

July 12, 2021

## **Recommendations of the Social Justice & Health Disparities Working Group to the District of Columbia Health Benefit Exchange Authority**

This report is submitted by the Social Justice & Health Disparities Working Group, chaired by DC Health Benefit Exchange Authority Executive Board Chair Diane Lewis and vice-chaired by Dr. Cara James.

In early 2020, the DC Health Benefit Exchange (HBX) Authority Executive Board, led by Board Chair Diane Lewis, investigated what steps insurers could take to increase access to medical services in the District's Wards 7 and 8. In the resulting report, entitled "[How Health Insurance Companies Offering Coverage through DC Health Link are Taking Steps to Improve Access to Services for District Residents East of the River](#)," the HBX Executive Board concluded:

*As a next step, the HBX Executive Board is establishing a Working Group on Social Justice whose focus will be to examine practices, structures, and policies that can be implemented to:*

- *Expand access to providers and health systems for communities of color in the District;*
- *Eliminate health outcome disparities for communities of color in the District; and*
- *Ensure equitable treatment for patients of color in health care settings and in the delivery of health care services in the District.*

*The Working Group will include health insurance companies, medical professionals, hospitals, community health centers, public health experts, consumer and patient advocates, employers, brokers, and others committed to achieving social justice and equity in health insurance coverage.*

### **Background on the Social Justice & Health Disparities Working Group Initiative**

At the direction of the HBX Executive Board, HBX leadership established the Social Justice & Health Disparities Working Group (Working Group) during the fall of 2020. As a first step, they brainstormed and developed an extensive list of potential options for advancing equity within each of the focus areas described above. Simultaneously, HBX searched to identify an expert in health equity, who could inform and facilitate the activities of the Working Group, in collaboration with HBX. This search led to Dr. Dora Hughes, Associate Research Professor at the Milken Institute School of Public Health at The George Washington University (GWU).

Dr. Hughes has worked in the field of minority health and health equity for two decades, spanning health care, philanthropy, and public service. In addition to her medical training, she completed a policy fellowship in minority health, through which she obtained her master's in public health. She was a senior program officer at The Commonwealth Fund, overseeing its

Quality of Care for Underserved Patient Populations program, and later worked for the late Senator Edward M. Kennedy and former Senator Barack Obama, playing a key role in drafting minority health legislation. As a senior official in the U.S. Department of Health & Human Services (HHS), she advised and implemented policy across a range of priorities for disadvantaged populations, including the Affordable Care Act, the HHS Action Plan to Reduce Racial and Ethnic Health Disparities, and the HHS sickle cell disease initiative. Dr. Hughes' current work focuses on community and clinical health integration, social determinants of health, and health equity. In addition to her policy expertise, her background as a physician was critical in assessing and explaining the practical implications of proposals to tackle health inequities in the system.

After engaging Dr. Hughes, HBX reached out to request support from the State Health and Value Strategies (SHVS) program at Princeton University, which is supported by the Robert Wood Johnson Foundation. With input from HBX, Dr. Hughes drafted a grant proposal to support the Working Group initiative, which was funded by SHVS for a six-month period.

HBX and Dr. Hughes met multiple times to develop the work plan for the initiative. As an early action step, HBX identified and invited members to participate in the Working Group, which is composed of representatives from DC Health Link's four health insurance companies, medical professionals, hospitals, community health centers, public health experts, consumer and patient advocates, employers, brokers, and others committed to achieving social justice and health care equity. HBX Board Chair Diane Lewis chaired this Working Group, and Dr. Cara James, the President and CEO of Grantmakers in Health (GIH) and former director of the Office of Minority Health at HHS' Centers for Medicare & Medicaid Services, served as vice-chair. Helen Mittmann, also from GWU, served as the research assistant for this project. A full list of Working Group members is included at the end of this report.

In preparation for the first meeting, Dr. Hughes, Ms. Mittmann, and HBX staff researched health issues of concern for communities of color in the District and nationally, as well as the demographics of DC Health Link enrollees. These findings informed the development of a brief [background paper](#) for the Working Group that described the challenges faced by Black and Brown communities within each of the three focus areas (listed above). This report also described potential solutions and, importantly, strategies that some health plans have implemented already or begun to explore.

From February to June 2021, Dr. Hughes facilitated 12 virtual Social Justice & Health Disparities Working Group meetings to examine and discuss potential policies and interventions for addressing health equity. These meetings included "deep dive" presentations on selected topics by Dr. Hughes and by representatives of the four carriers, with focus on feasibility and potential impact. In addition, Dr. Hughes interviewed multiple subject matter experts to identify guest speakers on various topics. All Working Group meetings were recorded and summarized

by Ms. Mittmann. The recordings and meeting materials are available on the HBX website (see Appendix A).

