Issue
Brief

Using Data on Race and Ethnicity to Improve Health Care Quality for Medicaid Beneficiaries

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Medicaid is the largest provider of health insurance for minority populations in America. According to the Centers for Medicare and Medicaid Services (CMS), in 2003 over half of the 52 million beneficiaries of Medicaid were minority Americans. Medicaid covers at least one in five non-elderly Latinos and African Americans compared to one in 10 whites.[1]

State Medicaid agencies have a responsibility and vested interest to reduce disparities in health care. Racially and ethnically diverse Medicaid consumers, due to language or cultural barriers may face increased barriers to and disparities in health care. States that work to reduce health disparities, will likely see improved health outcomes that may result in long-term cost savings. However, in order for states to address disparities, they must have information systems to capture data on race and ethnicity to identify the presence, magnitude, and significance of the problem. Because states tend to collect data on enrollees' race and ethnicity on a voluntary basis, often with a limited number of race/ethnicity categories, the data are frequently incomplete or miscategorized.[2] Without accurate information, it is extremely difficult for states to effectively address disparities in care. Reducing racial disparities should be viewed as one part of a state's overall quality improvement strategy that can lead to better health care quality for all of its Medicaid beneficiaries.

The Center for Health Care Strategies (CHCS) Purchasing Institute, *Leveraging Data to Reduce Racial and Ethnic Health Disparitie*s, helped state teams enhance their data mining skills, build agency capacity, and create strategic plans for interventions aimed at reducing disparities. This issue brief provides examples of how states can use data on race and ethnicity to improve the quality of care for their Medicaid beneficiaries.

The Role of Medicaid in Using Data to Reduce Health Disparities

State Medicaid programs can play a critical role as purchasers of health care services and as catalysts for efforts to eliminate racial and ethnic disparities. Medicaid provides states with the following opportunities to gather and use data on race/ethnicity to reduce disparities in health care:

- **Eligibility Data:** Unlike other health care purchasers, state Medicaid programs have the advantage of access to data on race and ethnicity. Eligibility data can provide

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[1] Centers for Medicare and Medicaid Services, FY 2003 National MSIS Tables.
[2] R.T. Perot and M. Youdelman, "Racial, Ethnic, and Primary Language Data Collection in the Health Care System: An Assessment of Federal Policies and Practices," The Commonwealth Fund, September 2001.

Medicaid programs with member-specific information on race/ethnicity that may not be readily available to other health care purchasers.

- **Managed Care Accountability:** Many state Medicaid programs have a significant managed care component. Managed care plans carry formal responsibilities for quality measurement and improvement. Health Employer Data and Information Set (HEDIS®) and Consumer Assessment of Healthcare Providers and Systems (CAHPS®) reports can be stratified by race/ethnicity at either the health plan or state level to identify disparities and track progress on disparity-reduction efforts. Managed care contracts can also provide financial and administrative incentives to encourage health plan participation in disparity-reduction initiatives.[3,4]

- **Purchasing Leverage**: Medicaid programs potentially have significant leverage over health plans, hospitals, and individual providers that depend heavily on Medicaid payments.

- **Population Demographic:** Minority populations are disproportionately represented in Medicaid. Improving the quality of care for the entire Medicaid population will have a positive impact on the total population and will also inevitably focus attention on disparities related to race/ethnicity.

- **Population Politics**: The Medicaid population is at risk for health care disparities by virtue of the major eligibility criteria (low income, young or old age, and/or disability) and often has little or no choice in either insurance options or health care providers.

Improving Health Care Quality for Racially and Ethnically Diverse Populations in Medicaid Managed Care

CHCS is working with health plans and state Medicaid agencies to improve the quality of care for racially and ethnically diverse populations and to raise the bar for the provision of high quality, evidence-based care for *all* beneficiaries. This multi=prong project, funded by the **Robert Wood Johnson Foundation** and **The Commonwealth Fund**, aims to enhance the capacity of states to collect and use data related to race and ethnicity to drive quality improvements and help health plans develop innovative clinical and administrative strategies applicable in Medicaid/SCHIP, but also relevant to Medicare and employer-based coverage programs.

Best Clinical and Administrative Practices (BCAP) Workgroup: *Improving Health Care Quality for Racially and Ethnically Diverse Populations*
Twelve organizations, including 10 Medicaid health plans, one state primary care case management program, and one state collaborative, are working with appropriate stakeholders (consumers, providers, and state purchasers) to develop strategies for identifying and addressing health disparities experienced by their racially and ethnically diverse group of members. CHCS is also working with commercial health plans in the *National Health Plan Collaborative to Reduce Disparities and Improve Quality*. The collaborative is coordinated and managed by CHCS, with additional assistance and leadership provided by the U.S. Department of Health and Human Services' Agency for Healthcare Research and Quality, the Institute for Healthcare Improvement, RAND Corporation, and the Robert Wood Johnson Foundation.

Purchasing Institute: Leveraging Data to Reduce Racial and Ethnic Health Disparities
In November 2004, CHCS conducted a Purchasing Institute for 12 state Medicaid agencies. The Purchasing Institute provided guidance to states on data mining techniques and contracting strategies to support statewide quality improvement initiatives for a group of racially and ethnically diverse beneficiaries.

