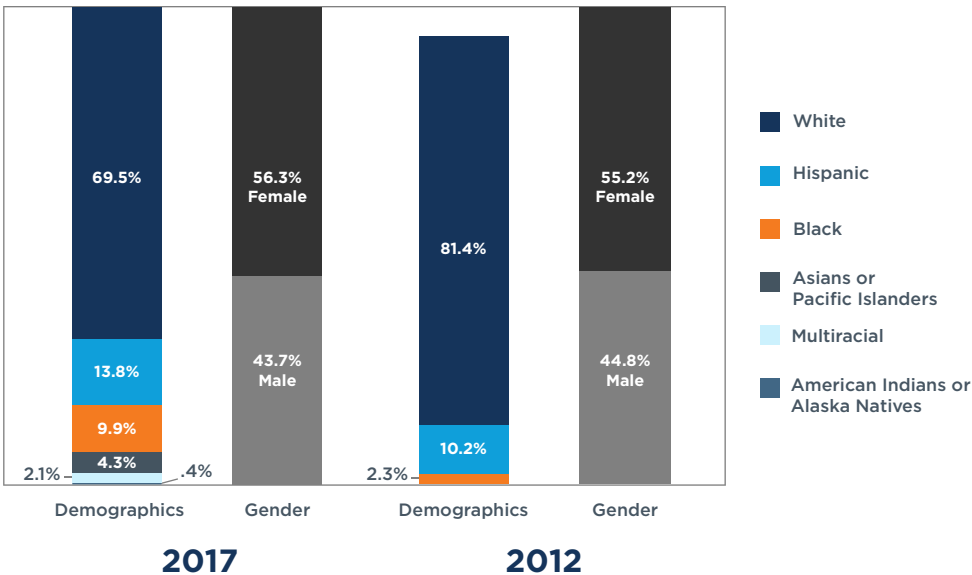
The Centers for Disease Control and Prevention (CDC) defines health disparities as, “preventable differences in the burden of disease, injury, violence, or opportunities to achieve optimal health that are experienced by socially disadvantaged populations.”¹ Health disparities confronting vulnerable populations are extensive and are driven by persistent discrimination and prejudice in American society as well as by the social, economic, environmental and behavioral determinants of health. In the last decade, efforts have been made by policymakers, educators, and providers to improve health equity. Despite these efforts, broad challenges remain, and disparities persist. By addressing the social determinants of health, providers and plans are afforded opportunities to identify and mitigate disparities in health care.

Health disparities exist throughout the US health care system, including within Medicare Advantage. Yet, there are unique opportunities for Medicare Advantage to tackle health disparities, as demonstrated in its ability to address many of the shortfalls in financing and delivery of care. Medicare Advantage has shown success in improving outcomes for millions of Medicare beneficiaries as a result of a determined effort to change coverage and care to meet patient needs clinically, socially, and practically.

The importance of addressing health disparities is magnified as America’s population becomes increasingly diverse, including the population of those eligible for Medicare. According to recent research, minority beneficiaries are choosing to enroll in Medicare Advantage at a higher rate than those in Traditional Fee-for-Service (FFS) Medicare.² Overall, Medicare Advantage has a higher proportion of lower income, dual-eligible, and minority beneficiaries than Traditional FFS Medicare.³

FIGURE 1:

2017 vs. 2012 Medicare Advantage Beneficiaries⁴



Understanding Health Disparities in Medicare

2019 marks the 40th anniversary of the first Congressional hearing to directly address the minority health and health disparities problem in our country. It was during this hearing that policymakers highlighted the poor utilization and quality of care afforded racial and ethnic minorities, the lack of diversity in the health care workforce, and the poor health outcomes among individuals of lower socioeconomic status and minorities. Congress charged the Institute of Medicine, now known as the National Academy of Medicine, with examining the issues further. This charge led to the development of a report entitled, *Health Care in a Context of Civil Rights*, which highlighted racial, socioeconomic, and disability-based differences in access to and value of care – including within Medicare.⁵

While racial and ethnic disparities are not unique to Medicare, the fact that Medicare is a highly regulated part of the health care system with oversight by the federal government means there are opportunities for reporting, goal-setting, and systematized measurement of quality and access. Within Medicare, is Medicare Advantage, the public-private partnership in which health plans have the ability to align the financial incentives of the payers, providers, and patients to improve health outcomes in ways that are not possible in Traditional FFS Medicare. The body of evidence continues to grow, showing that Medicare Advantage increases health access, expands benefits, and provides critical financial protections for vulnerable populations.⁶ Moreover, Medicare Advantage is leading the transition to value-based care, with a higher proportion of payments flowing through outcomes-based payment models than in commercial insurance or in Medicaid.

