Health Equity

Supplemental Report

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United Healthcare | ATI Advisory

Supported by UnitedHealthcare Community & State, ATI Advisory undertook this research to identify data on complex care populations that will assist states and MCOs in developing programs to advance health equity targeted interventions for individuals with disabilities.

Introduction

Medicaid beneficiaries are a diverse population who often experience social needs and disparities that negatively impact healthcare access and health outcomes. These disparities can appear as an increased prevalence of certain medical conditions, negative social determinants of health (SDoH), or poor health outcomes, that may vary by race, ethnicity, or other demographics. For example, 25% of Black adults and 16% of Latino adults in the general U.S. population experience disability,[1] yet these rates are higher among the Medicaid population; for beneficiaries younger than 65, 31% of Black Medicaid beneficiaries and 24% of Latino beneficiaries experience disability.[2] Additionally, among Medicaid beneficiaries who do not speak English, 42% have a disability, compared to 35% who do speak English. American Indian and Alaskan Native (AI/AN) Medicaid beneficiaries also face a significant proportional disparity with regards to disability. While they make up just one percent of the Medicaid population, 30% of AI/AN beneficiaries younger than 65 experience disability, with that rate climbing to 67% among those 65 and older. This prevalence among the 65 and older population ranks highest among all racial and ethnic cohorts and is eight percentage points higher than the average across all races.

While Medicaid beneficiaries overall experience increased health disparities, dual eligible beneficiaries and those with disabilities are at particular risk for poor outcomes. Challenges such as discrimination and structural inequities based on race, ethnicity, or sexual identity interact with these individuals' healthcare conditions, disabilities, living situations, and geography, worsening their experiences with the healthcare system and deepening health disparities. It is important for states and Medicaid managed care organizations (MCOs) to be aware of such disparities so that they can be equipped to identify opportunities to address them.

This document includes information on beneficiary characteristics, spending and utilization, and implications for MCOs for three distinct but overlapping Medicaid populations:

- Dual Eligible Beneficiaries
- Beneficiaries with Long-Term Services and Supports (LTSS) Need
- Individuals with Intellectual and Developmental Disabilities (I/DD)

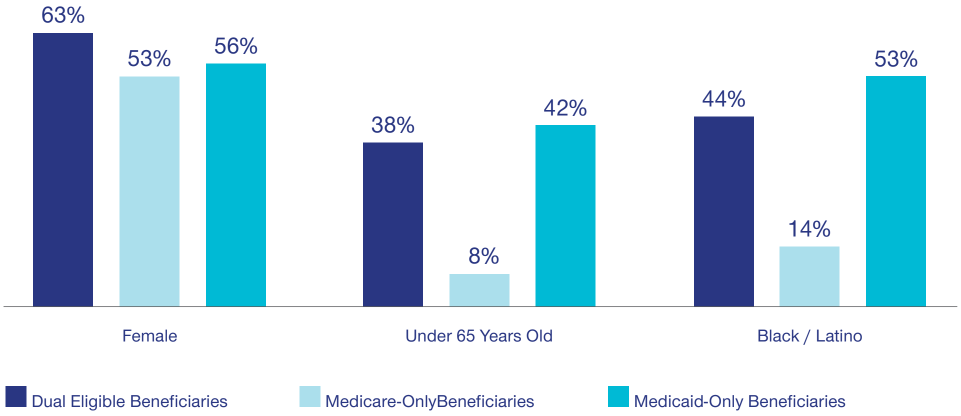
Dual Eligible Beneficiaries

Overview

Approximately 12 million individuals are dually eligible for both Medicare and Medicaid coverage. Among this population, 69% are eligible for full Medicaid benefits ("full dual beneficiaries"), while the remaining 31% receive assistance from their state for Medicare costs but no other Medicaid benefits ("partial dual beneficiaries"). This report primarily refers to full dual eligible beneficiaries, unless otherwise noted. Because dual eligible beneficiaries are eligible for both Medicare and Medicaid, they typically must navigate conflicting or uncoordinated program rules, provider networks, benefit designs, and member materials. This fragmentation exacerbates dual eligible individuals' medical, social, and functional care needs and is a key reason why policymakers have sought to integrate Medicare and Medicaid for several decades. In addition, the intersectionality between dual eligibility and characteristics such as race and ethnicity, need for LTSS, social risk factors, and geography can increase the risk of health disparities and poor health outcomes for this population.