Quality Summit
CHCS will share findings from the BCAP Workgroup, Purchasing Institute, and the National Health Plan Collaborative in a Quality Summit in December 2006 in Miami, Florida. This national summit will offer tools for improving care for racially and ethnically diverse populations in Medicaid and other insurance coverage programs.

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[3] HEDIS® is a registered trademark of the National Committee for Quality Assurance.
[4] CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality.

Collecting and Using Data on Race and Ethnicity

While all state Medicaid agencies collect some form of data on race and ethnicity, data sources and frequency of collection vary significantly across states. In 2004, CHCS conducted a national survey to catalog and assess how states collect racial and ethnic data for their beneficiaries. Twenty states and the District of Columbia, responded to the CHCS state survey (see CHCS state survey results at www.chcs.org).

Figure 1. Collection Methods Used by State Medicaid Programs to Gather Data on Race and Ethnicity (n=21)
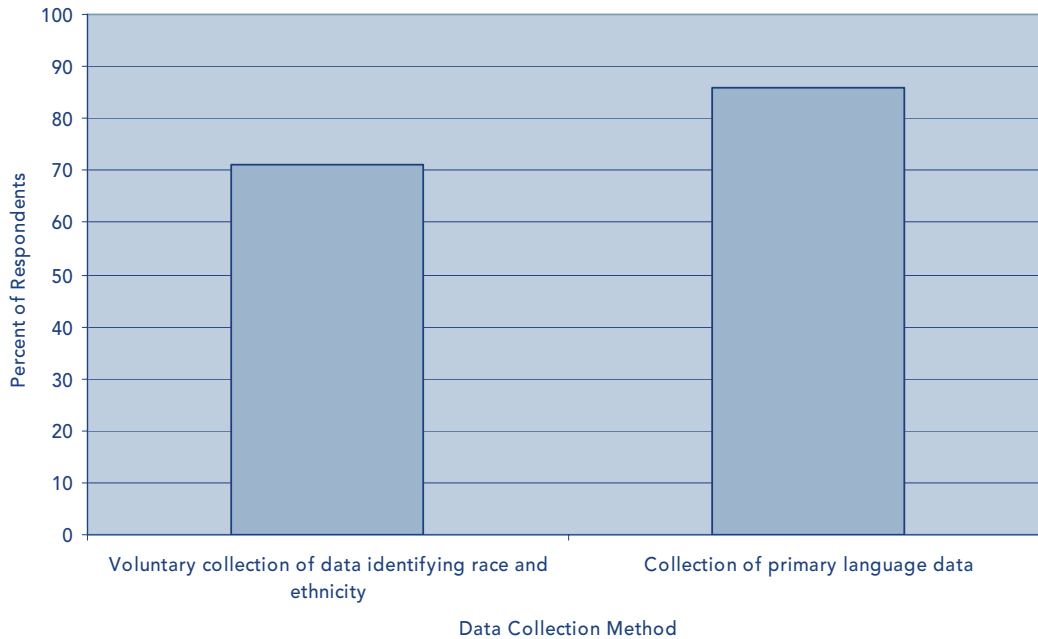
Figure 2. Validation Methods Used by State Medicaid Programs (n=21)
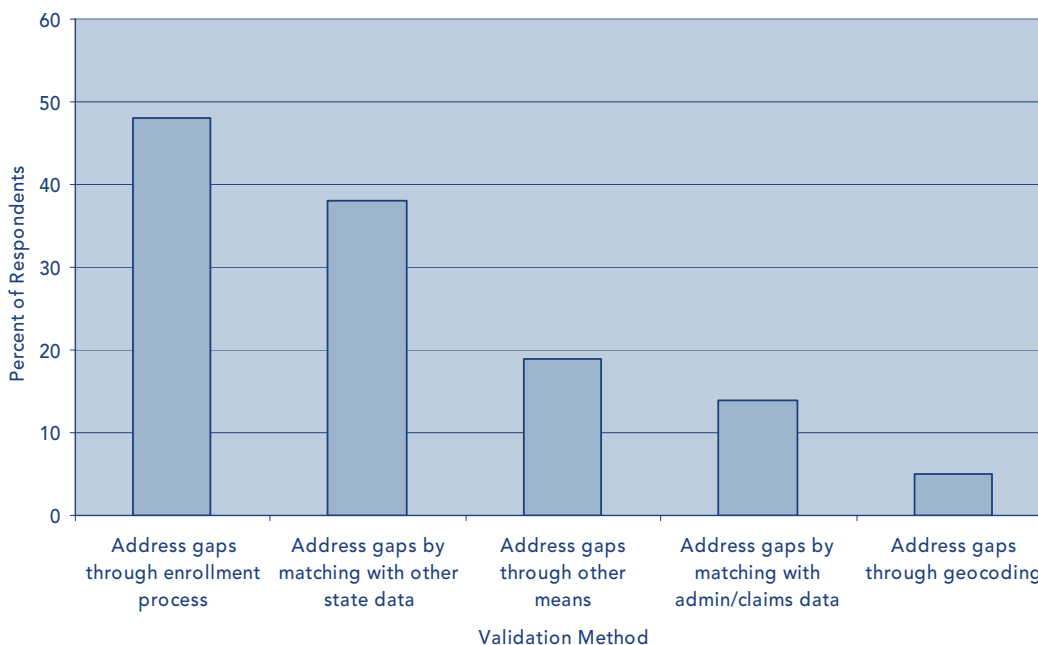
All of the responding states collect data on race and ethnicity to some degree. The majority of states collect self-reported race, ethnicity, and primary language data from their benefici-