In addition, there are performance measures and ratings for providers in the Medicare program that also offer tools for measurement. In Medicare Advantage, tools like the Star Ratings System provide the opportunity to identify and review disparities in patient outcomes and consumer experience. For these reasons, Medicare Advantage is well-positioned to lead the effort to address health inequity and reduce disparities in vulnerable populations.

Federal agencies have been charged with providing public reports on the status of health disparities.¹ The Centers for Medicare and Medicaid Services (CMS) Office of Minority Health (OMH) issues an annual report examining racial and ethnic health care disparities observed in Medicare Advantage. The most recent report makes the point that more effort is needed in areas like accessibility to and diversity of clinical trials, updating medical curricula, improving access to a broad range of culturally competent services, treatments, and diversifying the healthcare workforce.⁷

The CMS Office of Minority of Health report is based on analysis of data from two sources: (1) the Consumer Assessment of Healthcare Providers Systems (CAHPS) survey, with seven composite measures with multiple measures in each; and (2) the Healthcare Effectiveness Data and Information Set (HEDIS), with 33 composite measures with multiple measures in each, as well as a number of single clinical measures. In 2018, CMS' report found that racial and ethnic minorities in Medicare Advantage reported experiences with care that were either similar or worse than the experiences reported by white beneficiaries.⁸

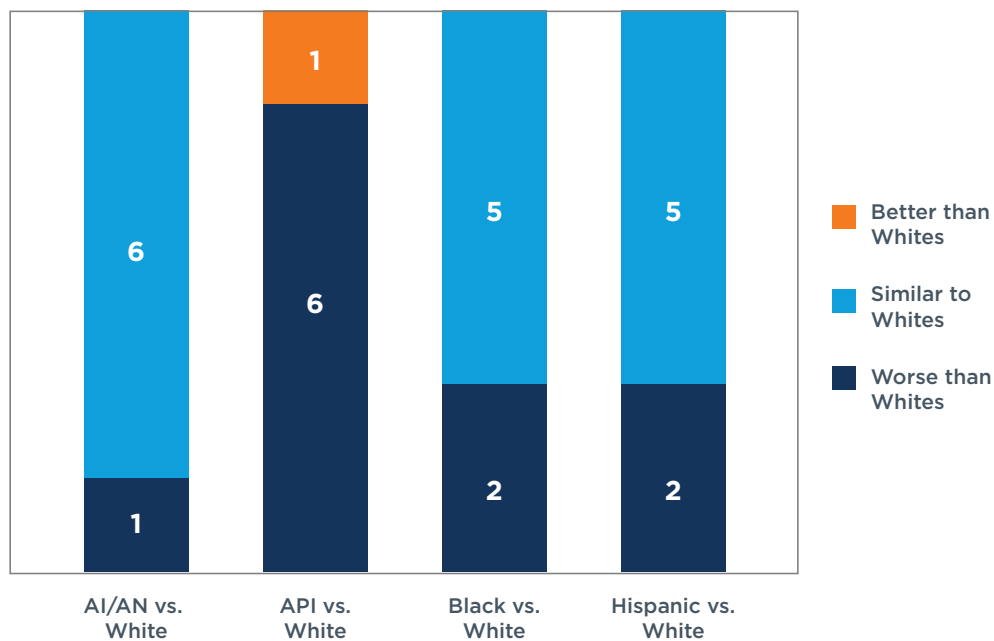
These patient experience composite measures from CAHPS include:

- Access to needed care
- Access to appointments and care quickly
- Customer service
- Doctors who communicate well
- Care coordination
- Access to needed prescription drugs
- Annual flu vaccine (single measure)

FIGURE 2

Racial and Ethnic Disparities in Care: All Patient Experience Measures

Number of patient experience measure (out of 7) for which members of selected groups reported experiences that were worse than, similar to, or better than the experiences report by Whites in 2017.



SOURCE: This chart summarizes data from all Medicare Advantage beneficiaries nationwide who participated in the 2017 Medicare CAHPS survey.

NOTES: AI/AN = American Indian or Alaska Native. API = Asian or Pacific Islander. Racial groups such as Blacks and Whites are non-Hispanic. Hispanic ethnicity includes all races.