Beneficiary Demographic Characteristics

The dual eligible population is more demographically diverse than Medicare-only and Medicaid-only populations. For example, dual eligible beneficiaries are more likely to be female, and considerably more likely to be under age 65 or identify as Black or Latino compared to Medicare-only beneficiaries.



Source: ATI Advisory analysis of 2020 Medicare Current Beneficiary Survey and MACPAC's MACStats: Medicaid and CHIP Data Book

Note: Dual Eligible Beneficiaries refers to full dual eligible beneficiaries only. Medicaid-Only Beneficiaries data from MACPAC excludes beneficiaries under 18.

Social and Functional Needs

Compared to Medicare-only beneficiaries, dual eligible beneficiaries are more likely to experience challenges related to SDoH that exacerbate disparities and lead to complex and costly care needs. Three quarters of all dual eligible beneficiaries live below 100% of the Federal Poverty Level (FPL), 80% are currently unmarried or have never been married, and 32% speak a language other than English at home. Black and Latino dual eligible beneficiaries are twice as likely to not have received a high school diploma compared to white beneficiaries. Additionally, dual eligible beneficiaries experience high rates of food insecurity (38%) compared to Medicare-only beneficiaries (9%). Latino dual beneficiaries are particularly likely to experience food insecurity, at a rate of 42%. Rural dual eligible beneficiaries are also highly likely to experience food insecurity at 42% compared to 37% for those living in urban communities, potentially due to more limited options for nutritious food and/or transportation further hindering access.

These high rates of social need coupled with inequities resulting from disability, race, ethnicity, and other demographic characteristics can be detrimental to long-term health outcomes. For example, dual eligible beneficiaries experiencing food insecurity are more likely to have at least one hospital visit in a year than dual eligible beneficiaries who are not experiencing food insecurity (17% vs 11%).

Activities of Daily Living (ADL):
Daily tasks of everyday life, including bathing, dressing, transferring (e.g., from a bed to a chair), eating, and toileting.

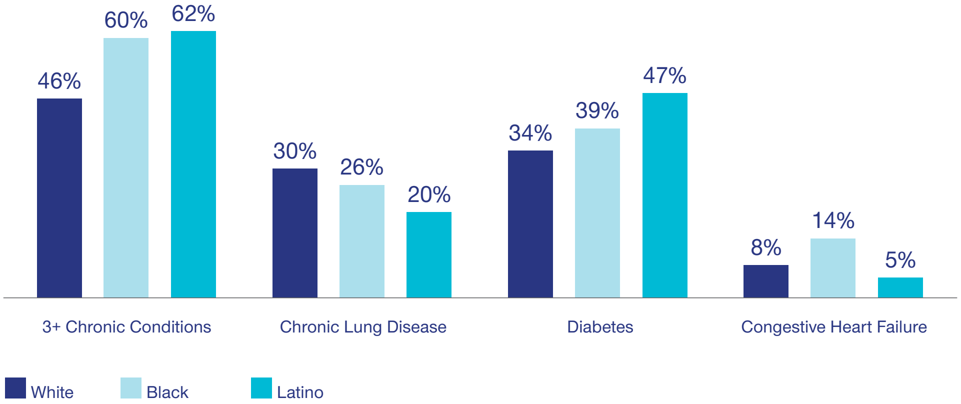
Instrumental Activities of Daily Living (IADL):
Activities required to care for oneself and home, including taking medication, preparing meals, managing money, and shopping for groceries.[3]

Functional and cognitive limitations are also a significant area of focus when managing the care of dual eligible beneficiaries. For example, 27% of dual eligible beneficiaries receive help with two or more ADLs, and among those living in the community, 37% receive help with two or more IADLs. Among dual eligible beneficiaries receiving help with two or more ADLs, 36% are Black or Latino, 39% experience food insecurity, and 36% speak a language other than English at home.

