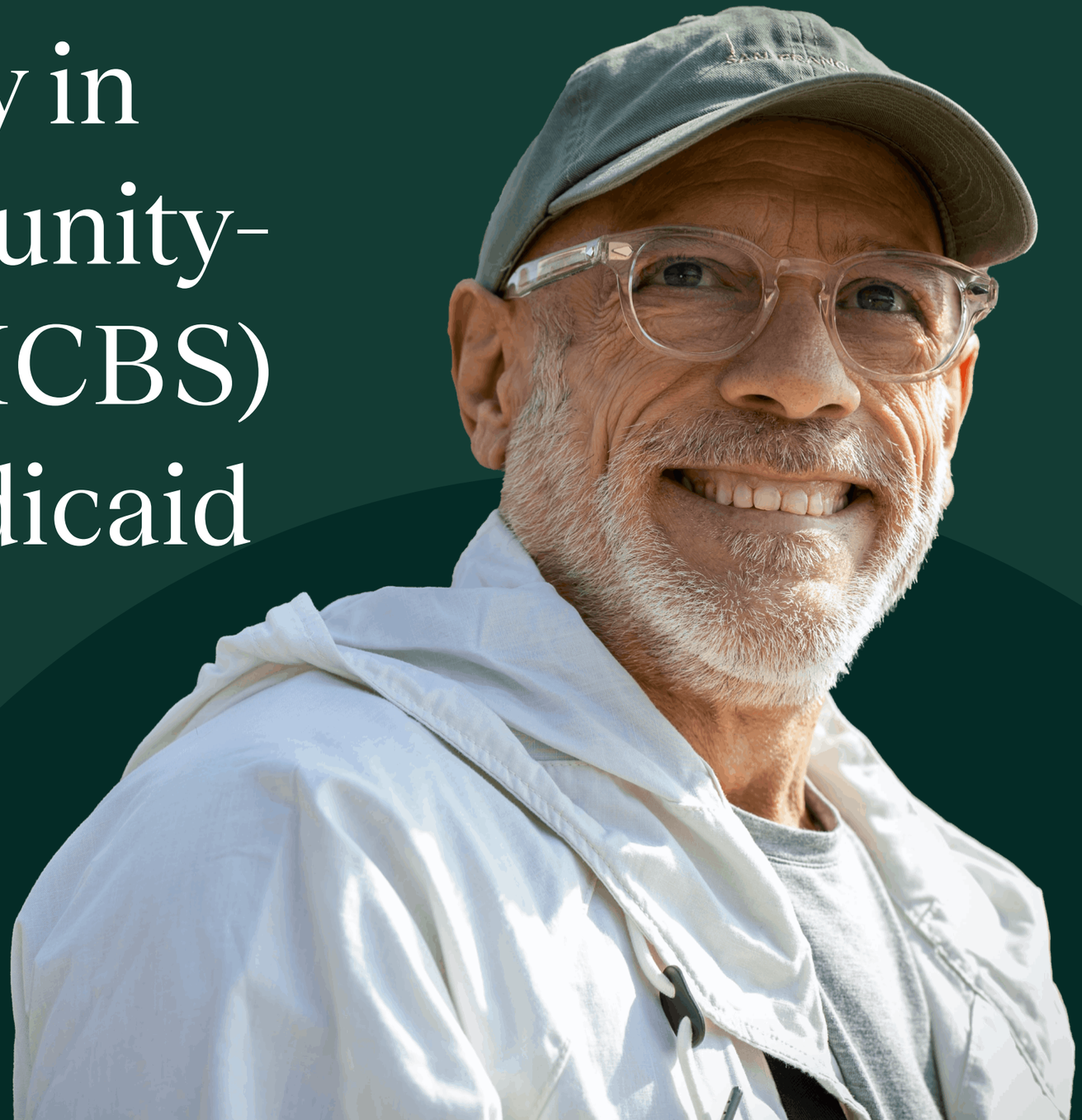
Addressing Equity in Home and Community-Based Services (HCBS) for Medicare-Medicaid Beneficiaries



Community Catalyst

Today's Presenters:

Marc Cohen, Ph.D., Co-Director LeadingAge LTSS Center @UMass Boston and Research Director, Center for Community Engagement, Community Catalyst