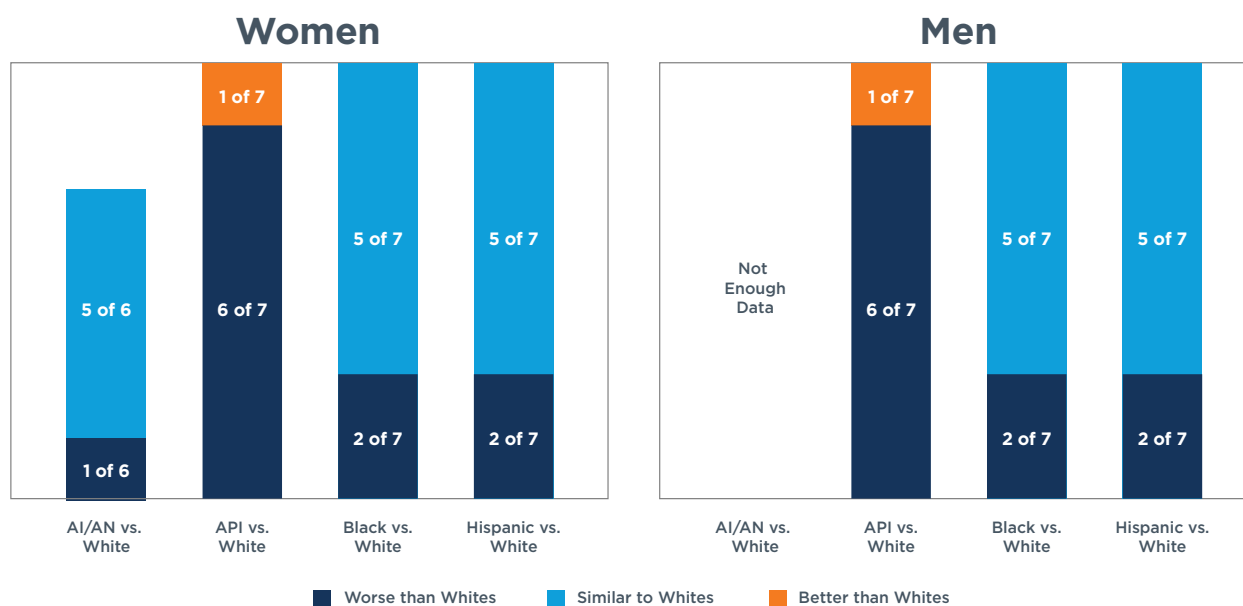
The 2019 CMS OMH report made similar conclusions. As to consumer experience, in the seven composite measures and one single measure specifically, when compared with white beneficiaries: American Indian / Alaska Natives reported poorer experiences on one measure (getting appointments and care quickly), Hispanic beneficiaries reported poorer experiences on two measures (getting appointments and care quickly and annual flu vaccine), black beneficiaries reported poorer experiences on two measures (getting appointments and care quickly and annual flu vaccine), and Asian or Pacific Islanders reported poorer experiences on six measures (all of the patient experience measures except for annual flu vaccine which is a single clinical measure).

The CMS OMH report also points to the need for broader discussion of the intersection of health disparities and quality improvement based on the 33 composite clinical measures. According to the report’s authors, “although [the] analysis revealed few gender differences in care, it did reveal patterns in which (1) black and Hispanic beneficiaries received worse clinical care than white beneficiaries on a large portion of the clinical care measures examined and (2) Asian or Pacific Islanders reported worse patient experiences than white beneficiaries on almost all measures of patient experience.”⁹ As a result, the report urged health care leaders to focus quality improvement efforts on “enhancing clinical care for black and Hispanic beneficiaries and investigating difference between Asian or Pacific Islanders and white beneficiaries’ patient experience” (see Figures 1, 2 and 3).

FIGURE 3

Racial and Ethnic Disparities in Care by Gender: All Patient Experience Measures

Number of patient experience measure (out of 7) for which women/men of selected racial and ethnic minority groups reported experiences that were worse than, similar to, or better than the experiences reported by White women/men in 2017



