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IssueBrief

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By documenting health disparities across the country, the Commonwealth Fund scorecard highlights how CCMs can better support clients

"Profound racial and ethnic disparities in health and well-being have long been the norm in the United States." That line opens the Commonwealth Fund's most recent health equity scorecard, titled *"Achieving Racial and Ethnic Equity in U.S. Health Care: A Scorecard of State Performance."*[1] Researchers found that health care systems continue to fail many people of color in every state. Even in states with high-performing health systems, people of color often receive much worse health care than white people.

The Commonwealth Fund is a nonprofit foundation that promotes better access to health care for all. The report evaluates health equity across race and ethnicity, both within and between states, to illuminate how state health systems perform for Black, white, Latinx/Hispanic, American Indian/Alaska Native (AIAN), and Asian American, Native Hawaiian, and Pacific Islander (AANHPI) populations.

Decades of policy choices have led to structural economic suppression, unequal educational access, and residential segregation, explains one of the scorecard's authors, Jesse Baumgartner, MPH, CFA. "Racial and ethnic inequities in health and health care are longstanding. They're rooted in structural racism embedded throughout U.S. policies, and they've been exacerbated during the COVID-19 pandemic."

"Racial and ethnic inequities in health and health care are longstanding. They're rooted in structural racism embedded throughout U.S. policies, and they've been exacerbated during the COVID-19 pandemic."

—JESSE BAUMGARTNER, MPH, CFA

1 David C. Radley et al., *Achieving Racial and Ethnic Equity in U.S. Health Care: A Scorecard of State Performance (Commonwealth Fund, Nov. 2021).* https://doi.org/10.26099/ggmq-mm33

Although the details of the report are revelatory, the thesis comes as no surprise to most case managers, says MaryBeth Kurland, MPA, CAE, ICE-CCP, chief executive officer, Commission for Case Manager Certification. "This is one of the many reasons we embrace diversity. The Commission values diversity among its case manager and disability management specialists because having a diverse workforce helps broaden our reach." The scorecard will help case managers understand the challenges their clients face and be better equipped to address them.

The forest and the trees

The report offers a national overview *and* drills down to the state level. "State averages can really cover up profound, underlying inequities when you're just looking at one single average number." The study found not only national disparities, but tremendous differences between states. Figure 1 offers a glimpse of this by comparing Minnesota, Montana, New York and North Carolina.

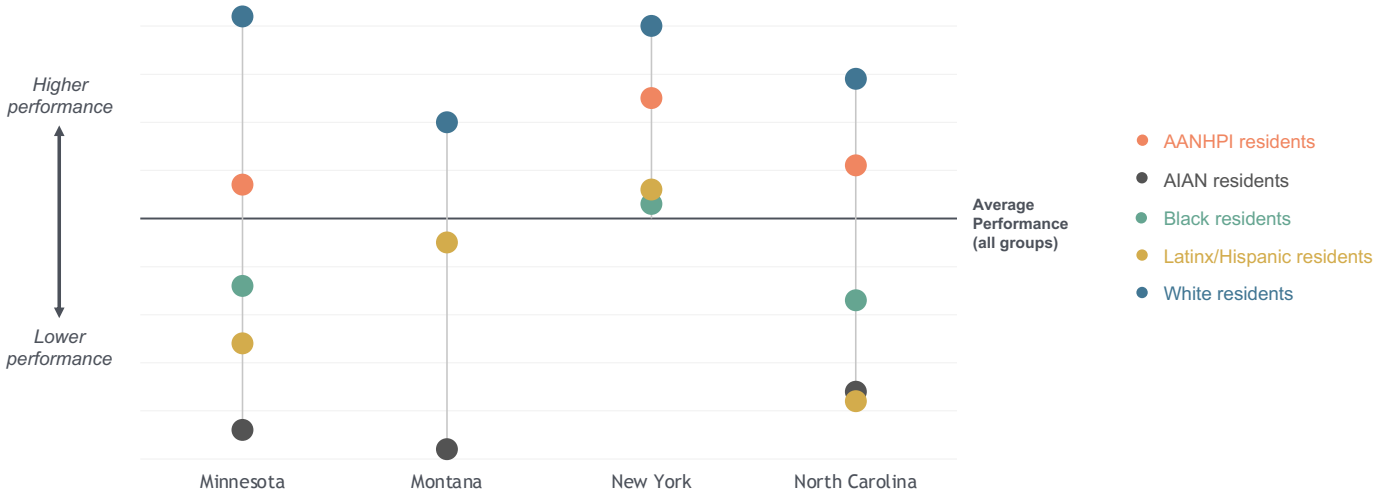
Medicaid expansion post-ACA offers a textbook example of how different state policies yield dramatically different results. Figure 2 (see next page) illustrates the variation between expansion states and non-expansion states. "Policy matters," he says.

