ISSUE BRIEF

8 Recommendations for Health Plans Serving Dually Eligible Individuals to Center Equity: An Overdue and Necessary Response to COVID-19

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INTRODUCTION

Despite claims that the novel coronavirus (COVID-19) does not discriminate, we know that the virus does disparately target people who are older, have disabilities, or have underlying health conditions. COVID-19 comes on top of generations of discrimination in healthcare systems, housing opportunities, and the economy. These colliding realities mean that people who are dually eligible for Medicare and Medicaid and other older adults and people with disabilities—especially those in congregate living settings and/or in communities of color*—are more at risk of and suffer a disproportionate share of serious COVID-19 illnesses and related deaths.

Nearly five million dually eligible individuals are enrolled in Medicare Advantage plans or integrated Medicare-Medicaid plans (MMPs). MMPs and other integrated plans were created to improve care coordination for dually eligible individuals and are mandated to meet the unique needs and improve the health and well-being of their members. As the country continues to fight the pandemic, integrated plans and all plans that serve dually eligible individuals must do more to actively fight the racial disparities COVID-19 has laid bare. In addition, the Centers for Medicare & Medicaid Services (CMS), as the regulatory agency overseeing these health plans, must act swiftly to center equity by issuing guidance and working with plans to implement targeted interventions to ensure older adults of color are not disproportionately at risk during the pandemic. Advocates play a key role in holding health plans accountable and bringing on-the-ground experiences of dual-eligible enrollees to CMS' attention. This issue brief is the first in a series on centering equity in serving dually eligible individuals and focuses on immediate actions health plans can take during the crisis.

**Throughout this issue brief, we use Black, Indigenous, Latinx, and Asian American Pacific Islander when identifying specific communities of color. When citing data, we include in the endnotes the terms used in the original source.*

DUAL-ELIGIBLE ENROLLEES: CHARACTERISTICS

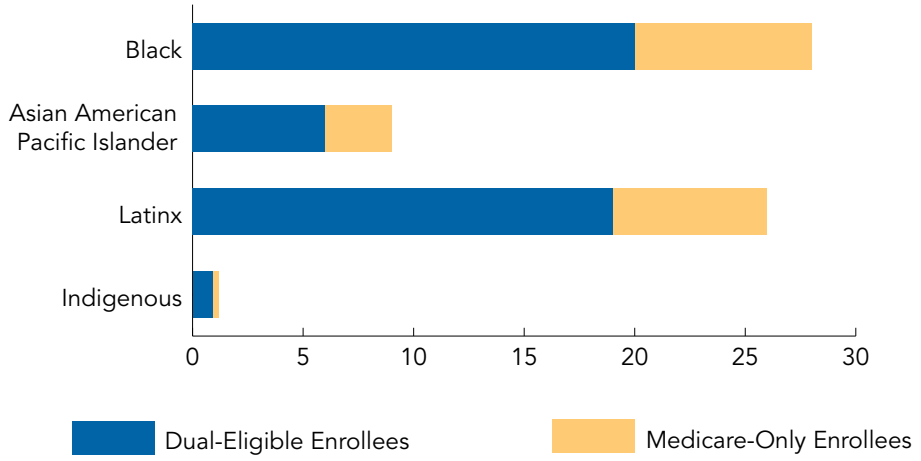
> Due to systemic racism, **Medicare enrollees of color are more likely to be dually eligible for Medicaid and more susceptible to COVID-19.**

Over twelve million older adults and people with disabilities are dually enrolled in Medicare and Medicaid.[1] Because dual-eligible enrollees have limited income and wealth and higher health care needs than most Medicare-only enrollees, Medicaid is critical to both their access to care and their economic security.

Medicare enrollees of color are more likely than white enrollees to be dually enrolled in Medicaid, reflecting disparities in income and wealth due to historic and present-day systemic racism. For example, in 2013, Black Medicare enrollees were three times as likely as white enrollees to be dually enrolled in Medicaid.[2] This also means that dual-eligible enrollees are disproportionately people of color, accounting for nearly half of the dual-eligible population but only about 20% of all Medicare enrollees. Of people of color who are dually enrolled, 20.1% are Black; 17.8% are Latinx; 6.4% are Asian American/Pacific Islander; and 0.9% are Indigenous.[3]

Medicare Enrollees by Race & Eligibility for Medicaid

Source: Data Analysis Brief: Medicare-Medicaid Dual Enrollment, CMS Medicare-Medicaid Coordination Office.