Carolyn Fisher, Ph.D., Research and Evaluation Scientist, Institute for Community Health

Mike Brand, MSW, Policy Analyst,
Community Catalyst

Community Catalyst

Our project team:

Community Catalyst is national organization dedicated to building the power of people to create a health system rooted in race equity and health justice and a society where health is a right for all. Together with partners, we're building a powerful, united movement with a shared vision of and strategy for a health system accountable to all people. Team: Leena Sharma, Mike Brand, Siena Ruggeri

The **LeadingAge LTSS Center @UMass Boston** conducts research designed to help the nation address the challenges and seize the opportunities associated with a growing older population. The LTSS Center's primary goal is to translate research into policy and practice so its work can serve as a foundation for government policies and provider actions to improve quality of care and quality of life for vulnerable older adults. Team: Marc Cohen, Jane Tavares, Eileen J. Tell.

The **Institute for Community Health** is a nonprofit consulting organization specializing in participatory program evaluation, applied research, assessment and planning, and training and technical assistance to help local communities and organizations create sustainable health. The cornerstone of our mission is a commitment to community engagement in all aspects of the assessment, planning, and evaluation process, and a deep appreciation for the diverse experiences and values that communities contribute to health improvement.
Team: Carrie Fisher, Nithershini Narayanan, Nathaly Perez Rojas.

Today's Agenda:

Overview of the Project
Quantitative Findings
Focus Group Processes and Outcomes
Policy and Practice Implications
Discussion and Q&A

Project Overview

Project Goal:

Understand the impact of HCBS on dual-eligible beneficiaries of color who are age 50 and older, with a particular focus on potential disparities in access to care.

Research Questions:

- What disparities in access to and quality of HCBS exist for dually eligible beneficiaries of color?
- How can we mitigate the disparities through policy and practice changes?

Method:

- Environmental Scan
- Quantitative: Health and Retirement Study (HRS) Analysis
- Qualitative: Focus Groups, Key Informant Interviews

Project Components

Environmental Scan

Conduct a strategic analysis of scientific and grey literature to capture the national landscape of disparities in access to HCBS and changes over time. 34 academic articles (peer-reviewed) literature and 19 papers