Only six states had above average health system performance for all racial and ethnic groups, and even in those states there were still large gaps. "This is definitely a 50-state problem," Baumgartner says.

No matter how well states do, there's a gap, he explains. Some Midwest states, such as Minnesota and Wisconsin, have historically performed strongly overall in the Commonwealth Fund's *State Scorecard* series, but they report some of the largest racial inequities between groups. "Others, like Mississippi and Oklahoma, show substandard performance for all groups, but still report sizable inequities within the state."

White residents in almost every state experience above average health system performance, as illustrated in Figure 3 (see next page). However, Figure 4 (see page four) shows that health system performance for Black people is below average in most states.

Some states report particularly wide performance gaps, but large disparities exist in each of these four states



Notes: Height of the point represents state performance on a 1-100 point scale, with the centerline marking average performance (equivalent to the all-group median at the 50th percentile) among all the groups measured. Summary performance scores not available for all racial and ethnic groups in all states; missing dots for a particular group indicate that there are insufficient data for that state. AANHPI = Asian American, Native Hawaiian, and Pacific Islander; AIAN = American Indian/Alaska Native.
Data: Commonwealth Fund 2021 Health System Performance Scores

Source: David C. Radley et al., *Achieving Racial and Ethnic Equity in U.S. Health Care: A Scorecard of State Performance* (Commonwealth Fund, Nov. 2021).

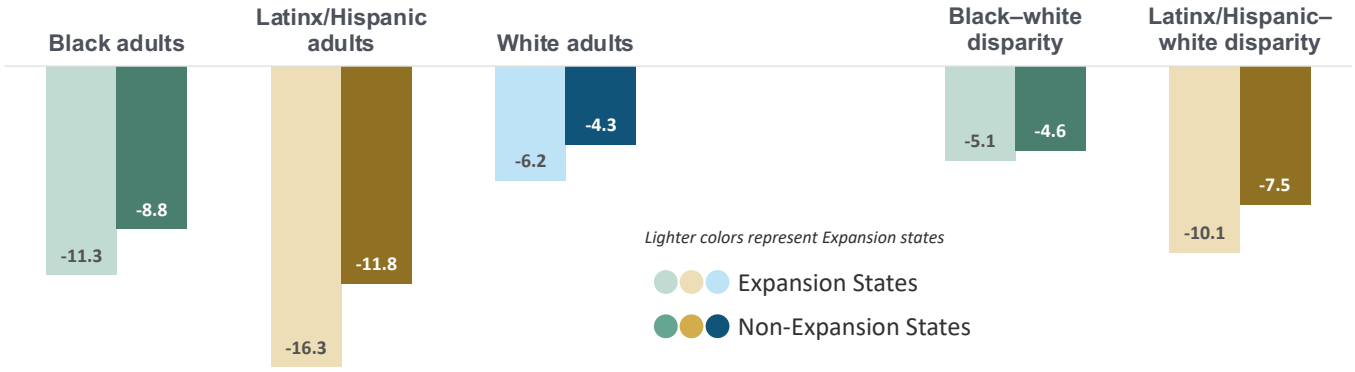
Figure 1

"Not only is the health system performing below average for many of its Black residents, but it's also reporting large disparities between other groups in that state," he explains. The trend holds for other groups, including Latinx/Hispanic populations and American Indian/Alaska Native populations.