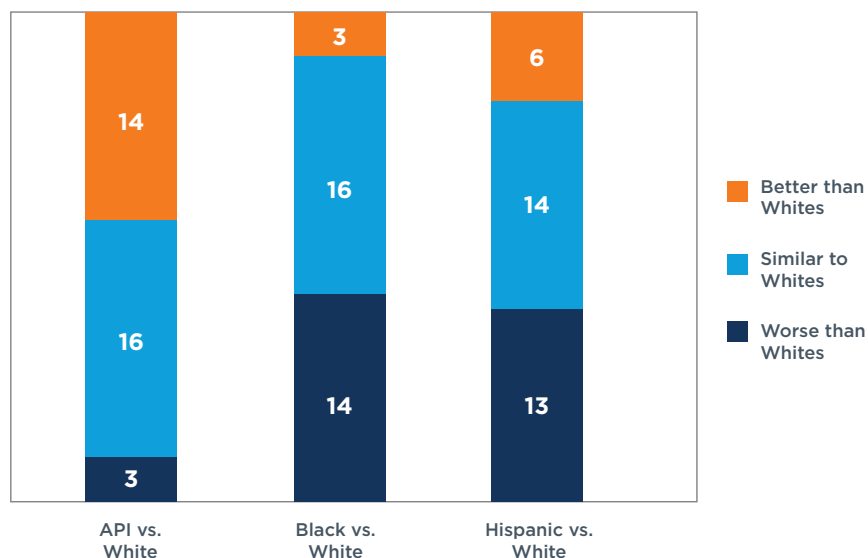
SOURCE: This chart summarizes data from all Medicare Advantage beneficiaries nationwide who participated in the 2017 Medicare CAHPs survey.

NOTES: AI/AN = American Indian or Alaska Native. API = Asian or Pacific Islander. Racial groups such as Blacks and Whites are non-Hispanic. Hispanic ethnicity includes all races. There were not enough data from AI/AN men to compare their patient experiences to those of White men. For one patient experience measure, there were not enough data from AI/AN women to permit a comparison to White women.

FIGURE 4

Racial and Ethnic Disparities in Care: All Clinical Care Measures

Number of clinical care measures (our of 33) for which members of selected group experienced care that was worse than, similar to, or better than the care experienced by Whites in 2017.



SOURCE: This chart summarizes data from all Medicare Advantage beneficiaries nationwide who participated in the 2017 Medicare CAHPs survey.

NOTES: AI/AN = American Indian or Alaska Native. API = Asian or Pacific Islander. Racial groups such as Blacks and Whites are non-Hispanic. Hispanic ethnicity includes all races.

During the convening, the issue of the lack of diversity in the health care workforce, particularly at the highest professional levels, was repeatedly pointed out during the presentations and discussions. The presentation on the low number of minority physicians currently practicing made clear the work to be done in this area to provide a safe and trusting environment for patients of varying ethnicities, races, and cultural backgrounds.

One of the presenters, Dr. William McDade, Chief Diversity Officer for the Accreditation Council for Graduate Medical Education, presented on the importance of ensuring diversity in the physician workforce to levels that reflect the American population. He referenced a number of charts and figures that showed the low representation of minorities in all medical specialties. He showed that there is strong evidence that racial, ethnic, and linguistic diversity among health care providers is correlated with better access to and quality of care for underserved populations. Dr. McDade outlined solutions through Medical Education, such as rethinking curricular innovation, use of Inclusive Clinical Learning Environments for Undergraduate Medical Education, and increased funding for Graduate Medical Education. Improving the number of minority physicians in the US is critically important as minority physicians disproportionately dedicate their careers to, and play a distinct role in, the care of underserved populations.

Tools in Medicare Advantage to Address Health Inequities

Medicare Advantage is paid through a prospective, capitated system in which health plans have responsibility for the provision of all Medicare benefits, including hospital and medical services, and puts plans at full financial risk for the cost of care for each beneficiary enrolled in their plan. In addition, without increased payment, Medicare Advantage health plans are allowed to provide extra benefits not offered under Traditional FFS Medicare, such as hearing, dental and vision care, known as supplemental benefits. In recent years, Medicare Advantage plans have been given flexibility to offer new benefits, such as wellness programs, non-emergency transportation, meal delivery services, and in-home support services. These new benefits can be targeted to beneficiaries with chronic conditions. In some instances, services do not need to be specifically health-related but must be intended to reduce hospitalizations and improve health status.

The integrated system of payment and care, as well as the added flexibility, enables and incentivizes Medicare Advantage health plans and providers to focus on primary care and early interventions, risk identification, and care management. Medicare Advantage has been shown to encourage more use of preventive care, reduce emergency room visits and hospitalizations, reduce lengths of facility stays, and improve outcomes. Moreover, Medicare Advantage has consumer cost protections and lower out-of-pocket costs not available in Traditional FFS Medicare which is attracting more low- and modest-income beneficiaries to Medicare Advantage.¹⁰

By focusing on value-based payment arrangements, tailored benefit design and care coordination, Medicare Advantage is able to deliver a higher value at an affordable cost for beneficiaries. These key elements of Medicare Advantage represent an opportunity to reduce inequities by addressing beneficiaries' social determinants of health.