Spend and Utilization

While all dual eligible beneficiaries comprise 15% of Medicaid enrollees, they represent a third of total Medicaid spending.[4] This is due to their higher likelihood of co-occurring, complex social, clinical, and functional needs. Dual eligible beneficiaries are particularly affected by chronic conditions, with 53% experiencing three or more chronic conditions. Higher rates of chronic conditions are linked to more frequent hospitalizations, increased prescription drug use, and can impact quality of life and mental health.[5] In particular, dual eligible beneficiaries experience higher rates of chronic lung disease, diabetes, and congestive heart failure compared to Medicare-only beneficiaries. Black and Latino dual eligible beneficiaries are more likely to experience access and communication barriers and higher chronic condition prevalence. This is an important concern for MCOs and states given that this clinical complexity occurs alongside a heightened likelihood of experiencing systemic racism, accessibility challenges, and social needs.

Rate of Chronic Conditions Among Dual Eligible Beneficiaries, by Race



Source: ATI Advisory analysis of 2020 Medicare Current Beneficiary Survey.

Note: Dual eligible beneficiaries refers to full dual eligible beneficiaries only. Chronic Lung Disease includes COPD and Asthma.

In addition, 55% of dual eligible beneficiaries have a mental health condition, which is associated with a higher likelihood of inpatient admission or emergency department (ED) visits, and 26% have a serious mental illness (SMI), including diagnoses such as schizophrenia that can result in the need for LTSS. Dual eligible beneficiaries who are Black or Latino report mental health conditions at lower rates (46% and 50% respectively) compared to white dual eligible beneficiaries (64%), potentially reflecting underreporting due to disparities in access to behavioral health services, cultural stigma, and other factors.[6] As anxiety and depression rates have increased among older adults during the COVID-19 pandemic and social isolation has become a greater concern, the prevalence of behavioral health needs in older dual eligible beneficiaries is likely to rise.[7]

Dual eligible beneficiaries also have high rates of healthcare utilization, with 21% having at least one inpatient admission and 27% having at least one ED visit in 2020. Utilization does not vary significantly by race but does vary by geography: rural dual eligible beneficiaries were more likely to visit the ED (35% vs. 25%) but were similarly likely to have an inpatient admission (22% vs. 21%) when compared to those living in urban communities. These utilization rates translate to higher costs for dual eligible beneficiaries, with Medicare Parts A & B spending, on average, $16,807 per dual eligible beneficiary compared to $7,994 per Medicare-only beneficiary.

Implications and Opportunities for MCOs and States

The intersecting social, clinical, and functional needs of dual eligible beneficiaries – alongside the challenges of navigating separate systems of care – underscore the importance of integrated, whole person programs for these individuals. As policymakers continue to advance Medicare-Medicaid integration, it will be important to ensure programs are reflective of and responsive to the demographic heterogeneity among dual eligible beneficiaries and disparities these beneficiaries are more likely to face. There are multiple opportunities to shape dual eligible program design and meaningfully address disparities.

- Due to their higher disease burden, dual eligible beneficiaries in particular stand to benefit from integrated high-touch models of care that include personalized care coordination to manage chronic conditions. Specifically, behavioral healthcare is critically important. Efforts to further integrate behavioral health and primary care services and to implement programs to reduce the stigma surrounding behavioral health in Black and Latino dual eligible populations are likely to positively effect health equity.
- Food insecurity is an increasingly prominent area of potential focus due to its long-term consequences on health outcomes and association with higher utilization of services, its growing relevance within Medicaid RFPs, and the Biden-Harris Administration's attention toward the issue as a priority topic via its National Strategy on Hunger, Nutrition, and Health.[8] The Administration proposes testing coverage of nutrition education and support programs in Medicaid through Section 1115 waivers and expanding access to nutrition and obesity counseling for Medicaid and Medicare beneficiaries. MCOs can capitalize on this focus through innovative nutrition programs that meet the complex needs of dual eligible beneficiaries. In particular, non-primary health-related supplemental benefits offered in D-SNPs allow meaningful support to dual eligible beneficiaries to reduce food insecurity. MCOs can leverage supplemental benefits to enhance access to foods that are affordable, appropriate for specific dietary needs, and cognizant of cultural preferences across racial and ethnic groups and geography.
- Finally, MCOs can leverage their existing relationships with states to make progress toward furthering Medicare-Medicaid integration efforts to strengthen access, quality, and resulting outcomes for dual eligible beneficiaries.