The online version of the report offers interactive exhibits of state rankings and specific performance indicators. It also includes a profile for each state. The

Policy Matters: Adults living in Medicaid expansion states reported greater coverage gains and disparity improvements from 2013 to 2019

Percentage-point change in uninsured rate for U.S. adults ages 19–64, 2013 to 2019

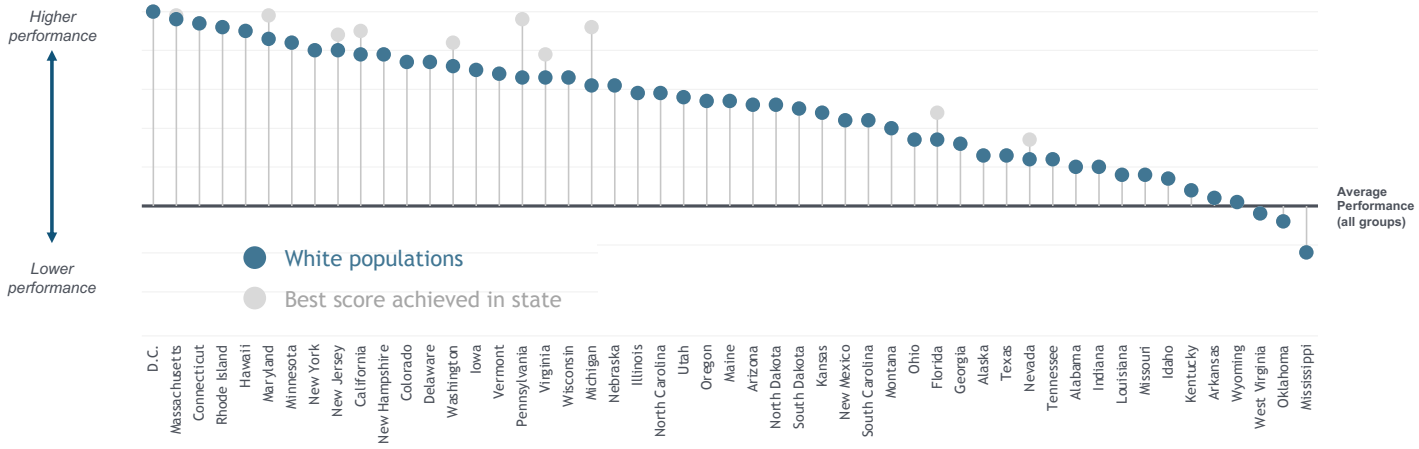


Data: American Community Survey Public Use Microdata Sample (ACS PUMS), 2013–2019.
Notes: Reported values for expansion/nonexpansion categories are averages among survey respondents, not averages of state rates. Expansion states are those that expanded Medicaid by January 1, 2019. As of that date, there were 17 states that had not yet expanded Medicaid. Idaho, Nebraska, and Utah implemented Medicaid expansion in 2020 and are considered nonexpansion for this analysis.

Source: Jesse C. Baumgartner, Sara R. Collins, and David C. Radley, *Racial and Ethnic Inequities in Health Care Coverage and Access,* 2013–2019 (Commonwealth Fund, June 2021).

Figure 2

Health system performance for white people is above average in most states



Notes: States are rank-ordered by highest state performance for white population. Grey dots represent the highest score achieved in each state by any of the five groups (if no grey dot is visible, the highlighted group has the top score). Height of the point represents state performance on a 1-100 point scale, with the centerline marking average performance (equivalent to the all-group median at the 50th percentile) among all the groups measured. Summary performance scores not available for all racial and ethnic groups in all states; missing dots for a particular group indicate that there are insufficient data for that state.
Data: Commonwealth Fund 2021 Health System Performance Scores

Source: David C. Radley et al., *Achieving Racial and Ethnic Equity in U.S. Health Care: A Scorecard of State Performance* (Commonwealth Fund, Nov. 2021).

Figure 3

Commonwealth Fund's State Data Center allows users to explore and download measures in the report.

In developing the scorecard, Commonwealth Fund researchers looked at three dimensions of health: access and affordability; health care use and quality; and health outcomes.

Access and affordability

The key question here is *Do people have access to affordable health care?* That breaks down to three more questions:

- *Do people have insurance coverage?*
- *Do they have a usual health care provider they can go to when they need care?*
- *Do people spend a large amount of their income on health expenses, and do they avoid seeking care because of concerns about how much it will cost?*

Among the Commonwealth Fund report findings:

- Researchers found significant disparities in access to care between white and most non-white populations across states. Latinx/Hispanic people typically face the highest barriers to care; however, they tend to have better health outcomes than many other groups.
- Lack of insurance coverage is a primary contributor to access. Insurance alone cannot guarantee access, but it is necessary for getting needed health care without incurring substantial financial risk. Although the ACA's coverage expansion has improved those inequities, uninsured rates are still much higher for many groups.