In addition, dually eligible individuals experience disproportionately high rates of chronic illness and poor health. They are three times as likely as Medicare-only enrollees to report being in "poor" health, and nearly half receive long-term services and supports.[4] All of these factors, resulting in large part from historic and present-day systemic discrimination, increase their risk of becoming seriously ill from COVID-19. For example, national data show that 76% of individuals who died from COVID-19 had an underlying health condition.[5] The most common underlying COVID-19 conditions are cardiovascular disease, diabetes mellitus, chronic kidney disease, and chronic lung disease, all of which are more prevalent among dual-eligible enrollees compared with Medicare-only enrollees.[6] Unfortunately, the Medicare claims data discussed below demonstrate that the increased risk of serious illness from COVID-19 is disproportionately burdening dual-eligible enrollees.

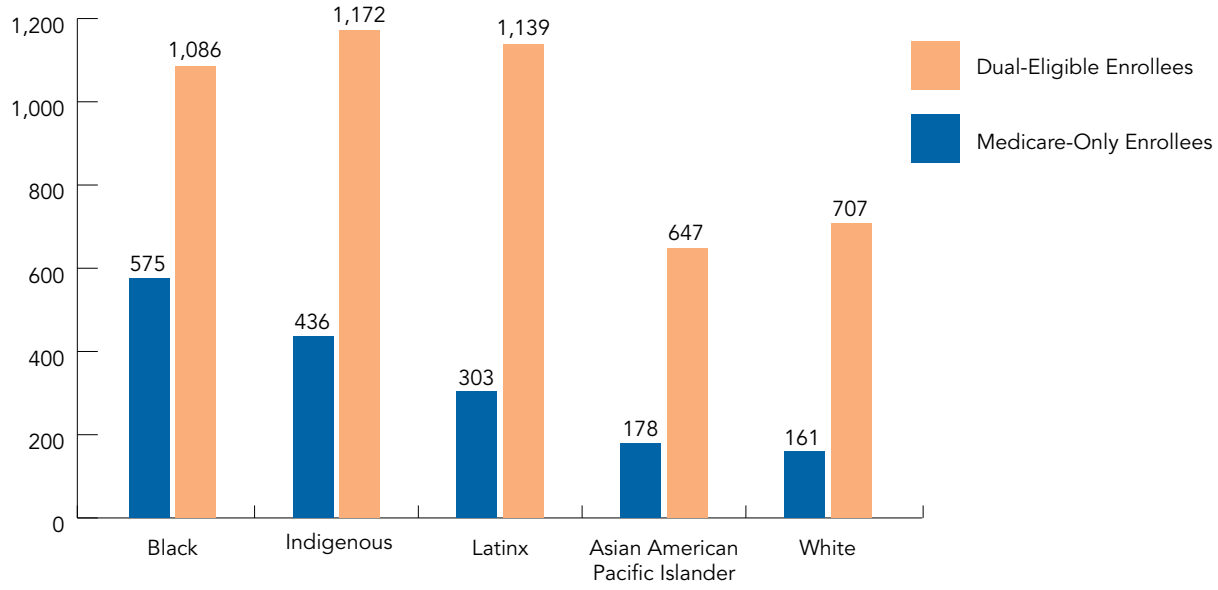
COVID-19 & DUAL-ELIGIBLE ENROLLEES: STAGGERING DISPARITIES

> Individuals dually enrolled in Medicare and Medicaid are **almost 4 times more likely to be infected** and **over 4.5 times more likely to be hospitalized** compared to Medicare-only enrollees.

