



Race, Ethnicity, and Language

Health disparities, due to differences in race, ethnicity, or language (REL), can lead to preventable hospital readmissions, reduced quality of care, and higher costs. Understanding medication use and health outcomes by REL can help managed care advise internal leadership and develop interventions that address REL inequities among health plan members.

CALL TO ACTION

- ❑ Develop comprehensive standards for REL data collection specific for subpopulations and ethnicity.
- ❑ Include REL in the standard member file to enable operational integration across pharmacy claims, member relations, and other data centers.
- ❑ Augment REL data with algorithms to provide a more complete view of REL data.
- ❑ Build trust with plan members by explaining why the plan collects REL data and how the health plan will use this information.
- ❑ Enable members to opt-out of information collection rather than opt-in.
- ❑ Stratify medication use and quality measures by race, ethnicity, and language to identify gaps in care.



WHY THIS MATTERS

Inconsistent and incomplete REL data can lead to missed opportunities to provide appropriate care. Improving REL data collection and assessment can help plans understand their members' unique needs, develop targeted initiatives, and customize interventions.

Compared to whites, **Blacks/African Americans** were

26% LESS LIKELY

to be **prescribed opioids** for pain.¹



Compared to non-Hispanic whites, **Mexican Americans** were

13% LESS LIKELY

to **adhere to hypertension medications**.²



Compared to English-speaking Latinos, **limited English proficiency Latino patients** were

16% LESS LIKELY

to **adhere to oral diabetes medication**.³



Existing Standards

The US Department of Health and Human Services (HHS) does not mandate the collection of REL data. Two standards are used widely, the US Office of Management and Budget (OMB) and the HHS standards. The OMB standards have five classifications of race and one option for ethnicity.^{8,9} In contrast, the 2011 HHS standards include 14 race options, three options for ethnicity, and a question to measure English proficiency. Some states and organizations have additional guidance on racial subcategories, such as Oregon.¹⁰

Example of Inclusive REL Questions: Oregon Health Plan⁹

What is the member's ethnicity or racial identity? Check all that apply.

- | | | | |
|-------------------------------------|---|---|--|
| American Indian or Alaska Native | <input type="checkbox"/> American Indian | <input type="checkbox"/> Alaska Native | <input type="checkbox"/> Canadian Inuit, Metis, First Nation |
| | <input type="checkbox"/> Indigenous Mexican, | <input type="checkbox"/> Central American, South American | |
| Asian | <input type="checkbox"/> Chinese | <input type="checkbox"/> Vietnamese | <input type="checkbox"/> Korean |
| | <input type="checkbox"/> Filipino/a | <input type="checkbox"/> Japanese | <input type="checkbox"/> South Asian |
| | <input type="checkbox"/> Asian Indian | <input type="checkbox"/> Other Asian | |
| Black or African American | <input type="checkbox"/> African American | <input type="checkbox"/> African (black) | <input type="checkbox"/> Caribbean |
| | <input type="checkbox"/> Other Black | | |
| Hispanic or Latino/a | <input type="checkbox"/> Mexican | <input type="checkbox"/> Central American | <input type="checkbox"/> South American |
| | <input type="checkbox"/> Other Hispanic/Latino | | |
| Native Hawaiian or Pacific Islander | <input type="checkbox"/> Native Hawaiian | <input type="checkbox"/> Guamanian or Chamorro | <input type="checkbox"/> Samoan |
| | <input type="checkbox"/> Micronesian | <input type="checkbox"/> Tongan | |
| | <input type="checkbox"/> Other Pacific Islander | | |
| White | <input type="checkbox"/> Western European | <input type="checkbox"/> Eastern European | <input type="checkbox"/> Slavic Middle Eastern |
| | <input type="checkbox"/> Northern African | <input type="checkbox"/> Other White | |
| Other | <input type="checkbox"/> Unknown | <input type="checkbox"/> Decline to Answer | |

If more than one ethnic or racial identity is chosen, please CIRCLE the one that best represents this person's primary identity.

REL Data Sources Used by Health Plans

- REL data is commonly collected through claims data or plan enrollment forms. It may be collected in case management programs, health risk assessments, patient experience surveys, electronic medical records, or transfer of clinical information. This data is not always easily transferable between health plans and health systems.^{4,5,7,9,11,12}
- REL data can be augmented with geocoding software based on US-Census data, surname recognition software, and private data collection organizations.^{4,5,7,9,11,12}

Challenges and Opportunities to Improve the Collection, Analysis, and Use of REL Data



CHALLENGE

Plan members can be reluctant to provide REL data due to mistrust related to the historical use of REL data or unclear reasons to collect this data.^{5,6,7,11}



OPPORTUNITIES

- Include standard language regarding why REL data are collected and how it will be used. Information should be available in multiple languages and publicly.
- Facilitate member trust by using community navigators and other health care advocates to assist members with health plan enrollment.



CHALLENGE

Federal guidance on the collection of REL data varies widely. OMB REL standards are not comprehensive and do not include guidance on collecting language data.^{5,6,7,11}



OPPORTUNITIES

- Utilize HHS standards to collect REL data, at minimum.
- Partner with other organizations to develop more inclusive national, universal data standards for REL.

Challenges and Opportunities to Improve the Collection, Analysis, and Use of REL Data



CHALLENGE

REL data are not often comprehensive or complete. Demographic data are most frequently self-reported and optional.^{5, 6, 7, 11}



OPPORTUNITIES

- Allow REL data collection are an “opt-out” rather than an “opt-in” feature to increase data completeness.



CHALLENGE

Data collected may not be easily accessible throughout the health care system (e.g., enrollment, claims, prior authorization, or electronic health record data) due to a lack of interoperability of the platforms.^{5, 6, 7, 11}



OPPORTUNITIES

- Integrate REL data and the provenance of this data into health plan databases and systems.

How Managed Care Pharmacy Organizations are Addressing REL Inequities



Blue Cross Blue Shield of Massachusetts: To identify racial disparities among plan members, **48 quality measures were stratified by race and ethnicity and shared publicly.** In 2023, equity measures will be incorporated into clinician contracts and payment programs.¹³



Michigan Department of Health and Human Services: To track equity outcomes, Michigan publishes an annual Healthcare Effectiveness Data and Information Set (HEDIS) health equity report where measures are stratified by race and ethnicity. Managed care contracts include a **performance bonus for improving rates for five measures among specific race/ethnicity categories.**¹⁴



New York State of Health: New York made changes to the 2022 Marketplace enrollment application and **reduced missing race and ethnicity data by 45%.** Changes included an explanation of how the collected information will be used, new categories for race, new subcategories for applicants who identify as Hispanic, Latin(o/a/x), or of Spanish origin, mandatory responses with options for “don’t know” or “choose not to answer,” and education and sample scripts for enrollment assisters and brokers.¹⁵

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