Beneficiaries with Long Term Services and Supports Need

Overview

LTSS include a range of services that assist individuals with functional limitations on their ability to carry out daily activities. LTSS can be provided through home- and community-based services (HCBS) or through institutional LTSS benefits. Historically, LTSS expenditures were primarily on institutional care, but in recent years the share of LTSS spending has shifted from institutional settings to home- and community-based settings, an approach often referred to as "LTSS rebalancing."[9] An estimated 7.7 million individuals utilize Medicaid-covered LTSS, with three fourths receiving LTSS delivered in home- and community-based settings. Medicaid carries a significant burden of LTSS spending, paying for over half (54%) of the more than $400 billion of total LTSS spending in the U.S. in 2020.[10] Of its LTSS expenditures, Medicaid paid $52 billion on institutional care and $162 billion on HCBS.

> Individuals typically prefer to receive LTSS in home- and community-based settings, allowing them to age in place and in the setting of their choice.

In addition, HCBS is typically less expensive per person than institutional LTSS options such as nursing facility care.[11] Yet, unlike institutional LTSS, states are not required to cover most HCBS. To provide HCBS services, states can obtain waivers from CMS. Although all states currently leverage waivers, the waiver design may not include all potentially eligible populations. Additionally, the number of individuals that can be served under the waiver, often referred to as "waiver slots," is dependent upon a state's budget. There are an estimated 665,000 individuals on Medicaid 1915(c) and 1115 HCBS waiver wait lists, of which individuals with intellectual and developmental disabilities (I/DD) make up the majority of wait list slots (70%).[12] However, fully quantifying the extent of LTSS and HCBS need, identifying which populations are more at risk of disparities, and collecting meaningful demographic-based experiences with LTSS have proven difficult due to inconsistent state data on LTSS and no standardized measurement and reporting framework for all states to follow in place from CMS.

Beneficiary Demographic Characteristics

Most HCBS users are age 19 to 64 and qualify for Medicaid-covered HCBS due to a disability.[13] Individuals with disabilities are often in poorer health compared to individuals without disabilities and experience disparities and discrimination in the healthcare system based simply on having a disability.[14] Individuals with disability or LTSS need also often experience additional disparities based on racial and ethnic background and sexual identity, making their already multidimensional needs more complex. For example, research shows that Black, Indigenous, and people of color (BIPOC) older adults receiving LTSS often receive lower quality care and experience worse health outcomes than their white older adults receiving LTSS.[15] This is a critically important disparity to address, especially when considering that BIPOC beneficiaries receiving LTSS are more likely to experience Alzheimer's disease and related dementias as a result of past trauma, discrimination, and structural racism.[16]

LGBTQ+ individuals receiving LTSS are also at a particularly high risk of discrimination and poor health outcomes. For example, 81% of LGBTQ+ older adults fear entering LTSS institutions because of potential discrimination, particularly those in rural communities who fear higher rates of hostility against the LGBTQ+ community.[17] This population's potential avoidance of LTSS can mean forgoing needed care and assistance placing them at risk for conditions to worsen or accidents at home to occur.

Spend and Utilization

The intersection of disability with demographic characteristics such as race, ethnicity, language spoken, income, and sexual identity tends to result in worse health outcomes and higher utilization and spending. For example, among dual eligible beneficiaries who receive assistance with two or more ADLs, 13% report trouble getting needed care and 33% did not receive a COVID-19 vaccine by Winter 2021, compared to 10% and 29%, respectively, among dual eligible beneficiaries who receive help with one or no ADLs. Additionally, Black and Latino dually eligible HCBS users have higher hospitalization rates and hospital spending than white dually eligible HCBS users, indicating the existence of significant disparities in access, quality, and services that meet the needs of this population.[18] Cultural norms, discrimination, and distrust of the healthcare system resulting from systemic racism may also contribute to these rates. Black and Latino older adults may delay needed care and are more than seven times as likely (25% and 23%) to report they have felt they were treated unfairly or that their health concerns were not taken seriously by providers because of their racial or ethnic background compared to white older adults (3%).[19]