In June 2020, CMS started releasing data showing the impact of COVID-19 on Medicare enrollees, including those dually enrolled in Medicare and Medicaid.[7] The latest data, based on Medicare claims from January to July 2020, reveal disturbing trends in both COVID-19 infections and related hospitalizations.[8]

Medicare enrollees of color—i.e., Indigenous, Asian American Pacific Islander, Black, and Latinx enrollees—experience higher rates of COVID-19 infection and related hospitalization than white Medicare beneficiaries. Across races, the data on dually eligible individuals show that poverty also exacerbates these rates. Dually eligible individuals are experiencing both infections and hospitalizations at higher rates than Medicare-only individuals. Specifically, individuals dually enrolled in Medicare and Medicaid are almost 4 times more likely to be infected and over 4.5 times more likely to be hospitalized compared to Medicare-only enrollees. In addition, at the intersection of race and dual eligibility, Black dually eligible individuals experienced 1.25 times as many infections and almost 2 times as many hospitalizations as white dually eligible individuals.[9]

COVID-19 Hospitalizations per 100,000 Among Medicare Enrollees by Race & Eligibility for Medicaid



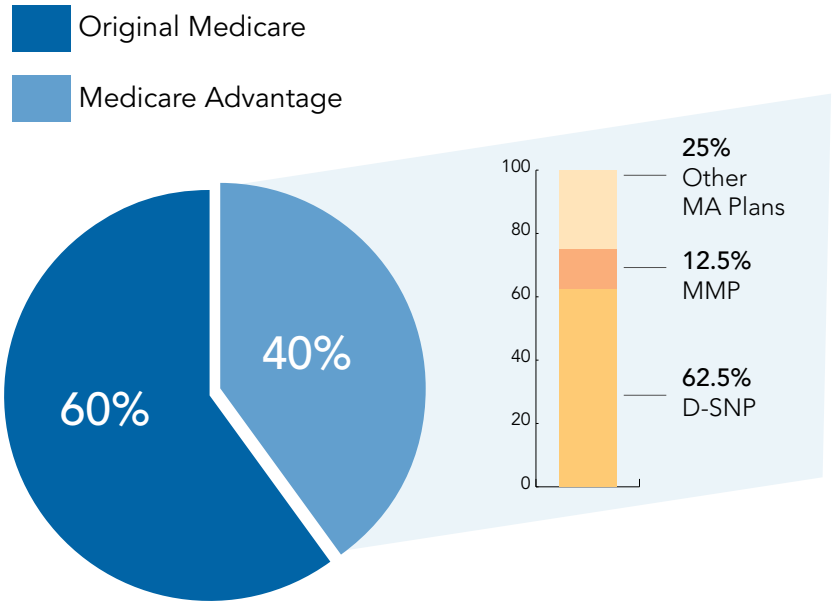
Source: CMS, Preliminary Medicare COVID-19 Data Snapshot Medicare Claims and Encounter Data: Services January 1 to July 18, 2020.

HEALTH PLANS FOR DUALLY ELIGIBLE INDIVIDUALS: OPPORTUNITIES TO CENTER EQUITY DURING THE PANDEMIC

Given that almost half of dually eligible individuals are people of color and people of color are disproportionately at risk of COVID-19, the Medicare health plans that serve almost 5 million dual-eligible enrollees have a unique opportunity and responsibility to center equity right now. Like all Medicare enrollees, dually eligible individuals can opt to receive their Medicare benefits through Original (fee-for-service) Medicare or through a Medicare Advantage plan. Forty percent of all dually eligible individuals and 35% of those dually eligible for full Medicaid benefits are enrolled in some type of Medicare Advantage plan.[10] Among these plan enrollees, over 60% (3 million individuals) are enrolled in a special form of a Medicare Advantage plan known as Dual Eligible Special Needs Plans (D-SNPs), which are designed to coordinate Medicare benefits with Medicaid.[11] In addition, about ten states across the country are participating in demonstrations with MMPs that fully integrate Medicare and Medicaid benefits under one health plan. Almost 400,000 individuals are enrolled in MMPs.[12] An additional 49,000 or so dually eligible individuals are enrolled in PACE plans, another form of coordinated care, which typically provide Medicare and Medicaid services on-site at a center.[13] In recognizing the complex and high needs of dually eligible individuals, D-SNPs, MMPs, and PACE were all designed as alternatives to Original Medicare and typical Medicare Advantage plans. These alternative plans are tailored to coordinate care with the aim of improving health outcomes by better meeting the needs of dual-eligible enrollees.