Value-Based Care and Care Management: As a partnership that aligns the incentives of health plans and providers, Medicare Advantage is well-positioned to be a catalyst for change that can address health disparities and improve beneficiary outcomes. Medicare Advantage offers the ability for plans to introduce innovative, value-based care and services that address health disparities. Value-based care encompasses a number of strategies to support innovative care delivery models that focus on patient-centered primary care teams, enable early intervention, and offer care coordination and management. This drive to value, which has plans and providers working to improve quality, reduce cost, and address social determinants of health, is demonstrating improved outcomes for beneficiaries, including those with chronic conditions and high-risk factors. Value-based care arrangements are designed to hold providers and plans accountable for the outcomes they deliver, which also provides the opportunity to monitor progress made to reduce health disparities.

Flexible Benefit Design and Expanded Definition of Supplemental Benefits: In 2018, CMS reinterpreted what is known as the uniformity rule to allow health plans to target certain supplemental benefits to specific subsets of enrollees enabling improved management of care, including the ability to address social determinants of health and disparities in health. Beginning in 2019, health plans are able to target certain additional benefits to groups of enrollees who meet objective medical criteria. In addition, plans may offer new supplemental benefits including services to address functional limitations and reduce avoidable hospitalizations. Services that may be offered are in-home support services, non-opioid pain management, home safety modifications, and transportation. Further changes will take effect in 2020, with additional expanded benefits targeted to those individuals with chronic conditions. These benefits may include meal delivery and adult day care services.

These changes enable Medicare Advantage health plans to implement innovative strategies to eliminate barriers to care. Additionally, it offers beneficiaries with chronic conditions access to high-value care essential to treating and improving their conditions and health, such as food insecurity, lack of transportation to clinical appointments, wellness programs that address social isolation, and caregiver support to assist families caring for a chronically ill family member. The new flexibilities allow plans and providers to directly address social determinants of health and disparities in health care which has the potential to redefine health care for millions of beneficiaries.



One of the presenters, CareMore Health's Regional Medical Officer, Dr. Aelaf Worku, offered insights on how Medicare Advantage plans address health disparities through innovative models. The "CareMore at Home" model identifies and tackles unmet needs, whether medical or non-medical. The model strives to reduce utilization of emergency rooms and avoidable hospitalizations for the most complex beneficiaries, including individuals who are dual-eligible for both Medicare and Medicaid, who have too often had the experience of highly fragmented care.

To reduce rehospitalizations, the program co-manages a patient's care with the hospitalist who cared for the patient in the hospital and will check-in with the patient in the days after discharge. They will also make calls and visit the patient at their home, as needed. The result has been a more seamless transition for the patient and the opportunity to ensure that the patient's needs are addressed at home without a return to the hospital.

The Star Rating System. Quality care in Medicare Advantage is measured and reported through a quality accountability system, called the Star Rating System. The system plays a critical role in promoting quality, ensuring public accountability, and giving beneficiaries the tools to choose high-quality plans. The Star Rating System evaluates Medicare Advantage plans on a 1-5 scale, with a 5-star rating indicating the highest quality. Performance is based on health plan and prescription drug specific measures and includes both consumer experience and clinical measures.

Medicare Advantage health plans with 4 or 5 Stars receive quality bonus payments that must be used to directly benefit enrollees. These payments are used to invest in supplemental benefits including home-based care, risk stratification to identify high-need patients, care management, wellness programs, and telehealth, as well as reduced cost sharing, dental, vision and hearing services for beneficiaries, all of which enhance the availability of services and play a role in identifying and addressing the social determinants of health.

The Star Rating System does to some extent recognize the degree to which social determinants impact the difficulty of reaching improved outcomes for populations that have a high risk of social risk factors. CMS is testing segmentation of populations to take into account social determinants of health, without diminishing quality goals.