aries on a voluntary, rather than mandatory, basis (Figure 1). However, missing and incomplete data are often a problem, and 14 states concluded there are real or perceived issues of accuracy with the collected data. States deal with gaps in data in numerous ways; the most common, is to document (through self-reporting or by the enrollment broker) a person's racial and ethnic identity during the enrollment process. (Figure 2). Other options used by states include matching with other types of state data, such as vital statistics and immunization registries or other state programs, as well as matching with administrative or claims data. Only one state currently uses geocoding, a way to infer the characteristics of a person (e.g., race and/or ethnic background) based on the characteristics of the area or neighborhood where he or she lives.

Using Geocoding to Identify Racial And Ethnic Health Disparities

Geocoding is used to infer the characteristics of a person (e.g., race and/or ethnic background) based on the characteristics of the area or neighborhood where he or she lives. While geocoding is not an exact science, it offers health plans a tool to identify geographic areas and/or particular ethnic groups needed for quality improvement interventions. The use of geocoding to infer race/ethnicity of individuals depends on a high degree of residential segregation, i.e., a single race/ethnicity is shared by a vast majority of residents in a particular geographic area. For commercial insurers, where racial and ethnic data are more difficult to collect, geocoding may provide a rough marker of a person's racial and ethnic characteristics. Because geocoding makes assumptions based on limited information, it is important to note that opportunities for inaccuracies exist.

The RAND organization is applying geocoding in Medicare and has conducted a study to identify disparities within nine Medicare+Choice health plans and 10 commercial health plans.[5] The study focused on HEDIS 2000 measures for diabetes and cardiovascular care. The diabetes measures included: HbA1c testing, LDL levels, urine protein check, and eye exams for people with diabetes. The other measures were beta-blocker prescribed for myocardial infarction patients and LDL checks in patients after a cardiac event. The study pinpointed racial and ethnic disparities within the commercial enrollees and the Medicare+Choice enrollees in receiving a beta blocker after a myocardial infarction and an LDL check after a cardiac event.

Figure 3. Racial/Ethnic Categories Used in Data Collection by State Medicaid Programs

| Racial/Ethnic Categories	Number of States Collecting (out of 21)[6]
White	20
American Indian/Native American	20
Black/African American	19
Hispanic or Latino	19
Asian	16
Native Hawaiian/Other (other) Pacific Islander	14
Other	9
Not Hispanic or Latino	7

Because the CMS has not established uniform data categories in state reporting systems for race, ethnicity, primary language, or country of origin, data collection practices vary considerably from state to state. While most states appear to collect data using major categories of "white," "black or African American," "American Indian or Native Alaskan," and "Hispanic

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[5] A. Fremont, et al., "Use of Geocoding in Managed Care Settings to Identify Quality Disparities," *Health Affairs*: 24:2 (2005): 516-526.
[6] Note: Not all participating states responded to each question.

or Latino," states vary considerably in their use of more precise sub-population groupings (Figure 3).

Figure 4. How Data on Race and Ethnicity is Used within State Medicaid Programs (n=21)
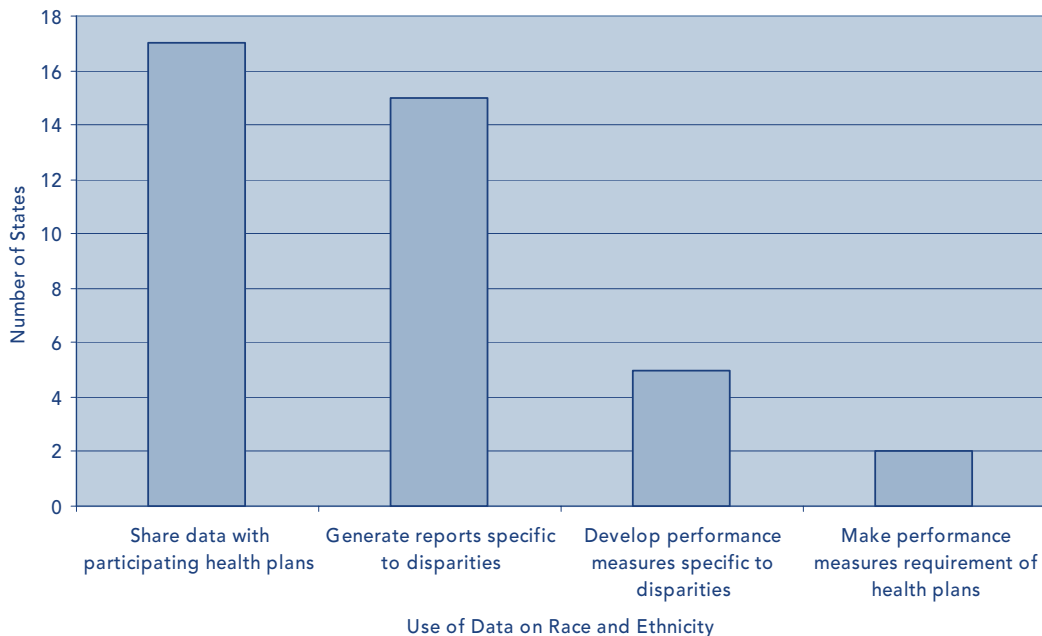
Most states also share the data on race and ethnicity they collect with their managed care plans. However, some states only share these data with a plan if specifically requested. Many plans also collect data on race and ethnicity from their members directly through outreach and enrollment processes, from providers, or through CAHPS survey results.