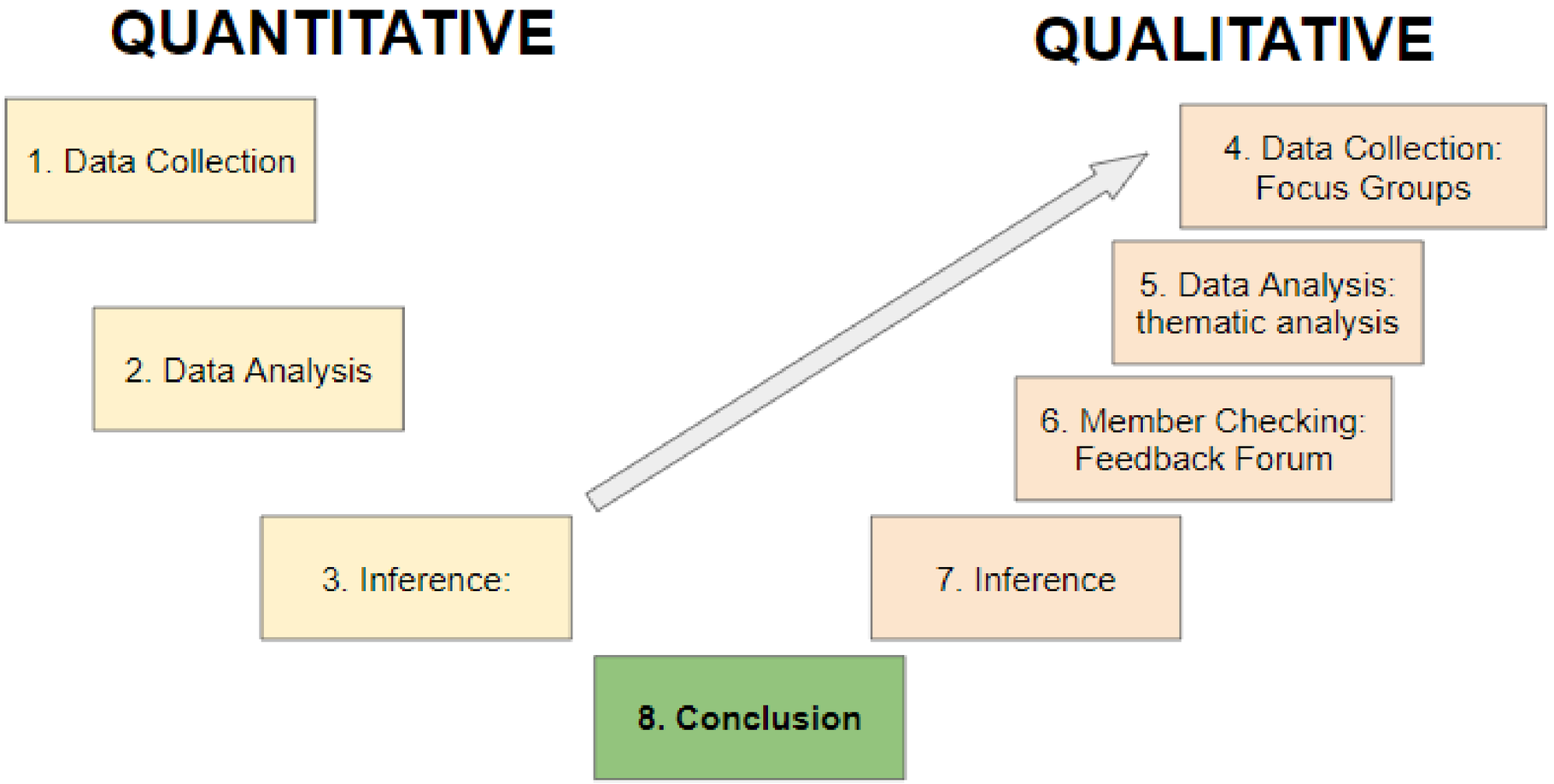
Quantitative Analysis

Utilize the longitudinal database to understand changes in access to care, factors influencing how and why individuals begin using care, and disparities based on a range of characteristics.

Qualitative Research

Seven interviews: individuals of color in HCBS provider organizations, managed care plans, state and federal officials and advocates. 8 virtual focus groups**:** 52 dually eligible beneficiaries of color in four regions.

Design: Sequential explanatory mixed methods



Key Findings: Environmental Scan

People of color are more likely to have:

- LTSS (long-term services and supports) needs and receive no help from informal care and/or HCBS
- More limited access to a wide variety of HCBS
- Poorer health outcomes, which are postulated to be related to not having their needs met through family or HCBS
- Lower HCBS utilization and expenditures overall and with regard to specific services

Key drivers Contributing to Disparities:

- Inequities in the supply of resources in communities of color
- Limited access to managed care
- Individual bias and systemic racism are likely factors in creating inequities in access and quality
- Other factors including underlying health conditions of various populations (SDOH)

Quantitative Analysis

Data & Sample

- We utilized the 2010 – 2018 waves of the Health and Retirement Study (HRS) to analyze demographic, health, and financial factors in relation to HCBS utilization.

- The HRS is a U.S. nationally representative survey of those age 50 and older conducted biennially since 1998.

- The 2018 HRS sample of community-dwelling dually eligible beneficiaries aged 50 and older (N=1,429).

Analyses

- Descriptive and bivariate analyses to identify differences by race and ethnicity in LTSS needs and how they are met.