One of the presenters, Dr. Gaurov Dayal, President of New Markets and Chief Growth Officer for ChenMed, discussed how his organization is using supplemental benefits to address health disparities and social determinants of health. ChenMed operates physician-led, integrated care medical centers that deliver high-quality health care for seniors who are Medicare Advantage beneficiaries. The ChenMed model provides patient-centered care by elevating primary care to increase access to services, enhance care coordination, and address social determinants of health. ChenMed makes preventive care as easy as possible to access by encouraging office visits and providing patients with transportation to and from ChenMed facilities. Door-to-door transportation ensures these physician practices can focus on high-touch care to address patients' needs. In addition, ChenMed engages beneficiaries through programs like cooking classes to improve diet, on-site exercise classes like Silver Sneakers and Tai Chi to improve strength and balance. ChenMed also leverages expertise in the community by working with organizations like Meals on Wheels and The Salvation Army to address food insecurity among seniors.



Summary of Presentations

Presenters at the convening included thought leaders on health inequities, advocates, and those directly involved in addressing social determinants of health. The subjects covered were wide-ranging, including institutional racism, gun violence, lack of minority health professional students, efforts to change established bias and create cultural competence and awareness. In addition, health care providers presented on how they are working to deliver holistic care that is attentive to social risk factors. The providers also spoke about their care models and engagement with community partner organizations and local communities. The presenters were involved in sessions throughout the day as participants, adding their experience and insights on how to meet the challenges and seize opportunities for change.

Both presenters and participants expressed frustration at the slow pace of the health care system in taking action towards reducing health disparities. At the same time, it became clear through the course of the discussions, that they were keenly aware of progress made and opportunities ahead. Many of the health care experts saw Medicare Advantage as an opportunity to bring the change that addresses both social determinants and offers evidence of how they could impact health care more broadly.

The discussions, both informal and with the panelists and speakers, were highly engaging, open, and honest, drawing from professional and personal experiences. While no one was unrealistic as to how difficult it is to move the health care system to address health disparities, they spoke to their own efforts, successes, and expectations for future changes in Medicare to embrace the need to address health disparities and ultimately eliminate health inequities.



Presentations Included:

- *Remarks on Medicare Advantage*, Congresswoman Allyson Y. Schwartz, President & CEO, Better Medicare Alliance
- *Key Barriers and Opportunities*, presented by Daniel E. Dawes, JD, Executive Director, Satcher Health Leadership Institute Morehouse School of Medicine
- *Federal Legislation and Medicare and Medicare Advantage*, remarks by Representative Karen Bass and Representative Robin Kelly
- *Federal Response to Health Inequities: Accountable Healthy Communities*, RADM (ret) Pamela Schweitzer, PharmD, BCACP, Former Assistant Surgeon General 10th Chief Pharmacist Officer, USPHS Commissioned Corps
 - Followed by a conversation with Gary Puckrein, PhD, President & CEO, National Minority Quality Forum
- *Equitable Approaches to Health: Lessons and Opportunities*, moderated by Leila Nowroozi, MBA, MPH, National Partnerships Business Strategy and Consumer Experience Group, Aetna
 - Charmaine Ruddock, Project Director, Bronx Health REACH, The Institute for Family Health
 - Danielle Casanova, MBA, American Medical Group Association Senior Director
 - Marjorie A. Innocent, PhD, NAACP, Senior Director of Health Programs
- *Tools in Medicare Advantage to Address Health Inequities*, Gaurov Dayal, MD, ChenMed, President New Markets and Chief Growth Officer, in conversation with Congresswoman Allyson Y. Schwartz
- *Diversity in Graduate Medical Education*, William McDade, MD, PhD, Chief Diversity & Inclusion Officer, Accreditation Council for Graduate Medical Education
- *Health Equity & Vulnerable Populations: Improving Access, Care Coordination, and Communication*
 - Aletha Maybank, MD, Vice President, Health Equity, American Medical Association
 - Niva Lubin-Johnson, MD, FACP, President, National Medical Association
 - Danielle Turnipseed, JD, MPP, MHSA, Vice President, Government Affairs and Policy Solera Health, Inc.
- *What Medicare Advantage Allows*, Blair Childs, Senior Vice President, Premier, Inc.
- *How the CareMore Model of Care is Addressing Health Disparities in Medicare*, Aelaf D. Worku, MD, Regional Medical Officer, Washington D.C. Market, CareMore Health Systems, an Anthem, Inc.

Summary of Roundtable Discussions

Attendees were divided into three facilitated roundtable discussions that were designed to foster engagement among participants and to generate feedback to specific prompting questions. The discussions were framed around problem statements, then followed by recommendations for action. Below is a summary of the major subject areas of the discussions.