The state, as both purchaser and payer of services, has a unique opportunity to encourage Medicaid managed care organizations to identify and actively address racial and ethnic disparities. However, for most states, this opportunity has not yet been fully realized. While five of the responding states, Florida, Hawaii, Maryland, Oklahoma, and Oregon, indicated they had developed performance measures related to racial and ethnic disparities, only Florida requires its health plans to implement targeted interventions specific to this area.

Key Obstacles to Collecting and Analyzing Data on Race and Ethnicity
Through its work with states, CHCS identified a number of common barriers that may significantly impede a state's ability to collect and analyze data on race and ethnicity. In addition to basic technical problems, these obstacles generally fall into three categories: data accuracy, legality, and privacy.

Data Accuracy: The accuracy of the data collected is perhaps the most significant challenge, in terms of correctly identifying racial and ethnic groups. While self-reporting of data on race and ethnicity is the collection method of choice for most states (and is likely more accurate than having an enrollment broker assign race and/or ethnicity to beneficiaries), it is most often done on a voluntary basis, leading to problems of missing data. In some cases, states assign data on race and ethnicity to consumers if it is not self-reported. This type of data, based on assumptions regarding factors such as surname, geographical location, or physical appearance, can lead to additional race/ethnicity identification inaccuracies.

Finally, the categories of race and ethnicity collected by each state can contribute to the quality and validity of the available Medicaid data. Broad racial and ethnic categories that lack specificity are likely to fall short in terms of capturing meaningful detail about benefici-

aries and correctly identifying disparities. For example, if only three categories are used (white, black, Hispanic), then the ability to capture and interpret health care differences may be limited by the state's inability to identify any disparities related to Native Americans or Asian subgroups. This challenge is made more difficult by the lack of uniform standards regarding Medicaid data collection. The Office of Management and Budget (OMB), supported by the Department of Health and Human Services, published recommendations in 1997 that now serve as the national standard for data collection.[7] Implementation, however, has never been mandated and state practices vary widely. Some states collect as few as two basic categories of racial and ethnic data, others gather up to seven outlined by the OMB, and others go further to define specific subgroups reflecting the race, ethnicity, and primary language of people within a state. Furthermore, how a state addresses, or chooses not to, the issue of multi-race or ethnicity is also a factor. Of the 21 states that CHCS surveyed, only five follow the OMB directive.

Legality: Another barrier to the collection and use of data on race and ethnicity in Medicaid has been the perception that the collection of such data may be illegal. In fact, there are no federal statutes prohibiting the collection of these data. Title VI of the Civil Rights Act of 1964, which prohibits intentional discrimination on the basis of race or national origin in the provision of services supported by federal funds, is considered the broadest mandate the federal government has to require collection and/or reporting of racial and ethnic data, although no such requirements currently exist.[8] Only four states have established restrictions regarding the collection of data on race and ethnicity. None have done so across the board; instead they have prohibited some health plans from collecting data on race and ethnicity in "certain contracts." [9] These restrictions are generally dependent upon *when* the data are collected as opposed to whether they are collected at all.

Privacy: Issues surrounding the privacy of health information represent the final major hurdle to the collection and use of data on race and ethnicity by state Medicaid agencies. Data confidentiality and the potential for misuse of data are frequently cited as obstacles to data collection.[10] A number of recent regulations surrounding privacy concerns over the last few years have resulted in a confusing array of policies. In general, none of these laws preclude the collection of data on race and ethnicity data for states or health plans. Some, such as the Department of Health and Human Services Privacy Rule, contain provisions that protect the confidentiality of such data.[11] Finally, there is a concern that this type of sensitive data, once collected, could potentially be used inappropriately and could even harm Medicaid beneficiaries.

Emerging Practices for Collection of Data on Race and Ethnicity
Data accuracy is one of the most significant obstacles states currently face in identifying racial and ethnic disparities. In spite of these barriers, several states have found ways to obtain more complete data to understand the demographics of the people they serve. For example, Massachusetts collects information on race and ethnicity at numerous points, including at eligibility determination, enrollment into a health plan, and at the time of treatment to validate self-reported data.

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[7] Federal Register, October 30, 1997 (vol. 62 no. 210) page 58782.

[8] R.T. Perot, et al., op. cit.

[9] J. McDonough, et al., "A State Policy Agenda to Eliminate Racial and Ethnic Health Disparities." The Commonwealth Fund. June 2004. http://www.cmwf.org/programs/minority/mcdonough_statepolicyagenda_746.pdf.

[10] "A Primer on Collaborating with Medicaid Agencies and Using Medicaid Data in Efforts to Eliminate Racial and Ethnic Disparities in Health," Center for Health Program Development and Management, University of Maryland Baltimore County, January 2002.