These disparities are more prominent for individuals in nursing facilities. Black individuals receiving LTSS tend to be admitted to nursing facilities that have limited financial and staffing resources, poor performance, and high re-hospitalization rates compared to nursing facilities white individuals are admitted to.[20] These facility characteristics correlate with worse health outcomes for Black residents, who are more likely to be re-hospitalized within the first 30 to 90 days of a nursing facility stay and, if they have a severe impairment, are more likely to be hospitalized at any time during a nursing facility stay compared to white residents.[21] This is an increasingly relevant disparity as the proportions of Black and Latino individuals receiving LTSS is rising, representing nearly one fifth of the population receiving LTSS in nursing facilities.[22]

Implications and Opportunities for MCOs and States

As the American population continues to age, diversify, and experience a rising prevalence of disability,[23] these shifting demographics make addressing the inequalities present in LTSS an increasingly important priority for states and MCOs. Particularly as states anticipate a growing need for LTSS,[24] MCOs have several opportunities to assist its state partners with improving experiences for individuals with disability and using LTSS.

- MCOs can work with states to develop common data collection frameworks on LTSS and demographics to better understand intersectional needs of this population. This can include efforts that are broad-based or targeted toward specific populations or conditions with significant implications for LTSS. Examples include racial disparities in risk factors for dementia and the related likelihood of escalation to nursing facilities, or disparities by race among individuals with I/DD receiving LTSS.
- MCOs can assist states in preparing the direct support professional workforce to meet increasing need and enhance coordination between LTSS and other services. Professional caregiver training programs should build workforce quality and focus on culturally responsive care for specific populations. Support programs, services, and trainings for family caregivers have the potential to impact beneficiary and caregiver outcomes as well.[25, 26]

Individuals with Intellectual and Developmental Disabilities

Overview

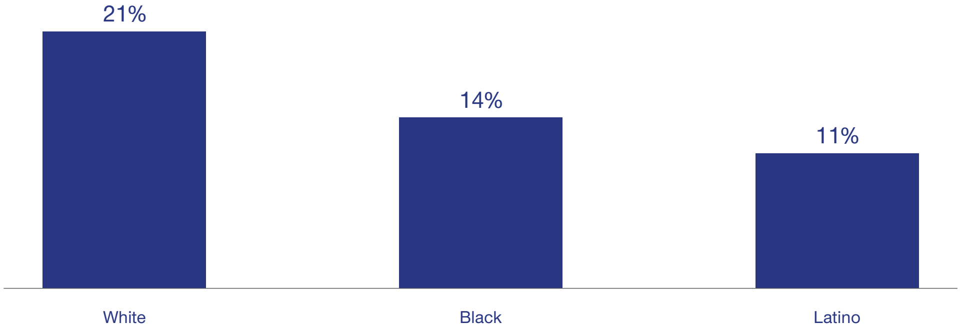
Individuals with Intellectual and Developmental Disabilities (I/DD) are at unique risk of experiencing inequities in their healthcare and often face discrimination in their experiences with the healthcare system as a result of their disability. Given that this is a population with high healthcare costs associated with long-term care needs, and that the prevalence of I/DD is increasing,[27] meeting the care needs of individuals with I/DD to ensure quality care and positive outcomes should be a priority for MCOs serving this population.