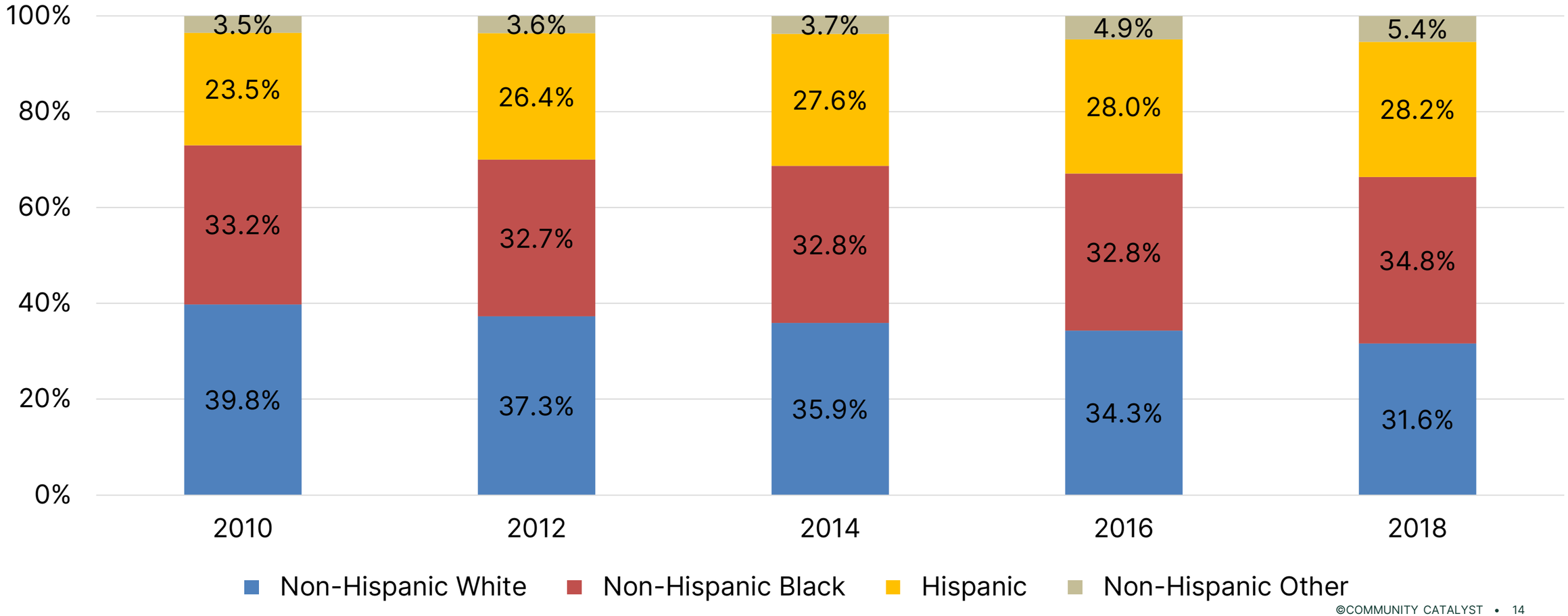
- Descriptive and bivariate analyses longitudinally (2010 to 2018) to observe changes over time, patterns of disparity, LTSS need and HCBS utilization.

- Cross-sectional and lagged variables regression models to:
    - Identify predictors of unmet LTSS need and HCBS utilization
    - Observe differences in unmet need and HCBS utilization by race and ethnicity after controlling for sociodemographic characteristics
    - Explore managed care and usual source of care status as moderators of differences in unmet need and HCBS utilization by race and ethnicity