[11] Code of Federal Regulations revised October 2002. Title 45 Subtitle A, Parts 160 and 164 (subparts A and E).

Another way that some states collect and/or validate their data is through contracts with managed care organizations (MCOs). A majority of Medicaid consumers nationally are enrolled in managed care plans or use providers that contract with state Medicaid agencies. As a result, states have a significant opportunity to encourage or even require participating MCOs to collect additional data on the race and ethnicity of the Medicaid beneficiaries they serve. South Carolina is currently the only state that mandates the collection of data identifying race by Medicaid MCOs. The regulation requires managed care organizations to "establish procedures to develop, compile, evaluate, and report statistics annually, which must include the collection/maintenance of data including the race of enrollees."[12]

States may also link encounter data (data from office visits) with eligibility files to identify data on race and ethnicity of insured people. States with improved encounter data reporting have had additional success in data collection practices. Maryland, for example, routinely uses encounter data for rate setting/adjustment purposes, providing Medicaid MCOs with tremendous incentive to report encounter data to the state. Maryland uses encounter-level data to evaluate the performance of the managed care program in general, and services used by racial and ethnic groups in particular.[13] Delaware has had similar success in capturing Medicaid encounter data from MCOs. The state uses disincentives, such as withholding a portion of the capitation payment, to encourage plans to submit required encounter data. State Medicaid agencies can build data gathering and analytic capabilities by requiring MCOs to provide additional data on race and/or ethnicity through direct or indirect means. This allows states to refine a quality improvement strategy that targets, and eventually reduces racial and ethnic disparities. However, it is important to note that because encounter data is completed by the provider (not self-reported by the individual) and is collected at a less frequent rate than eligibility data, it may not be as accurate as other sources of data.

What Can CMS Do To Support State Efforts?

CMS can assist states in their efforts to reduce racial and ethnic disparities in the following ways:

- Require states to use a minimum number of data collection categories (used to identify race and ethnicity) as outlined in the OMB directive. For example, states that only use three data collection categories (white, black, Hispanic) have a greater chance of collecting inaccurate racial and ethnic information than states that collect data in five categories (white, black, Hispanic, Asian, other).
- Encourage all state Medicaid agencies to implement the Federal requirement to share their data on race and ethnicity (member-level) with health plans. With this information, health plans are better able to understand their membership and target quality improvement efforts accordingly.
- Promote states' use of pay-for-performance strategies to encourage practices that seek to eliminate health care disparities (health plan and provider level).
- Require states to periodically survey health plan staff to identify linguistic or cultural competency deficiencies.

The Data Feedback Loop

Creating a feedback loop by sharing, linking, and jointly analyzing data on race and ethnicity among a state Medicaid agency and its managed care organizations, as well as other public health agencies (e.g., minority health agencies), can greatly improve Medicaid's ability to accurately identify and reduce racial and ethnic disparities in health care. In 1999, the Health Resources and Services Administration (HRSA), CMS, and the Centers for Disease

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[12] "State Policies on Collecting Racial and Ethnic Data: South Carolina." National Health Law Program of California. http://www.omhrc.gov/cultural/project51/southcarolina.pdf
[13] Center for Health Program Development and Management, University of Maryland Baltimore County, op. cit.

Control and Prevention, outlined a number of benefits that can be derived from such activity, including:

- Encouraging states to develop integrated information systems to support appropriate, accessible, and cost-effective care.
- Improving the technical capacity of states to analyze data from multiple sources to support policy-making and program monitoring.
- Promoting the development and implementation of common performance measures across multiple programs to improve effectiveness.[14]

In addition, collaboration among state agencies can help alleviate the problem of data accuracy by offering multiple opportunities for data validation. For example, by establishing a formal data-sharing relationship with the University of Maryland Baltimore County (UMBC), the Maryland Department of Health and Mental Hygiene (the Medicaid agency) is able to validate its data and enhance its analytic capabilities.

This partnership illustrates the value of outsourcing with a technically capable organization to improve the quality of care for racially and ethnically diverse populations. By working with an academic institution experienced in information technology, Maryland's Medicaid agency heightened its capacity for analyzing and using data on race and ethnicity in a highly efficient manner, saving both time and financial resources. In addition to pooling resources and building state capacity for information technology, collaboration with external partners can improve data accuracy through greater scrutiny of Medicaid data, provide new opportunities to conduct research on health disparities within a state Medicaid program, and coordinate the goals, objectives, and activities for data collection and use (see Maryland/UMBC data-sharing presentation at www.chcs.org).

Despite the fact that some states have established data warehouses, integrated information systems, and shared data with other state agencies, many states still operate under the guidance that data sharing should be restricted to the agency that generated the data.[15] This may inhibit potential collaboration to obtain accurate, member-level data in some states that feel unable to enter into the type of arrangement that Maryland has established with UMBC.