Dual-Eligible Enrollees in Medicare Advantage Plans

Source: A Data Book: Health Care Spending and the Medicare Program, MedPAC, and Monthly Enrollment in Medicare-Medicaid Plans by Plan and by State, August 2019 to August 2020, Integrated Care Resource Center.



Plans that are designed to serve dually eligible individuals have a critical, time-limited opportunity and responsibility to implement practices targeted at reducing the risk of their dual-eligible members from becoming infected with COVID-19. Advocates can hold plans accountable. Relatedly, CMS—and in particular the Medicare-Medicaid Coordination Office (MMCO)—has a responsibility to educate plans, providers, and dually eligible individuals about the virus and act to ensure the most susceptible individuals are safe. This includes issuing guidance to MMPs, D-SNPs, and all Medicare plans serving dually eligible individuals, as well as conducting appropriate oversight and

monitoring of plans to that end. Again, advocates play an important role in reflecting to CMS the inequities that many of their dual-eligible clients face and communicating how plans could fight those inequities.

All MMPs, D-SNPs, and PACE plans are required to provide some level of care coordination for their members, but, in addition to ensuring robust and enhanced care coordination, more must be done to address the disparities in outcomes among dual-eligible enrollees—particularly Black enrollees and other individuals of color. The following are eight recommendations for health plans serving dually eligible individuals to center equity and better serve their members during the pandemic:

1. Center People of Color in Outreach Efforts.

Plans should use available data, including race and ethnicity data, to better target outreach activities to people of color and assess unmet need during the pandemic. Plans serving dually eligible individuals are uniquely positioned to reach and improve outcomes for a population at high risk of contracting, being hospitalized, and dying from COVID-19. This outreach should include improving care coordination efforts, a key feature of integrated care that ensures the member has their physical, mental, and social needs met. It is likely that at least some of these needs are unmet and perhaps even more so while dually eligible individuals shelter in place. In addition, plans should include disease education in outreach efforts by focusing on diseases that disproportionately impact people of color and those that are known to increase risk of serious illness from COVID-19. For example, a study shows that people with dementia, which disproportionately affects Latinx and Black older adults,[14] are at higher risk of becoming severely ill from COVID-19. CMS outreach on the flu vaccination, which should be updated to include COVID-19 information, and health plan education on Alzheimer's and related dementia should be used as models. Improving systems of care for people with these conditions would generate better health outcomes for older adults of color while at the same time lowering their risk from COVID-19.

In conducting this outreach, **plans should renew efforts to ensure that education and outreach is provided in a culturally competent manner.** Plans should leverage learnings from the experiences of doing targeted, culturally competent outreach during the launch of the MMP demonstration projects[15] and work with community-based organizations serving dually eligible people of color to ensure they reach those communities.[16]

2. Prioritize Diversion for Individuals Who Can Live Safely at Home.

Reports indicate that older adults and people with disabilities residing in congregate settings are at great risk of becoming infected with COVID-19, and older adults of color in congregate settings are even more susceptible.[17] This troubling dynamic occurs at the same time as growing research confirming that older adults of color are admitted to nursing facilities at a higher rate than their growth in the general population and are more likely to receive lower quality care upon admission.[18]

Given these dangers, plans should **prioritize transitioning residents of congregate settings out who can safely live at home with proper supports, drawing on existing diversion and de-institutionalization programs**[19] that demonstrations have shown to be successful.[20] Similarly, plans should implement strategies developed by CMS and the Administration on Community Living to help dual-eligible enrollees with long-term services and supports (LTSS) needs who are hospitalized during this time return home safely and with the supports they need to live independently.[21]

3. Support Caregivers.

Anecdotal reports from MMPs in California indicate that some plan members are not allowing caregivers into their homes out of an understandable fear of contracting COVID-19. **MMPs should outreach to caregivers to ensure they have adequate PPE and understand how to minimize the risk of infection when providing care in the home.** The plans should also provide information to members about how to safely interact with caregivers and other service providers. Supporting the safety of caregivers is especially critical to centering equity, as many paid and unpaid caregivers are themselves women of color.[22]

In addition, some plans reported members were shifting to unpaid supports like family, and others said they were paying for personal care services. Most likely, these decisions were made as temporary solutions when the duration of the pandemic was unknown and while nearly everyone was sheltering in place. As the pandemic draws out, many older adults, especially those who live alone and whose family or friends have returned to work (or who do not have the proper training), may experience difficulty getting the support they need at home. Some may need more support than they did before because family may be quarantining separately or may be far away and restricted from traveling. Plans need to innovate, including working with members to create **temporary care plans or modify existing care plans to reflect these changes.** They should holistically assess all the different resources available to members, including the availability of options for paid family caregivers.