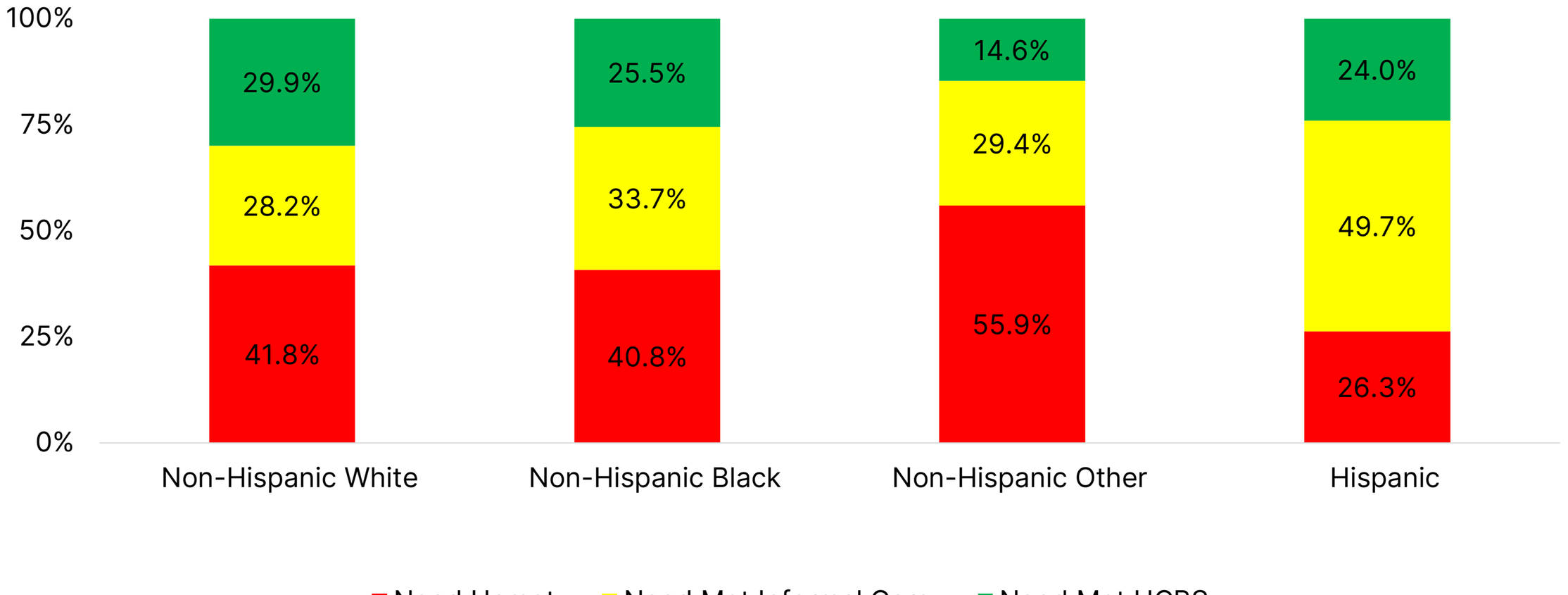
Selected Sample Characteristics

Sample Characteristic	Parameter
Mean Age	69.7 years
Sex: Female Male	64% 36%
Race and Ethnicity •Non-Hispanic White •Non-Hispanic Black •Hispanic •Non-Hispanic Other	 32% 35% 28% 5%
Married/Partnered	29%
Mean household income	$23,889 $14,448 (median)
Mean Net Wealth	$87,279 $3,200 (median)
Self-rated health status is Fair/Poor	57%
Retired	71%

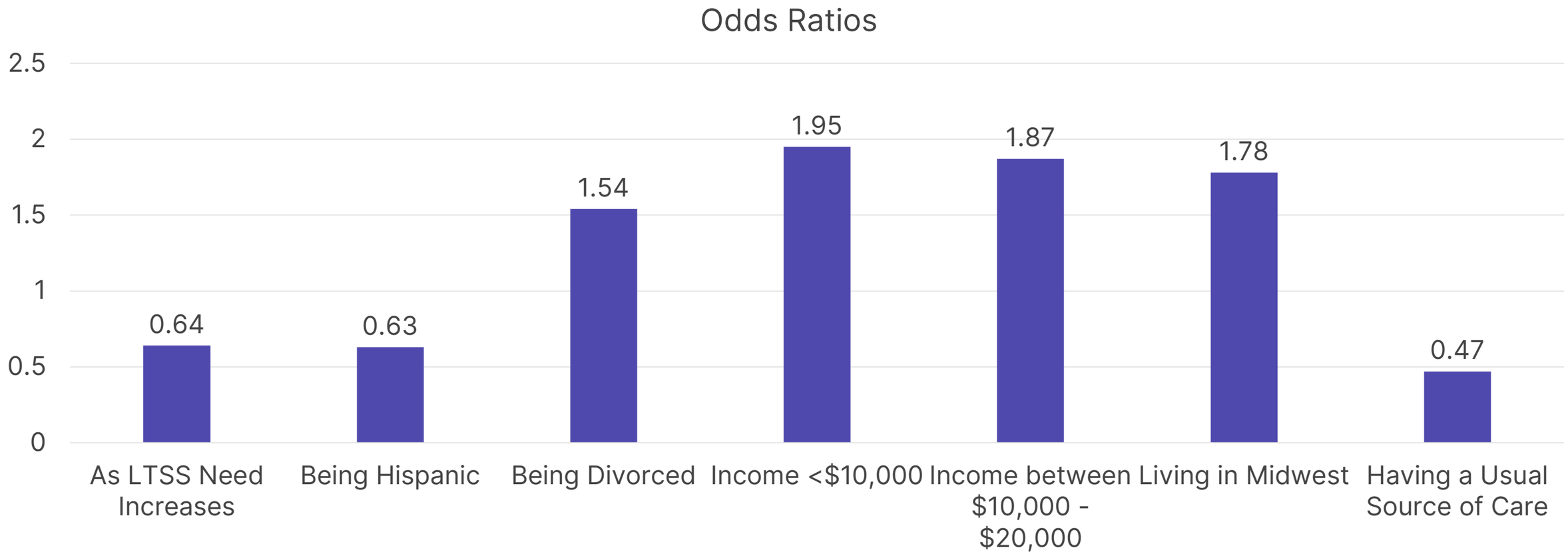
Race and Ethnicity Distribution of Dually Eligible Beneficiaries 2010-2018