Many neighborhoods with more Latinx or Black residents have a lower concentration of primary care providers. Baumgartner also points to inequities in the insurance types that are accepted by different providers.

"I think it's important to remember how the economic inequities

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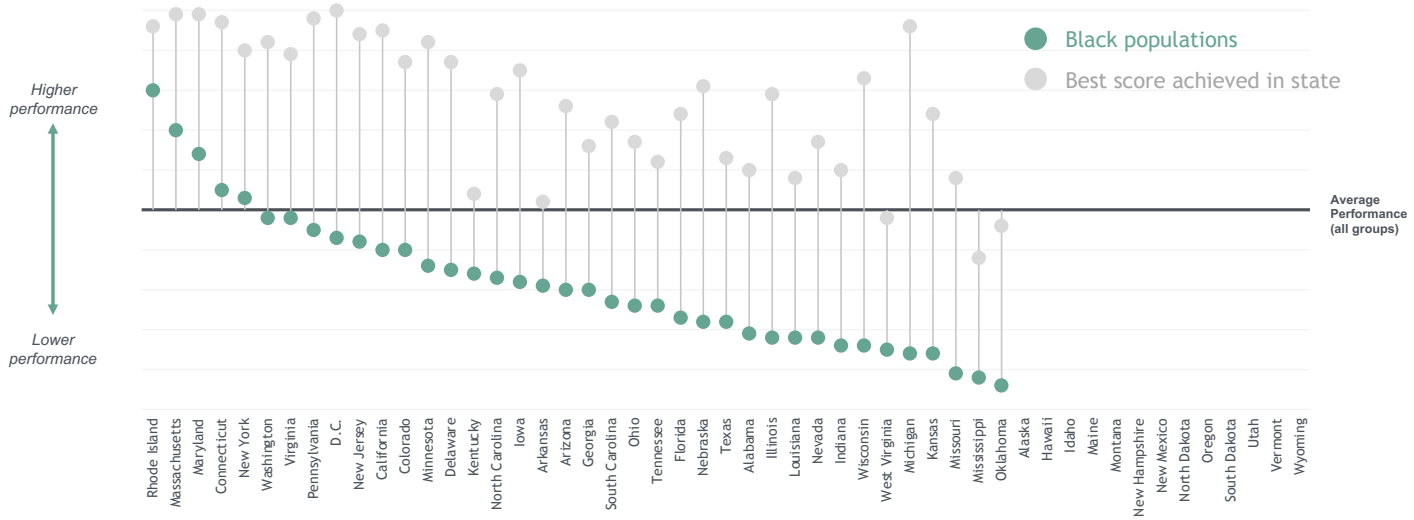
Health system performance for Black people is below average in most states and much worse than the best achieved in all states



Notes: States are rank-ordered by highest state performance for Black population. Grey dots represent the highest score achieved in each state by any of the five groups (if no grey dot is visible, the highlighted group has the top score). Height of the point represents state performance on a 1-100 point scale, with the centerline marking average performance (equivalent to the all-group median at the 50th percentile) among all the groups measured. Summary performance scores not available for all racial and ethnic groups in all states; missing dots for a particular group indicate that there are insufficient data for that state.
Data: Commonwealth Fund 2021 Health System Performance Scores

Source: David C. Radley et al., *Achieving Racial and Ethnic Equity in U.S. Health Care: A Scorecard of State Performance* (Commonwealth Fund, Nov. 2021).

Figure 4

within the U.S. relate to this," Baumgartner says, "As people are asked to pay more out-of-pocket, we need to think about what type of wealth* people have. What type of liquid assets do people have?"

Health care use and quality

The key question here is "Are people receiving the high-quality care and services they need?" That includes:

- Are people consistently receiving services that help prevent future health problems and help manage existing chronic conditions?
- To what extent are people seeking care from emergency departments or other costly settings for conditions that could be effectively managed through primary care?