The interaction between Medicaid agencies and their managed care organizations may present the best opportunities for improving the quality of available data on race and ethnicity. In 2002, the CMS initiated a new regulation requiring state quality strategies to include "procedures that identify the race, ethnicity, and primary language of each Medicaid enrollee" to the MCO or prepaid inpatient health plan (PIHP) at the time of enrollment.[16]

The CHCS survey found that plans are frequently unable to merge state data with their own demographic data. Health plan data are often automatically overwritten by monthly enrollment data from the state, making the simple correction of member information incredibly difficult. The survey also showed that data sharing between the state Medicaid agency and managed care organizations is generally a one-way street; for the most part, data on race and ethnicity collected by managed care plans are not shared with or used by the state. In sum, while the potential for improved accuracy of data on race and ethnicity data resulting from state and MCO interaction is great, it has not yet been fully tapped.

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[14] Ibid.
[15] Ibid.
[16] *Federal Register* June 14, 2002. (vol. 67, no. 115) pages 40989-41038 .

Data Analysis

To ensure the most accurate data on race and ethnicity, states should validate the data to minimize the impact of gaps and inaccuracies. New York, for example, developed a series of support tools to evaluate data accuracy. One such support tool compares the data collected during the eligibility process with self-reported race/ethnicity from the CAHPS survey through the following steps:

1. Prior to the survey, race and ethnicity information (in addition to other demographic information) is provided to the survey vendor.

2. Upon completion of the survey, cross tabulations are calculated between the self-assessment of race and ethnicity from the survey and the eligibility data.

This process allows the state to find possible inaccuracies. The New York eligibility system allows for beneficiaries to select only one race or ethnicity. However, the CAHPS survey allows for a beneficiary to indicate multiple race and ethnicity combinations. Therefore, New York compares the data on race and ethnicity from eligibility files (only one per beneficiary) to each race and ethnicity field from CAHPS (could be many per person). For example, the eligibility system might report 100 African American in a survey, versus a CAHPS survey, in which 79 of the 100 said they were African American. Through this process, the state can test and validate its data. It is important to note, however, that this process will only provide a general indication of the accuracy of data in the eligibility files and it is not a person-by-person check of all enrollees.

The index of disparity (ID), created by researchers, Jeffrey Pearcy and Kenneth Keppel, is another tool that states can use to measure disparity across populations, particularly among different racial and ethnic groups.[17] The ID examines the average of the absolute difference between rates of specific race/ethnicities within a population and the overall population rate, which is then divided by the rate of the overall population. This index can be used is to prioritize areas in need of improvement by targeting measures of health performance that have the most variation across race ethnicities. In New York, for example, the ID was applied to 20-25 health care measures. Areas with high ID percentages included: inpatient acute hospitalizations, Chlamydia screenings, annual dental visits, and emergency department visits. A high percentage of variation can indicate that a particular racial/ethnic group is experiencing access barriers to these services. Areas/services with high variation could then be targeted for quality improvement interventions to reduce disparities (see more about the Index of Disparity at www.chcs.org).

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[17] J.N. Pearcy and K.G. Keppel, *Public Health Reports*, vol. 117 number 3 (2002):273-280.

Using a New Disparities Index for Medicaid Populations

CHCS has worked with participants in the BCAP Workgroup on *Improving Health Care Quality for Racially and Ethnically Diverse Populations* and others in the field to develop a disparities index for use within Medicaid populations.

The CHCS Disparities Index[18], which is still being tested, measures changes in racial and ethnic health disparities, as well as overall changes in quality of care. The DI measures each health plan's progress toward eliminating disparities by comparing the difference between each racial and ethnic subgroup's rate on a measure and the "best" performing subgroup's rate for the same measure. The quality component of the Disparities Index measures each subgroup's performance against an external norm such as the HEDIS 75th percentile (the national Medicaid rate per measure). The index can potentially be used as part of a needs assessment, to identify an overall pattern of disparities at the plan level, to evaluate ongoing disease management programs, and to determine whether the disparities experienced by racial/ethnic groups are increasing or decreasing. Results for this new tool will be released in Spring 2007.

Working with Health Plans to Improve Racial and Ethnic Health Disparities: Oregon, Michigan, and Virginia

States and health plans that identify gaps in care through creative analysis of data on race and ethnicity can then take the next step to reduce these disparities. A series of demonstration projects funded by The Commonwealth Fund and HRSA worked with states and health plans to use data on race and ethnicity to identify and reduce disparities. From 2002-2004, 12 Medicaid managed care plans in six states (Michigan, Montana, Oregon, Texas, Virginia, and Washington) obtained data on enrollee race and ethnicity from state Medicaid agencies, used that data to prepare HEDIS and CAHPS reports that were stratified by race and ethnicity, identified disparities, and implemented quality improvement initiatives to reduce or eliminate the disparities.[19] The projects addressed diabetes care, prenatal-perinatal care, adult preventive care services, smoking cessation, appropriate asthma medication, well-child care visits, and breast and cervical cancer screenings. The approaches used in the quality improvement projects ranged from disease/case management to partnerships with community organizations. Every health plan implemented at least one quality improvement initiative and several plans demonstrated progress in addressing disparities within one year.[20]

The following case studies provide examples of how three states in this project collaborated with health plans to improve the care and quality for their racially and ethnically diverse Medicaid beneficiaries.