How Need is met among Dually Eligible Beneficiaries with LTSS Needs by Race and Ethnicity



Variables Predicting Unmet Need among those with LTSS Need



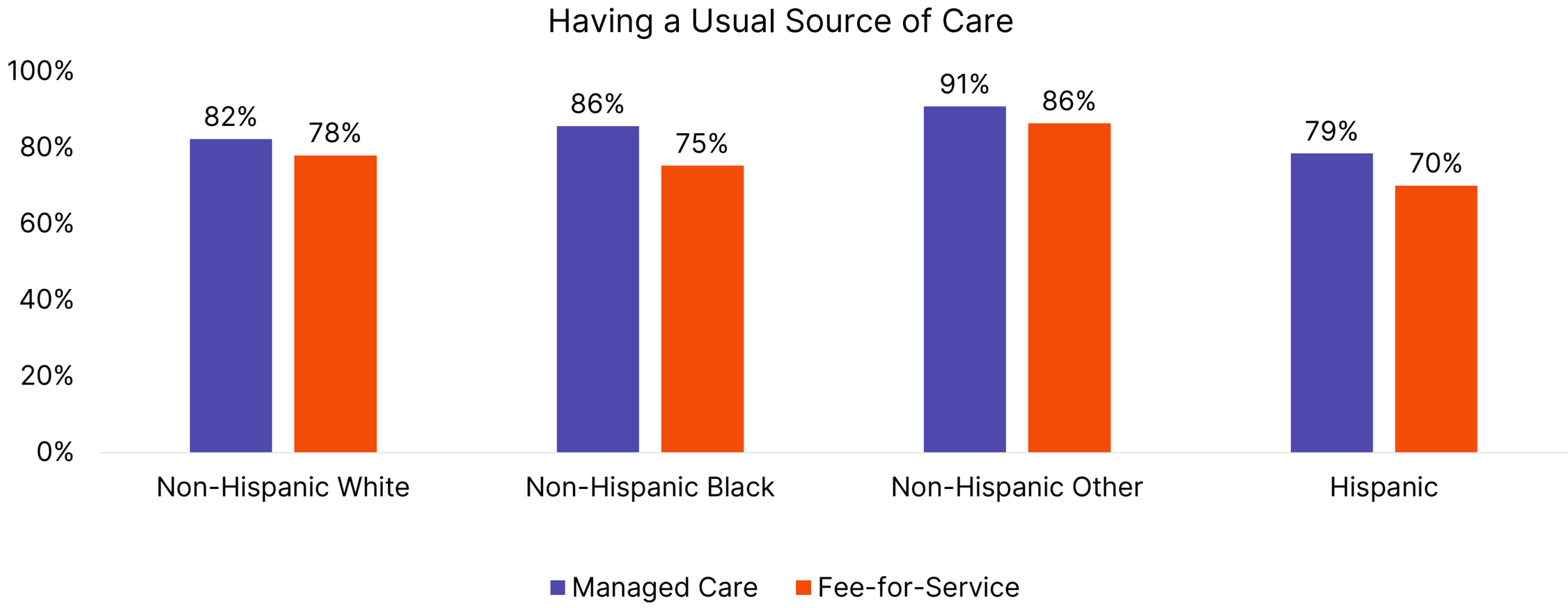
The Role of Having a Usual Source of Care: Multivariate Modeling Results

- Among Hispanic beneficiaries, having a usual source of care increases the odds of utilizing HCBS

- Non-Hispanic Black beneficiaries with a usual source of care have higher odds than non-Hispanic White beneficiaries of utilizing HCBS.