Among the Commonwealth Fund report findings:

- Across and within most states, white populations overall typically receive better care than Black, Latinx/Hispanic, American Indian/Alaska Native (AIAN), and, often, Asian American, Pacific Islander, and Native Hawaiian (AANHPI) populations.
- Expanded access to primary care improves health outcomes, so given the relatively lower use of primary care by Black, Latinx/ Hispanic, and AIAN people, these groups in particular are likely to see a greater health impact from improved access and quality

Cancer-screening rates are an important metric, but they don't tell the whole story, Baumgartner warns. Cancers are often detected at later stages for Black adults.

Perhaps more concerning, no matter at what stage the cancer is diagnosed, we still see lower five-year survival rates for Black adults. "And what that would indicate what's already documented throughout the literature: Even when a diagnosis is made, cancer patients who identify as Black are more likely to experience subpar treatment that departs from standard clinical guidelines[2]. So the quality of the treatment may also be leading to some of these disparities."

It's a reminder, he says, to make sure the *right* service is being delivered. "Is it the highest quality?"

Health outcomes

The key question here is *How often are they reporting high-risk health behaviors or experiencing mortality from treatable conditions?*

- How often are people dying early from preventable or treatable causes?
- How prevalent are high-risk behaviors like smoking or health conditions like obesity that put people at higher risk for poor health?

Among the Commonwealth Fund report findings:

- Health outcomes, as measured primarily by mortality rates and the prevalence of health-related problems, differ significantly by race and ethnicity. In most states, Black and AIAN populations tend to fare worse than white, Latinx/ Hispanic, and AANHPI populations.
- In nearly every state, Black people are more likely than white people to die early from preventable causes. Latinx/ Hispanic individuals, however, generally have lower preventable mortality rates, despite their comparatively poor access to health care.*

One metric the study uses is "mortality amenable to health care." It relates to deaths before age 75 from conditions such as heart disease, diabetes, appendicitis and maternal mortality that would be treatable through a high quality, timely health care system. But as figure 5 (see next page) illustrates, the rate of mortality amenable to health care for Black people is generally much

* Note: Wealth refers to income, generational wealth, assets, and any other financial resources affecting a person's ability to access health care.

2 Source/Data: Figures 8 & 9 from Angela N. Giaquinto, et al., "Cancer statistics for African American/Black People 2022," *CA: A Cancer Journal for Clinicians* (Feb. 2022): https://doi.org/10.3322/caac.21718

* Note: Scientists have researched this phenomenon, commonly known as "The Latino Paradox", without yet finding conclusive evidence as to how and why it exists. Some researchers have explored theories, such as more collectivist cultural norms driving community members to help one another more, but they usually state that additional research is needed.

higher—sometimes even double—than the overall rate in the U.S.

Diabetes offers an example of this. Baumgartner points to mortality data for diabetes death before age 75 for each of the groups for four states, Minnesota, Montana, New York, and North Carolina. Figure 6 (see next page) Diabetes takes a disproportionate toll on AIAN, Black, and Latinx residents in these four states) illustrates tremendous disparities.

He cites several factors: Diabetes treatment rates are lower for Black and Latinx/Hispanic people. Even with insurance, Black Americans with the condition are less likely than others to receive newer types of medication. Black Medicare beneficiaries are much less likely to be offered limb-saving procedures, and they are more likely to have diabetes-related amputations, than are white beneficiaries.

"There are many intervention points to think about here, a lot of ways to go back earlier in the care journey and think about where differences are appearing and how to address them," he says.

The complex patient journey

The U.S. health care system places a much heavier administrative burden on patients than do other high-income countries. The challenges are myriad, he says; they include navigating insurance companies, figuring out how to get in front of the right provider, finding a provider who takes a particular kind of insurance, and—once they find a doctor—understanding prior authorization forms.