Lack of trust between patient and provider, and the inability to effectively communicate, is a root cause of poor patient experience. Minority beneficiaries are more likely than white beneficiaries to feel disconnected from their primarily white providers. They are less likely to voice concerns or ask questions if they feel they may be misunderstood. As a result, it is more difficult for them to develop trusted relationships with their providers, which have a range of impacts that can result in a negative experience for the patient. Providers also have assumptions about their patients, and they may hesitate to address a subject they see as sensitive or outside of their control. Participants suggested that cultural competency training for providers is important and with increasingly diverse patient populations it is becoming essential for all providers.

There is underrepresentation of minority providers in the health care system which must be systematically addressed. Minorities are underrepresented in most health care professions, which leads to the issues described above. Growing minority representation in health care provider roles at all levels is also critical to building an atmosphere of trust and would help address this root cause of disparities. Speakers and participants discussed potential approaches to encourage more minorities to enter health care professions, such as creating incentives for graduate medical programs to enroll more non-white students and reserving residency slots for minority practitioners. Mentorship could be helpful in retaining minority students. Additionally, loan forgiveness, grants, and funding are needed to address the high cost of medical education, which is a barrier for minority students or those from lower income families.

Effective data collection and sharing of information is a critical barrier to effectively addressing health disparities and improving health equity. Participants discussed challenges resulting from the fact that data related to minority experience is not systematically collected across Medicare, and therefore is less effective in being used to target improvements. While CMS issues an annual report looking at minority experience in Medicare Advantage, there is no similar composite report assessing or comparing diversity in Traditional FFS Medicare. The group discussed identifying, basic questions that could start to distinguish certain trends, such as:

- While minorities are enrolling in Medicare and Medicare Advantage at higher rates than white beneficiaries, are they defaulting into or choosing Traditional FFS Medicare?
- In Medicare Advantage, what are the characteristics of plans they are electing?
- What information is available to minority beneficiaries before they turn 65 to help them prepare for enrollment? Are they receiving the information they need to make the right choice for themselves?

- How do plan satisfaction rates compare between minority and white beneficiaries?

These, and other questions, could be incorporated into existing surveys, such as the Medicare Current Beneficiary Survey or the Health Outcomes Survey.

There is a gap in available information to understand how to adequately scale up benefits and services that could be used to address disparities. With the recent expansions of supplemental benefits in Medicare Advantage, and specifically the ability to directly address non-medical needs, including social determinants of health, there was broad agreement that there is a significant opportunity for Medicare Advantage plans to design and offer benefits that work to identify and reduce disparities. Participants discussed the need for a centralized mechanism to evaluate which types of benefits are effective in reducing disparities, and for whom. Further, it would be beneficial for plans that have experience in offering benefits to address social determinants of health to make that information public so that other plans can more quickly adopt impactful benefits.

Quality measurement systems do not adequately measure and reflect the experience of minority beneficiaries. Participants discussed the lack of direct incentives for health plans to offer new types of benefits to reduce disparities. In addition, there is a lack of quality measures that would adequately measure where disparities exist and what efforts exist to effectively reduce them. Such measures are not only absent from the Medicare Advantage and Part D Quality Star Rating System, but from ratings systems in Traditional FFS Medicare, such as the Medicare Incentive Payment System (MIPS) and Accountable Care Organization (ACO) measurement systems. The Star Rating System has been successful in providing incentives that help achieve significant quality improvements and presents a model for use in reducing disparities as well.



Recommendations for Action

Medicare Advantage has led the way in moving care from fee-for-service, episodic care to integrated, patient-centered care, by creating teams of health professionals that work together to address clinical needs and tackle social determinants of health. The discussions throughout this convening pointed to actions already taken by plans and providers to address health disparities through extra benefits, personalized care delivery, and targeted care management. The presenters and participants pointed to these current successful efforts as an opportunity for Medicare Advantage to advance health equity.

The discussions provided the participants with the opportunity to suggest actionable recommendations for addressing health disparities in Medicare Advantage. Drawing from the roundtable discussions and presentations throughout the Convening, the following represents a number of recommendations for purposeful actions to be taken by policymakers, plans, and providers in Medicare Advantage to make meaningful progress toward addressing health disparities.