4. Educate All Members, Including Members of Color, about COVID-19.

MMPs, D-SNPs, and all Medicare and Medicaid plans should also be providing **outreach to all members to provide education on how to minimize risk of COVID-19 infection.** This outreach should be particularly targeted to local communities in which there is high community spread and higher proportions of individuals working in essential jobs and include how to obtain COVID-19 testing for themselves and their caregivers. This targeted outreach should be ongoing and include any vaccination that becomes available in the future.

5. Ensure Access to COVID-19 Testing & Care.

In states that are using primarily drive-through testing sites, **plans should consider how to get testing to their members who are sheltering in place or otherwise lack reliable transportation to a testing site,** which may disparately be older adults of color and those with Limited English Proficiency (LEP), especially in rural areas. For example, plans could set up their own mobile testing units, deployed to locations like low-income senior housing where they know many of their members live. This is particularly important for communities of color who experience more barriers to testing. In evaluating where to funnel extra resources, plans should consider whether any of the well-documented testing deserts are in their plan service area. **Plans should include reminders about transportation benefits—including to testing and other COVID-related services—as part of their regular and specialized outreach to dual-eligible members.**

Plans should also develop clear protocols for members who contract COVID-19 but are not hospitalized. This should include ensuring test results are sent to the plan and checking in with members to make sure the member is able to communicate with their provider, continues to have access to LTSS, knows how to get emergency help, has enough to eat, and more. And after a member recovers from COVID-19, the plans should have protocols in place to ensure follow-up for long-term effects, which may also impact people of color disparately.

6. Educate Members on COVID-19 Flexibilities & Continuing Routine Care.

Plans should provide information to all their members on COVID-19 flexibilities, such as 90-day refills, mail-order and pharmacy delivery services, using telehealth services and providers, and getting routine and non-COVID-19 care. Plans should conduct outreach to ensure that individuals with ongoing needs who may have postponed or neglected regular appointments get back to them, and that procedures get scheduled, etc. This outreach should be coordinated with the targeted outreach to people of color who are at greatest risk of serious illness from COVID-19. Wellness calls and visits should also continue while older adults remain sheltering in place.

7. Ensure Equitable Access to Telehealth.

Although familiarity with and use of telehealth is increasing among Medicare enrollees, an April 2020 AARP survey indicates that only about 30% of Latinx and 40% of Black adults ages 50-64 are familiar with telehealth terms compared to 50% of their white counterparts.[23]

Yet, of those who are interested in telehealth, Latinx respondents are the most interested in using it to renew prescriptions (86%), to get help providing care to a loved one (86%), to discuss a new medical issue (80%), for a routine doctor visit (82%), and for diagnosing an illness (82%). Moreover, a third of all respondents age 65 and older identified lack of access to high-speed internet and/or a computer as a barrier to using telehealth, and almost half said they do not know how to use telehealth. Among Latinx respondents, over 40% do not have access to high-speed internet and/or a computer, and almost 60% cite not knowing how to use telehealth as a barrier. These barriers are likely even more common among dually eligible individuals who are also low-wealth. These data demonstrate both an opportunity for plans to respond to an expressed interest among older adults of color to use telehealth and indicate that **plans must address how to ensure telehealth is accessible to older adults of color, especially their members who may not have consistent phone or broadband access, who may not own smartphones and other devices, or who may not understand how telehealth works.**

In addition, the expansion of telehealth presents an opportunity to ensure plans are compliant with federal language access laws by more widely using interpreters. However, to be successful, plans must build off the reality that LEP older adults may not be aware of or comfortable with telehealth, asking for interpreter services, the technology involved, and the intersection of all those pieces. **MMPs, D-SNPs, and other plans should ensure their members who are LEP are aware of telehealth and interpretation capabilities and feel comfortable asking for them.** Plans know the language in which their members prefer to receive communications and documents. Because of the deeply embedded culture and practice among many LEP older adults to simply make do, rely on family or other informal supports, and not ask for language assistance, plans will need to engage in proactive care coordination and work with the member to ensure their language access needs are met. **Plans should set up interpretation affirmatively, rather than placing the burden on members to request services, and explain to members what to expect from their interpreter in a telehealth environment.**