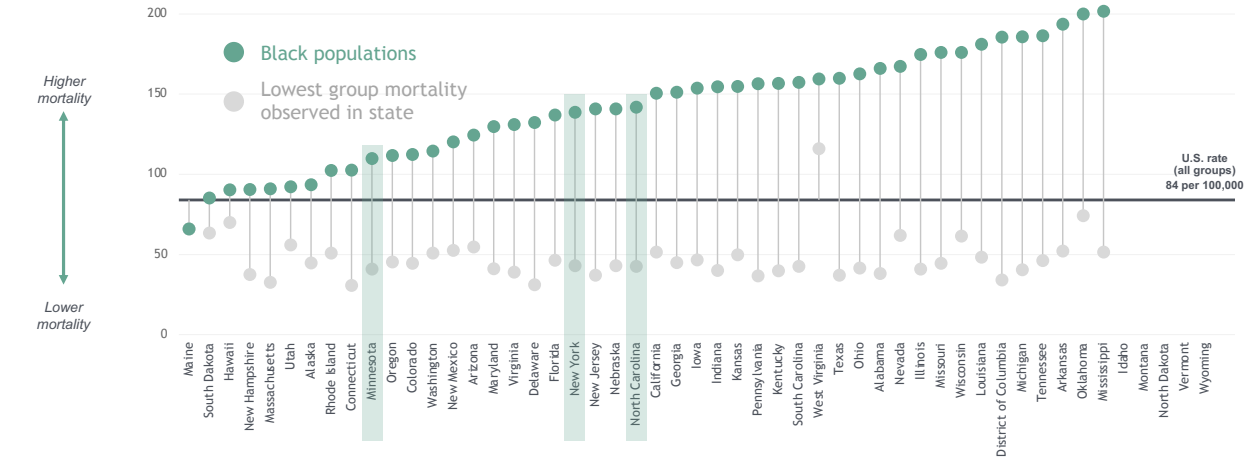
"This makes the journey more difficult overall, but such challenges are especially burdensome for communities of color and low-income communities," he says.

Compounding the problem is the fact that structural barriers *outside* of the health care system hold many patients back—many of these barriers are related to structural racism. These include inadequate transportation, unequal access to healthy foods, imperfect access to materials in preferred language, and inadequate access to social services.

Case managers, he says, are uniquely situated to help clients navigate the journey and overcome these barriers.

Black people are more likely, in most states, to die early in life from conditions that are treatable with timely access to high-quality health care

Mortality amenable to health care, deaths per 100,000 population



Notes: Grey dots represent the lowest mortality rate achieved in each state by any of the five groups (if no grey dot is visible, the highlighted group has the lowest rate). The centerline marks the U.S. premature mortality rate for all people. Data not available for all racial and ethnic groups in all states; missing dots for a particular group indicate that there are insufficient data for that state.
Data: CDC, 2018 and 2019 National Vital Statistics System (NVSS), All-County Micro Data, Restricted Use Files

Source: David C. Radley et al., *Achieving Racial and Ethnic Equity in U.S. Health Care: A Scorecard of State Performance* (Commonwealth Fund, Nov. 2021).

Figure 5

Key roles for case managers

Case managers can help us think about and address these disparities, he says. They understand the clinical challenges and the social determinants of health, such as access to housing, fresh food and primary care. They can, for example:

- Link patients to primary care providers and prioritize key preventive services
- Consider patient barriers outside of the health system
- Help clients navigate the complex journey to care—especially in terms of overcoming administrative hurdles
- Provide key insights and on-the-ground experience to policymakers.

The case manager perspective is important, Baumgartner says. "We do these scorecards because we believe they can affect change. That's why it's essential to get this information in front of state and federal policymakers."

But data can be impersonal. Case managers have the opportunity to bring to light the day-to-day stories, the people they interact with, the particular burdens or roadblocks they're running into. "Some of the wonkiest policy debates often really resonate with people when they hear a patient story." Case managers have a wealth of knowledge and an abundance of stories.