- Beneficiaries who changed to managed care during 2010 to 2018 had a significant increase in HCBS utilization during this same time period; acquisition of a usual source of care is critical component of this finding.

2018 Percentage of Dually Eligible Beneficiaries with a Usual Source of Care by Managed Care Status, Race and Ethnicity



Key Takeaways

- Racial/ethnic composition of dually eligible beneficiaries shifting towards a more diverse and younger population, leading to a decline in the prevalence of LTSS need

- Usual source of care is a key element of reducing racial/ethnic disparities in HCBS utilization and in reducing reported unmet LTSS need

- Hispanic beneficiaries have higher reliance on informal (family) care to meet their LTSS needs

Qualitative Analysis

Methods: Focus groups

Recruitment for the focus groups

- Focus group sessions with dually eligible candidates, across the United States
  - States: Alabama, Arizona, Tennessee, Michigan, Pennsylvania
- Eligibility criteria:
  - Age: 50 yrs and above
  - Enrolled in Medicare and Medicaid
  - Identify as Black/African American, Hispanic/Latino/a/x, or Native American
  - Adults with:
    - Activities of daily life (ADL) limitation
    - Long term services and supports (LTSS) needs

Key Findings: Focus groups

Participants choose providers based on practical considerations

- People did not feel like there was a choice between providers – significant difficulty in finding any appropriate provider
- People also take into eligibility requirements and personal recommendations into account

Few participants use only paid care

- Many participants meet their needs through combining paid and family care
- Family members may also fill gaps in care, manage paid caregivers
- Paid caregivers provide respite to family caregivers
- Relationships with family caregivers AND paid caregivers can be complex