There are varying operational definitions of I/DD, with estimates ranging between 7.4 million[28] and 16 million[29] individuals with I/DD, nationwide. Further, data on the demographics of enrollees with I/DD are limited, making it difficult to quantify need and outcomes. This can make improving health outcomes and addressing equity concerns difficult in this population.[30]

Beneficiary Demographic Characteristics

Significant disparities in access, quality, and outcomes related to racial and ethnic background exist among individuals with I/DD, raising concerns about culturally responsive care.[31] Twenty-six percent of individuals with I/DD receiving LTSS across institutional and community-based settings are Black or Latino.[32] Compared to white individuals with I/DD, Black and Latino individuals with I/DD are more likely to not trust their doctors and to forgo care due to accessibility issues such as not knowing where to get care.[33] Inequalities in access to LTSS are present as well; in North Carolina, for example, Black and Latino individuals with I/DD were 37% and 15% less likely than white individuals with I/DD to receive a waiver service, respectively.[34]

Percent of Dually Eligible Beneficiaries With I/DD, by Race



Source: ATI Advisory analysis of 2020 Medicare Current Beneficiary Survey.

Note: Dual eligible beneficiaries refers to full dual eligible beneficiaries only

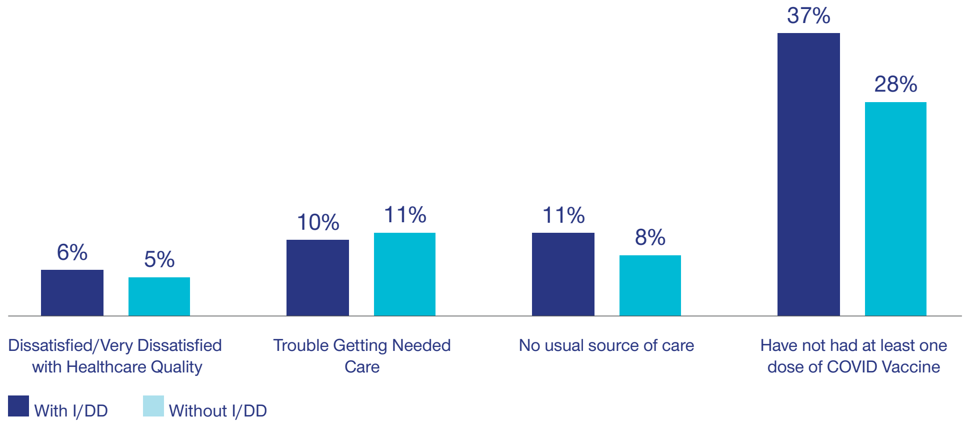
Additionally, while all individuals using LTSS have unique care planning needs and personal preferences, those with I/DD have particularly nuanced needs. For example, 72% of individuals[35] with I/DD live at home with their families compared to 66% of older adults with disabilities[36] who receive LTSS, placing a heightened importance on the role of family caregivers. Though recent strides have been made within the I/DD community toward self-advocacy in decision-making and independent living, some individuals with I/DD may have difficulty with the skills required for independent living and daily adult-life challenges without support, such as communication, social, and self-guidance skills.[37] Family caregivers of individuals with I/DD may be aging parents themselves in need of decision-making assistance, or might be sandwiched between caring for their child with I/DD and their own aging parents, further complicating care planning roles. Family caregivers to those with I/DD are often "career" unpaid caregivers and may be better versed in navigating community resources than direct support professionals and unpaid family caregivers in other populations (such as older adults).

Spend and Utilization

The responsibility of Medicaid to meet the care needs of individuals with I/DD is high, as this population accounts for considerable spending in Medicaid. While individuals with I/DD represent less than half (43%) of Section 1915(c) waivers (740,000 enrollees), they comprise over two-thirds (67%) of Section 1915(c) expenditures with an average cost of $47,392 per enrollee.[38] Additionally, given that individuals with I/DD represent more than two-thirds of HCBS waiver wait list slots, the proportion that Medicaid spends on the I/DD population is likely to grow as more waiver slots are granted over time.[39]
This disproportionately high spending is partly caused by co-occurring conditions that often interact with the LTSS needs of I/DD, creating more complexity in care. For example, 35% of all individuals with I/DD also have a co-occurring mental health diagnosis/condition.[40] Mental health conditions such as schizophrenia and mood disorders rank among the most frequent conditions for inpatient admissions in Medicaid beneficiaries with I/DD.[41] This is of particular importance as it relates to intersectional disparities, as Black individuals are almost five times as likely to be diagnosed with schizophrenia.[42] Among dual eligible beneficiaries with I/DD, 65% have a co-occurring mental health condition, and 51% have a SMI. However, incidence of seeking behavioral healthcare among individuals with I/DD is low due to a range of factors such as stigma, treatment accessibility and limited availability of specially trained providers, and affordability concerns. For example, just one in ten children and adolescents with I/DD and a co-occurring mental health condition receive specialized mental health services.[43] When left unaddressed from a young age, these conditions can create additional trauma and behavioral care needs over time.