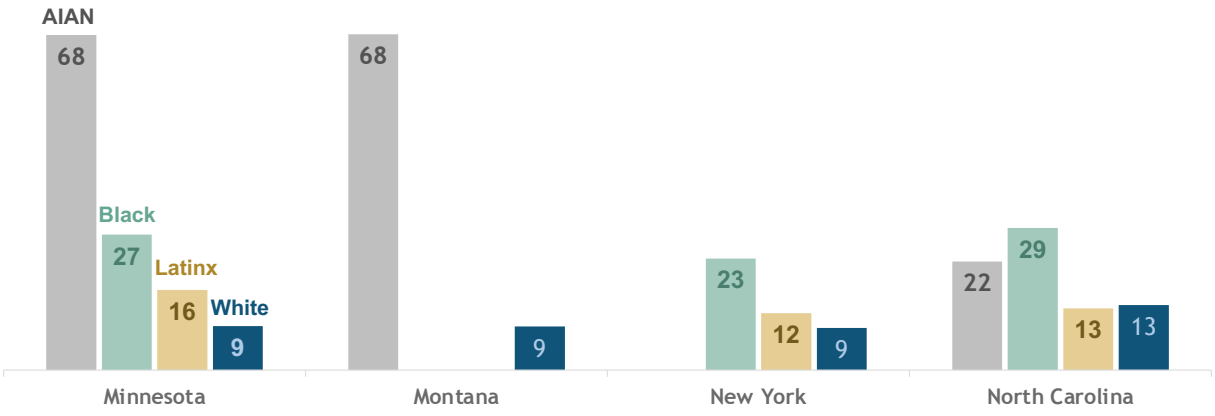
"I would just encourage them to (share) those, whether it's to policymakers in their communities, legislators or stakeholder groups. I think all of those getting surfaced would go a long way towards policy change."

By sharing their stories, case managers support the research. But the research also supports case managers.

"Research like this helps us by highlighting the inequities so that systems can be improved for those who traditionally have had worse health care outcomes as a result of these inequities," Kurland says. "Understanding data on health disparities will help case managers go the extra mile to help clients get better access to appropriate health care." ■

Diabetes takes a disproportionate toll on AIAN, Black, and Latinx residents in these four states

Age-adjusted deaths from diabetes before age 75, per 100,000 population



Data: 2020 National Vital Statistics System (NVSS), data accessed via CDC WONDER

Source: David C. Radley et al., *Achieving Racial and Ethnic Equity in U.S. Health Care: A Scorecard of State Performance* (Commonwealth Fund, Nov. 2021).

Figure 6

About the Experts

Jesse Baumgartner, MPH, CFA

Jesse Baumgartner is a research associate in the Health Care Coverage and Access & Tracking Health System Performance program at the Commonwealth Fund. In this role, he conducts a wide range of state- and national-level health system analyses with particular emphasis on insurance coverage, affordability, and the drug overdose crisis. He is a key contributor on the Fund's *State Scorecard* series, an annual analysis of how well state health systems are performing. Before joining the Fund in 2019, Jesse worked as a technology development/licensing manager at Memorial Sloan Kettering Cancer Center (2016–2018), a life sciences consultant at Stern Investor Relations (2012–2016), and earlier in his career as a reporter. He earned his B.A. in journalism and history from the University of North Carolina at Chapel Hill, and his M.P.H. in Health Policy and Management at the CUNY Graduate School of Public Health and Health Policy. He is also a CFA® charterholder.

MaryBeth Kurland, MPA, CAE, ICE-CCP

MaryBeth Kurland provides leadership for the Commission by supporting CCMC's strategic mission and vision. She manages relationships with likeminded organizations and oversees business development as well as the Commission's programs, products and services. She works directly with the Board of Commissioners, building its corps of volunteer and subject-matter experts who directly support and evaluate certification and related services. Prior to becoming CEO, Kurland served as the Commission's chief operations officer, and was staff lead for the development and launch of the Commission's signature conference, the CCMC New World Symposium®.

Kurland brings extensive experience to her position, having served as executive director of various organizations including the Association of Medical Media, Office Business Center Association International and the League of Professional System Administrators.

In addition, she served as chapter services manager at the Risk & Insurance Management Society in New York City, and Mid-West Regional Executive for the Risk Management Association in Philadelphia.

Kurland earned her ICE-CCP in 2021 and her CAE in 2008 and was also recognized as an Association TRENDS Young & Aspiring Association Professional in 2011. She holds a Master's in Public Administration from Rutgers University—Camden and a Bachelor of Arts from the University of Delaware. Kurland is a member of the Institute for Credentialing Excellence, the American Society of Association Executives, and the Mid-Atlantic Society of Association Executives, and the AMC Institute (AMCi).

"Having worked nearly 25 years with associations of all different types, I've learned that people are seeking professional development for themselves, but they also want to feel a sense of belonging to something bigger," Kurland says. "CCMC is not a membership organization; we're a certification body, and in that capacity I think we bring much to the table in terms of common purpose and community. Our tradition and common history make CCMC stand out and underscores the opportunity to build awareness and professional pride in the practice of case management."

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