RECOMMENDATIONS FOR ACTION INCLUDE:

- Health organizations should require training at all levels in unconscious bias and cultural sensitivity. Requiring this training as a condition for being credentialed/licensed in Medicare should be considered.
- Health organizations should establish specific goals and strategies to increase the diversity of professional staff.
- Congress and the Administration should consider policies to expand medical and health professional education opportunities across disciplines to racial and ethnic minority populations.
- HHS should engage stakeholders in establishing a process for collecting accurate and timely data on race, ethnicity, and gender and offer recommendations to target action to address and eliminate health disparities.
- CMS should continue to evaluate whether adjustments to the quality accountability measurement systems would be useful in monitoring and incentivizing improvements in racial, ethnic and gender health disparities.
- Concerted efforts should be taken by health agencies, policymakers, and stakeholders in the private sector to share best practices in addressing health disparities among Medicare Advantage plans and providers to encourage and support adoption of effective strategies and best practices.
- CMS should prioritize health equity as a goal across all payment and delivery models in Medicare and Medicaid, including creating initiatives to be undertaken by the Center for Medicare and Medicaid Innovation to implement demonstration or pilot projects that focus on decreasing health disparities, particularly for those individuals with multiple chronic diseases.



Conclusion

Each participant brought a unique perspective and background to the discussion of advancing health equity and eliminating health disparities. While there were diverse perspectives, there was often consensus on the challenges and call to action. Additionally, participants felt confident that there are advocates across the spectrum of organizations working to advance this cause, but acknowledge there is serious work to be done.

Health disparities in Medicare exist and will persist unless the recommendations in this report are seriously considered and implemented. Medicare Advantage has already proven itself to be capable of implementing major changes in health care delivery, including addressing the needs of those in unrepresented and minority communities. Medicare Advantage has led in the adoption and growth of value-based care to support improved health. Plans and providers have achieved high quality and better clinical outcomes, while lowering health care cost for beneficiaries. Given the goals and the capacity, as well as new opportunities to address social determinants of health, Medicare Advantage is poised to take on the role of leading the effort to address health disparities.

BMA provides this report to offer the insights of the convening participants and highlight current efforts by Medicare Advantage plans and providers to address racial and ethnic health disparities in an effort to advance the goal of improving health disparities through actionable policy recommendations. BMA will look to advance these recommendations as part of its advocacy, policy, and research efforts on Medicare Advantage to further the objective of building a health care system that achieves health equity for all beneficiaries.

Sources

- ¹ CDC. Community Health and Program Services (CHAPS): Health Disparities Among Racial/Ethnic Populations. Atlanta: U.S. Department of Health and Human Services; 2008
- ²ⁱ https://www.bettermedicarealliance.org/sites/default/files/2018-09/BMA_ThorpeReport_2018_09_13.pdf
- ³ https://www.bettermedicarealliance.org/sites/default/files/2019-07/BMA_Research%20Brief_2019_07_09_Income%20Populations.pdf
- ⁴ Medicare Advantage Demographics Report, 2015 (Rep.). (2018, June). Retrieved June 1, 2019, from America's Health Insurance Plans website: https://www.ahip.org/wp-content/uploads/2018/06/MADemographics_IssueBrief.pdf
- ⁵ Institute of Medicine. 1981. Health Care in a Context of Civil Rights. Washington, DC: The National Academies Press. <https://doi.org/10.17226/18680>.
- ⁶ <https://www.bettermedicarealliance.org/about-medicare-advantage/state-medicare-advantage>
- ⁷ United States, Centers for Medicare and Medicaid Services, Office of Minority Health. (2018, April). Racial, Ethnic, and Gender Disparities in Health Care in Medicare Advantage. Retrieved from <https://www.cms.gov/About-CMS/Agency-Information/OMH/Downloads/2018-National-Level-Results-by-Race-Ethnicity-and-Gender.pdf>
- ⁸ United States, Centers for Medicare and Medicaid Services, Office of Minority Health. (2018, April). Racial, Ethnic, and Gender Disparities in Health Care in Medicare Advantage. Retrieved from <https://www.cms.gov/About-CMS/Agency-Information/OMH/Downloads/2018-National-Level-Results-by-Race-Ethnicity-and-Gender.pdf>
- ⁹ United States, Centers for Medicare and Medicaid Services, Office of Minority Health. (2018, April). Racial, Ethnic, and Gender Disparities in Health Care in Medicare Advantage. Retrieved from <https://www.cms.gov/About-CMS/Agency-Information/OMH/Downloads/2018-National-Level-Results-by-Race-Ethnicity-and-Gender.pdf>
- ¹⁰ https://www.bettermedicarealliance.org/sites/default/files/2019-07/BMA_Research%20Brief_2019_07_09_Income%20Populations.pdf

BETTER MEDICARE
ALLIANCE

1411 K Street NW, Suite 1400 | Washington, DC 20005 | (202) 735-0037
[bettermedicarealliance.org](https://www.bettermedicarealliance.org)