8. Improve COVID-19 Data Collection & Analysis.

Plans should collect data on COVID-19 testing, infections, hospitalizations, and deaths disaggregated by race, ethnicity, age, sex, gender identity, sexual orientation, preferred language, disability, and service delivery setting (whether home or congregate) and in ways that recognize the intersections of their members' identities and characteristics. Plans should also make these data public and review them in consumer advisory councils.[24]

Relatedly, **CMS must continue to update and publish the COVID-19 Medicare claims data monthly.**[25] **Ensuring that these data are updated as frequently as possible** is important for implementing these recommendations, assessing what interventions are working, and understanding what other steps are necessary. CMS should expand its data collection to include COVID-19 related fatalities by race/ethnicity across all treatment and residential settings. CMS should also examine COVID-19 testing rates by race/ethnicity, dual-eligibility status, age, state, county, residential setting (home or congregate), and other demographic factors to assess whether there are disparities in testing among Medicare enrollees that could be masking disparities in infections and deaths. For example, a review of data for San Francisco revealed that Asian Americans and Pacific Islanders account for nearly half of the city's COVID-19 fatalities despite comprising only a third of the population.[26] This disparity, observed in other areas of the country with a significant Asian American Pacific Islander population, indicates that these communities either lack sufficient testing, face a higher risk of death from COVID-19, or both. All of these data should be disaggregated by Original Medicare enrollees and Medicare Advantage enrollees by plan type so that interventions can be better targeted and plans can be held accountable for improving outcomes for their members.

> "Health plans serving dually eligible individuals and CMS **can and must** act immediately and in a targeted way to **ensure that equity is centered in their response to the pandemic.**

CONCLUSION

Data confirm the extreme susceptibility of dually eligible individuals—particularly Black, Indigenous and Latinx people—to COVID-19 infections and related death. The structural racism embedded in our healthcare system and other systems explains these unacceptable trends, but, in this moment, health plans serving dually eligible individuals and CMS can and must act immediately and in a targeted way to ensure that equity is centered in their response to the pandemic. Advocates play an integral role in holding health plans and CMS accountable.

ENDNOTES

1 Sixty percent of dually eligible individuals are age 65 and older; 40% are under 65 and have disabilities and/or end-stage renal disease (ESRD). While most receive full Medicaid benefits (71%), about 30% are only eligible for so-called partial benefits that help them with their Medicare costs through the Medicare Savings Programs. CMS Medicare-Medicaid Coordination Office, "People Dually Eligible for Medicare and Medicaid" (March 2020), cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/MMCO_Factsheet.pdf.

2 Kaiser Family Foundation, *Medicare Beneficiaries' Out-of-Pocket Health Care Spending as a Share of Income Now and Projections for the Future*, at Note 7 (Jan. 16, 2018), kff.org/medicare/report/medicare-beneficiaries-out-of-pocket-health-care-spending-as-a-share-of-income-now-and-projections-for-the-future/.

3 CMS Medicare-Medicaid Coordination Office, *Data Analysis Brief: Medicare-Medicaid Dual Enrollment 2006 through 2018* (Sept. 2019), cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/DataStatisticalResources/Downloads/MedicareMedicaidDualEnrollmentEverEnrolledTrendsDataBrief2006-2018.pdf. The source uses "Black/African American", "Hispanic/Latino", "Asian/Pacific Islander", and "American Indian/Alaska Native."

4 "Forty-one percent of dually eligible individuals have at least one mental health diagnosis, 49 percent receive long-term care services and supports (LTSS), and 60 percent have multiple chronic conditions. Eighteen percent of dually eligible individuals report that they have "poor" health status, compared to six percent of other Medicare beneficiaries." CMS Medicare-Medicaid Coordination Office, *supra* note 1.