Oregon

Oregon's Medicaid program focused its quality improvement project on diabetes management and smoking cessation. An analysis of Oregon's HEDIS data showed significant disparities in both of these areas. The state selected three health plans to work on this project -- CareOregon, Providence, and FamilyCare, Inc. The three plans all serve the Portland area

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[18] For more information about the Disparities Index, contact Karl Weimer, CHCS Senior Research Officer, at 609.528.8400.

[19] D.R. Nerenz, "Health Care Organizations' Use of Race/Ethnicity Data to Address Quality Disparities," *Health Affairs* 24:2 (2005): 409-416.

[20] One of the states had a primary care case management (PCCM) model for Medicaid managed care rather than a set of contracting HMOs. In this case, the state Medicaid program took on many of the data analysis and quality improvement roles that individual health plan staff were responsible for in other states. The state with the PCCM program is not one of the states described in detail here.

and have partially overlapping provider networks. These plans were selected based on their interest in, and previous experience with, health disparities.

The project involved sharing data on race/ethnicity with the plans, analysis of HEDIS data stratified by race/ethnicity, and use of data available in 2004 to evaluate the impact of quality improvement/community education projects. Because the state Medicaid agency had much of the relevant data for many of these analyses, Oregon developed reports at multiple organizational levels – all plans in the state, all plans serving the Portland area, the three plans involved in the demonstration project taken together, and each of the three plans individually.

The state developed strong collaborations between the Medicaid program, the three health plans, and the local African American Health Coalition. The collaboration involved a partnership to distribute printed materials about diabetes management and smoking cessation to plan members in the Portland area. The health plan intervention to improve testing for diabetes management and smoking cessation was comprised of four targeted mailings designed, tested, and distributed by the coalition. As a result of the informational mailings, health plans measured an increase in the number of HbA1c and LDL tests in the target population.

Oregon shared the results of this project in its publicly distributed Minority Report Card. This practice of public disclosure took the project to a level of public visibility that was not found in other states participating in the demonstration projects.

Michigan
Michigan's Medicaid health plans cover the entire state, with the largest concentration of plans (and enrollees) in southeastern Michigan (Detroit and its suburbs). The state selected three health plans in southeastern Michigan to participate: CAPE Health Plan, Great Lakes Health Plan, and Health Plus. Two of these plans had experience with matching data identifying race/ethnicity from the state's enrollment files with their own membership or HEDIS files to stratify their HEDIS reports by race/ethnicity. Since all three health plans had relatively large percentages of African American members, the state selected this group as the target population for the quality improvement project.

Although each health plan had varying goals and interventions, they all focused on diabetes management (the testing or control of HbA1c and LDL levels). The health plans' broad range of interventions included establishing a disease management program and registry, developing physician profiles, providing culturally-sensitive educational materials to members, providing diabetes case management, and partnering with a home health agency. The multi-intervention approach was successful for Michigan, and its health plans either met their goals of increasing diabetes testing or learned valuable information about its members with diabetes and providers' practices.

The Michigan Department of Community Health identified how to position the disparities demonstration project as a part of, and not in competition with other ongoing quality improvement initiatives. During the final stages of the quality improvement project, the state sponsored a one-day workshop on health care disparities for all 19 managed care plans in the state. The February 2004 workshop included guest speakers on cultural competence and presentations from each of the three plans from the demonstration project. The goal of the workshop was to encourage non-participating health plans to organize similar data analysis and quality improvement efforts, with the three plans and the Michigan Department of Community Health serving as consultants for the "new" plans. To further establish elimination of health care disparities as a state priority, the state held another disparities workshop in spring 2005 and will continue to sponsor a disparities-related workshop annually. The Michigan

Department of Community Health formed a state-level Multi-Disciplinary Working Group on Health Disparities Reduction to continue efforts to address disparities.

Virginia

The Virginia Department of Medical Assistance Services (DMAS) focused its quality improvement project on asthma and diabetes with two health plan partners, Sentara Health Management and Unicare Health Plan of Virginia. The state involved its Managed Care Advisory Committee, which was updated regularly on the project's progress, to ensure internal buy-in for the quality initiative. Results from the project provided beneficial data for other areas of DMAS and contracted managed care plans.

To inform the plan activities, DMAS conducted two clinical focus studies on prenatal care and asthma and identified poorer outcomes for its African American members. In response, Unicare focused its project on African American members (children) with "high/severe" asthma. Unicare held asthma fairs, conducted home visitation programs for its members, enacted incentives for members to schedule primary care visits, and held trainings with the plan's highest utilization providers. The project resulted in a decrease of six percent of children categorized with high/severe asthma.

Sentara sought to improve physician practice behavior in the management of diabetes patients and to improve HEDIS-related diabetes measures. The health plan implemented a diabetes life coach program that provided services such as social support, telephonic support, education sessions, and real-time data analysis for physicians. Sentara improved comprehensive diabetes measures (HEDIS) by almost nine percent for black and white members.

Nearly every state participating in the HRSA demonstration project used their results to make racial/ethnic health disparities an ongoing priority issue. Many of the states are identifying how to include health disparities as part of their quality measurement and quality improvement activities. Developing quality improvement projects focused on reducing or eliminating health care disparities should be seen as a priority issue for all state Medicaid programs. States can use these demonstration projects as examples of useful strategies their state can test or adopt (view HRSA's final report at www.chcs.org).