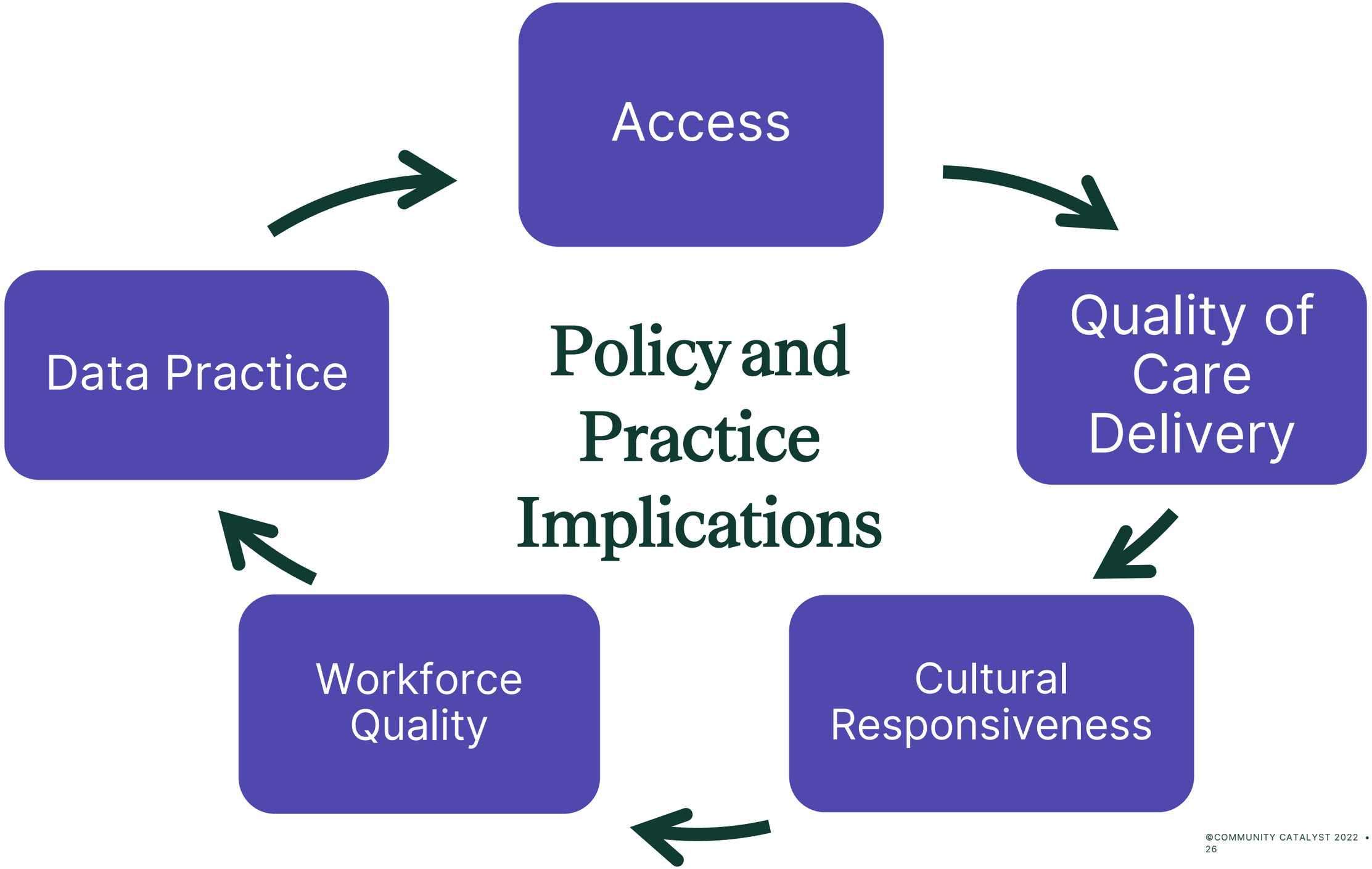
Key Findings: Focus groups

Participants want the same things from paid and family caregivers

- High quality caregivers are **trustworthy**, **reliable**, and **caring.**
- Participants also prioritized good **communication** and people with whom they could build relationships of **mutual respect**.

Racism has impacted participants' experiences with care

- Participants described both subtle and overt experiences of **racist interactions** with their HCBS caregivers or care managers
- Many participants shared an acute awareness of the impact of both past and ongoing **structural racism** on their lives and experiences of care
- Participants said they were **slow to trust** caregivers due to these experiences


Access
Quality of Care Delivery
Cultural Responsiveness
Workforce Quality
Data Practice
Policy and Practice Implications

Priority Policy Areas

Connect beneficiaries with a usual source of care.

A usual source of care is a medical provider or health care location (such as a doctor's office, clinic or health center) that an individual will usually go to if they are sick or in need of guidance related to their health.

Strengthen the HCBS workforce.

An adequate workforce which is high quality and has the ability to provide culturally and linguistically appropriate care is essential to reducing inequities in care.

Engage Beneficiaries, Family, and Caregivers

Engagement should be a key ingredient in all phases of policy creation and service provision including design, dissemination, and implementation.

Policy Levels to Connect Beneficiaries with a Usual Source of Care

States and Health Plans can provide incentives that encourage dually-eligible beneficiaries to enroll in managed care programs

Provide incentives to both managed care and traditional Medicare to connect beneficiaries to a usual source of care.

Policies that encourage managed care arrangements such as the PACE and CAPABLE programs, have been shown to improve both access and quality.

Community Catalyst

Policy Levers to Strengthen the HCBS Workforce

States can implement requirements that promote livable minimum wages for direct care workers

States and Localities Can Build Career Pathways and Fund Targeted Recruitment

CMS and States can implement differential provider payment rates.

"If they pay more, then we would get the quality of workers that we need to come out and assist us with our needs."

~ Focus group participant

Engaging Beneficiaries, Families and Caregivers

States, health plans, and health systems can create beneficiary/family advisory committees

Health systems and providers can promote active engagement in care planning.

Providers can engage HCBS users and family caregivers as managers and bosses.

Targeted Policy Interventions

- **Access:** Reduce Medicaid institutional bias and reduce waiting lists with federal legislations such as the HCBS Access Act
- **Quality**: Improve quality measures for HCBS and obtain input from people using HCBS around measures matter most to their communities.
- **Cultural Responsiveness:** Create pathways for community engagement so the needs of people served are at the center of service delivery.
- **Workforce:** Create federally-mandated minimum standards for staff training
- **Improve Data Practices:** Invest in and develop a data a research clearinghouse for HCBS research to support diffusion of information.

Discussion and Q&A

Thank You!

Community Catalyst