In addition to the high cost of long-term care itself, utilization of health services is a key contributor to high spending in this population. Medicaid beneficiaries with I/DD experience inpatient admissions at a rate three times higher than the general population, and experience ED visit utilization at a rate two times higher than the general population.[44] Among Medicaid beneficiaries with I/DD, 12% had at least one inpatient admission during the year and 34% had at least one ED visit during the year.[45] This trend holds true among the dual eligible population with I/DD, with 14% experiencing at least one inpatient admission during the year, and 21% with at least one ED visit during the year. Likely contributing to these utilization rates is that individuals with I/DD typically have poor experiences with the healthcare system. Additional disparities in utilization by race are likely, but data limitations make quantifying and highlighting these disparities challenging. MCOs can work to collect demographic data in the I/DD populations they serve at the plan level, or partner with states to develop strategies to streamline enhanced data collection to better identify and serve the needs of this population.

Experience with Healthcare Among Dual Eligible Beneficiaries, by I/DD Status



Source: Source: ATI Advisory analysis of 2020 Medicare Current Beneficiary Survey.

Note: Dual eligible beneficiaries refers to full dual eligible beneficiaries only.

Implications and Opportunities for MCOs and States

Health equity in the I/DD community is complex. It involves not only potential discrimination around an individual's disability, but also compounded inequities and discrimination on the basis of other characteristics, such as race or language. These disparities result in a population that continues to experience negative health outcomes and rising costs. Addressing equity concerns in the I/DD population is particularly critical for MCOs given the rising proportion of LTSS provided by managed care and the associated high costs of caring for individuals with I/DD through LTSS.[46] However, opportunities exist to improve the care experiences and health outcomes for this population.

- MCOs can develop programs that work to shift hospital and ED utilization to lower-acuity settings, particularly for conditions associated with high inpatient admissions that can be treatable in ambulatory settings for individuals with I/DD, such as behavioral health, urinary tract infections, and pneumonia.[47]
- MCOs can leverage their capabilities and partnerships with states to provide an improved and more equitable care experience for Medicaid beneficiaries with I/DD through provider trainings and engagement strategies that take into account the unique characteristics of this population. Doing so can enhance healthcare experiences, reduce unnecessary utilization, and ultimately improve health outcomes.
- Lastly, given current data limitations, efforts should be made to enhance the availability of relevant demographic data to better understand and respond to potential disparities and intersectional needs within the I/DD community, both at plan levels and in the greater population.

Conclusion

The Medicaid population is increasingly diverse and has high rates of complex clinical, functional, and social needs. Successfully addressing health disparities among those served by Medicaid requires a nuanced understanding of the unique features and likely improvement opportunities for specific sub-populations, particularly with an eye toward the intersectional impact of race and ethnicity, sexual identity, disability status, socioeconomic status, geography, language, and dual eligibility status on individual experiences and outcomes.

Data will be key for both capturing health disparities and implementing targeted interventions to reduce them; MCOs are well positioned to enhance plan-level data collection processes as well as to partner with states on data collection frameworks for better understanding intersectional needs and identifying opportunities to reduce inequity. Such data can inform activities at the plan and state level – spanning service delivery design, care management approaches, innovations in addressing social needs, provider training, and beyond.

Finally, given the importance of personalized and high-touch care approaches for populations disproportionately likely to experience healthcare disparities, ongoing and bolstered efforts to engage beneficiaries and caregivers to share their lived experiences – what is working well and what could be working better – is an important step in reducing mistrust and poor experiences with the health care system and ensuring the well-intentioned investments and innovations are truly responsive to the whole person and their holistic needs.

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