Improving Racial and Ethnic Health Care Quality: Additional State Strategies

Federal requirements for Medicaid programs provide a foundation for quality, but health plans need support from purchasers to move from meeting minimum standards to implementing quality improvement initiatives.

Public and private purchasers can play a key role in supporting disparity-reduction initiatives. For example, a state can work with its health plans to collect information at the enrollee level, use its external quality review organization (EQRO) to provide information about health plan activities to reduce disparities, and implement strategies at the state level to promote data collection and quality improvement. Following are additional innovative state examples:

Integrating Racial/Ethnic Quality Improvement Projects into the State's MCO Contract

Florida's Medicaid program, the Florida Agency for Health Care Administration, implemented two strategies to improve the state's ability to measure racial and ethnic health care disparities. The state is using CMS' required quality assessment performance improvement (QAPI) projects to learn more about the racial and ethnic diversity of its membership. In 2005, Florida began to require its contracting MCOs to implement QAPIs in areas that address racial and ethnic health disparities. Of the four required projects, Florida mandates that at least one must focus on one of the following: (1) language and culture; (2) clinical health care disparities; or (3) culturally or linguistically appropriate services. Examples of topics identified by the health plans include: identifying health disparities in cholesterol management among their Latino population; improving quality in the health plan's French Creole membership; and improving cultural competency training at the provider level.

In addition, the Florida Medicaid program set a goal to assess program capacity to provide appropriate health care to its racially and ethnically diverse population. The state is identifying an EQRO vender to assess health plan efforts for ongoing quality improvement and provide recommendations to improve the standards for health plan data collection and analysis on race and ethnicity. Implementation of the new assessment process will take approximately one year.

Stratifying Performance Measures by Race/Ethnic Categories

Most Medicaid managed care programs require health plans to collect a number of HEDIS measures and CAHPS. However, very few Medicaid programs require their health plans to stratify their HEDIS and CAHPS results by racial/ethnic categories. Oregon stratified the results of its CAHPS survey by the following categories: white, black, Hispanic, Native American, and other. By stratifying these data, the state and health plans will begin to identify racial and ethnic gaps in access to care, service utilization, and satisfaction with health plan performance. Based on the resulting data, states can design and target more effective quality improvement strategies. States that conduct CAHPS surveys in multiple languages have the option to analyze each language category separately.

Developing Performance Incentives

Performance incentives are increasingly being used in commercial, Medicare, and Medicaid areas to improve quality of health care for enrollees. Incentives have traditionally focused on performance measures such as well-child visits, preventive health care screenings, and appropriate asthma medication. States can also incorporate pay-for-performance strategies rewarding health plans that successfully develop and implement quality improvement strategies aimed at reducing health disparities. Further, states could reward health plans that attain higher HEDIS scores in areas where racial and ethnic disparities in health care are commonly found (e.g., well-child visits, preventive care, diabetes care).

Implementing this state strategy requires that health plans have the technical capability to collect and analyze racial and ethnic health data. Linking performance incentives to improvements in racial and ethnic health care disparities may not be an immediate step for all states, but it should be seen as a major consideration for the future.

Conclusion

State efforts to eliminate racial and ethnic disparities within Medicaid must begin with reliable data. While collecting data on race and ethnicity alone can not reduce or eliminate disparities, experts agree that gathering such data is a necessary first step in identifying disparities in treatment and targeting strategies to address them.[21] Indeed, the extent to which efforts – at the federal, state, or health plan level – are successful in reducing and eliminating disparities depends largely on the availability of reliable data. Without valid data on the race and ethnicity of members, insurers and purchasers can neither accurately define the problem, nor bring about any meaningful solution. Access to accurate data depends on the commitment, participation, and collaboration of Medicaid and other state agencies, managed care organizations, providers, and even local communities to support state Medicaid agencies in:

- Obtaining information on the race and ethnicity of their enrollees either directly and/or indirectly through their own enrollment process and/or Medicaid managed care organizations;
- Using data to generate reports stratified by race/ethnicity to identify potential disparities;
- Incorporating the goal to reduce racial and ethnic disparities into already existing quality improvement projects; and
- Developing quality improvement projects specifically designed to reduce and/or eliminate disparities in health care.

Because the Medicaid program covers more than 20 million minority members, state Medicaid purchasers and their managed care contractors are uniquely positioned to generate improvements in the quality of care and health outcomes for millions of racially and ethnically diverse beneficiaries with chronic illnesses. There is much that state Medicaid agencies can do to enlist managed care plans and others in reducing and/or eliminating racial and ethnic disparities, including:

- Continuing to improve state data collection processes;
- Collaborating with health plans to make improved health plan data collection a priority;
- Providing data on race and ethnicity to the health plans and ensuring the completeness and accuracy of data; and
- Offering technical, administrative, and financial incentives to health plans to address disparities in care.

Reducing disparities should be seen as a subset of all quality improvement activities, with the ultimate goal, not of reducing disparities for a few, but rather improving quality of care and services for all Medicaid beneficiaries.

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[21] N. Lurie, et al., "Disparities and Quality Improvement: Federal Policy Levers," *Health Affairs*. 24, no.2 (2005): 354-364.

IMPROVING THE QUALITY OF PUBLICLY FINANCED CARE