5 CDC, *Characteristics of Persons Who Died with COVID-19 — United States*, February 12–May 18, 2020, MMWR Vol. 69 No. 28 (July 17, 2020), cdc.gov/mmwr/volumes/69/wr/pdfs/mm6928e1-H.pdf.

6 CMS, Medicare-Medicaid Linked Enrollee Analytic Data Source (MMLEADS) Public Use File (PUF): 2006-2012 (Dec. 13, 2016), cms.gov/Research-Statistics-Data-and-Systems/Downloadable-Public-Use-Files/MMLEADS.

7 CMS, Preliminary Medicare COVID-19 Data Snapshot Medicare Claims and Encounter Data: Services January 1 to July 18, 2020, Received by August 14, 2020 [hereinafter "Data Snapshot"] (Sept. 3, 2020), cms.gov/files/document/medicare-covid-19-data-snapshot-fact-sheet.pdf.

8 These disturbing trends are likely understated. Given the lack of testing infrastructure in the early stages of the pandemic, the real infection and death count are probably higher, especially in communities of color. The Marshall Project, *COVID-19's Toll on People of Color Is Worse Than We Knew* (Aug. 21, 2020), themarshallproject.org/2020/08/21/covid-19-s-toll-on-people-of-color-is-worse-than-we-knew.

9 The data also show a number of other disparities, including across age, beneficiaries with End Stage Renal Disease, and more. Data Snapshot, *supra* note 7. The source uses "American Indian/Alaskan Native", "Asian", "Black", and "Hispanic."

10 MedPAC, *A Data Book: Health Care Spending and the Medicare Program, Chart 9-15* (July 2020), medpac.gov/docs/default-source/data-book/july2020_databook_sec9_sec.pdf?sfvrsn=0.

11 *Id*. at Chart 9-8.

12 Integrated Care Resource Ctr., *Monthly Enrollment in Medicare-Medicaid Plans by Plan and by State, August 2019 to August 2020* (Aug. 2020), www.integratedcareresourcecenter.com/resource/monthly-enrollment-medicare-medicaid-plans-plan-and-state-august-2019-august-2020.

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14 Us Against Alzheimer's, *Driving Health Equity in Dementia: About Racial and Ethnic Disparities in Alzheimer's,* www.usagainstalzheimers.org/learn/disparities. The source uses "Latino" and "African American."

15 The UCLA Ctr. for Health Policy Research, *Cal MediConnect Enrollment: Why Are Dual-Eligible Consumers in Los Angeles County Opting Out?* (Sept. 2017), healthpolicy.ucla.edu/publications/Documents/PDF/2017/calmediconnect-brief-sep2017.pdf.

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17 Robert Gebeloff *et al*., *The Striking Racial Divide in How Covid-19 Has Hit Nursing Homes*, N.Y. Times (May 16, 2020), nytimes.com/article/coronavirus-nursing-homes-racial-disparity.html. The source uses "black" and "Latino."

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21 HHS, Discharge Planning and Care Coordination during the COVID-19 Pandemic (Aug. 2020), phe.gov/emergency/events/COVID19/atrisk/discharge-planning/Pages/default.aspx.

22 PHI, *Racial and Gender Disparities Within the Direct Care Workforce: Five Key Findings* (Nov. 2017), phinational.org/wp-content/uploads/2017/11/Racial-and-Gender-Disparities-in-DCW-PHI-2017.pdf.

23 AARP Research, *Views on Telehealth* (June 2020), aarp.org/research/topics/health/info-2020/telehealth-second-look.html. The source uses "African American/Black" and "Hispanic/Latino."

24 Community Catalyst, *An Exploration of Consumer Advisory Councils within Medicare-Medicaid Plans Participating in the Financial Alignment Initiative* (Jan. 17, 2019), healthinnovation.org/resources/publications/an-exploration-of-consumer-advisory-councils-within-medicare-medicaid-plans.

25 CMS, COVID-19 Data Release External FAQs, 3, cms.gov/files/document/medicare-covid-19-data-snapshot-faqs.pdf.

26 Brandon W. Yan, *et al., Asian Americans Facing High COVID-19 Case Fatality, Health Affairs*, (July 13, 2020), healthaffairs.org/do/10.1377/hblog20200708.894552/full/. The source uses "Asian American," but clarifies that the data cited includes Asian Americans and Pacific Islanders.