Based on discussions at the Working Group meetings, Dr. Hughes and Ms. Mittmann met with HBX regularly to update the list of potential recommendations for the Working Group members to review and discuss over the course of the project. At the last Working Group meeting, Dr. Hughes and HBX presented the Working Group with the proposed recommendations for final review and vote.

Dr. Hughes and Ms. Mittmann prepared this report to accompany the recommendations, which includes member comments made during the meetings regarding patient impact, policy considerations, and potential implementation challenges. The draft version of this report was shared with the Working Group members for their review.

The remainder of this report summarizes the Working Group's kick-off meeting, carrier and "deep dive" presentations, and discussions on the recommendations in each of the three focus areas. This report concludes with the final recommendations that were voted and agreed upon by the Working Group.

### **I. Social Justice & Health Disparities Working Group Initial Meeting**

On February 3, 2021, the Working Group convened for the first time to begin the process of developing recommendations for actions that HBX and DC Health Link insurers could take to address long-standing health disparities and health care inequities in communities of color in the District. Working Group Chair Lewis, who also led the East of the River Initiative in 2020, reiterated that health inequities are District-wide issues. She said that in the past many stakeholders believed that expanding health insurance coverage in the District would guarantee equity and improve health outcomes, but as the COVID-19 pandemic clearly demonstrated, this has not been the case. HBX Executive Director Mila Kofman advised the Working Group to focus on issues related to health care delivery and payment systems that HBX can address under its authority and that are relevant to participating individual and small business market plans. She then reviewed strategies DC Health Link carriers currently use to improve access to services for District residents living in Wards 7 and 8, as described in the [East of the River Initiative report](#).

Dr. Hughes presented data on health and health disparities in the District, including information about DC Health Link plan enrollees. Dr. Hughes then initiated discussion on the three focus areas and potential solutions within each area. The Working Group expanded this list of potential solutions during later meetings to include the range of options listed below.

## Focus Area 1: Expand access to providers and health systems for communities of color in the District

The vast majority—over 96 percent—of District residents have health coverage, which ranks Washington, DC, among the best in the country for coverage. However, there is a shortage of hospitals, urgent care facilities, and other providers, particularly providers of color, in areas of DC, leading to difficulties with obtaining medical care for many minority residents.

Potential solutions:

- Telehealth, including minimizing cost-sharing and reciprocity for Maryland and Virginia providers
- Incentives for primary care and specialists to locate in underserved areas in DC
- Assistance to establish care sites in underserved areas in DC
- Network adequacy requirements based on access or other standards
- Access to community health centers
- Patient education programs to help consumers seek services
- Evaluation of provider networks for backgrounds/language spoken to determine whether it aligns with communities being served and to allow patient selection
- Patient navigators/community health workers

## Focus Area 2: Eliminate health outcome disparities for communities of color in the District

Blacks and Latinos are hospitalized at over three times the rate of their White counterparts. About 40 percent of non-Hispanic Blacks compared to 28 percent of non-Hispanic Whites have high blood pressure, and the rate of diagnosed diabetes is 77 percent higher among non-Hispanic Blacks than non-Hispanic Whites. African American men have the highest cancer death rate of any racial and ethnic group in the U.S.

Medical management techniques discourage excessive health care utilization and may include cost sharing through high deductibles, co-insurance, and co-payments. Such tactics disproportionately burden lower income populations and could lead to avoidance of care.

Potential solutions:

- Targeted interventions, programs, and community-based screening for conditions with disparate impacts
- Patient education programs to help consumers seek services
- Provider education campaigns focused on treatment of conditions with disparities
- Health plan programs that address conditions that disproportionately impact communities of color
- Payment models tied to reducing health outcome disparities

- Data collection, monitoring, and reporting on race and ethnicity and other demographics across private and public payers
- Reduced cost-sharing for conditions that disproportionately affect communities of color
- Insurance benefit design (such as value-based insurance design) for equitable access, particularly for conditions with disparate impact

Focus Area 3: Ensure equitable treatment for patients of color in health care settings and in the delivery of health care services in the District

Recent studies have identified significant racial bias in health care algorithms used to identify patients who would benefit from additional health care services and for medical decision-making. This results in people of color being less likely to (1) be eligible for intensive care management; and (2) receive timely diagnoses or appropriate care for heart failure, kidney disease, certain cancers, and osteoporosis.

Blacks are more likely to report providers treating them unfairly and with disrespect because of their race. Studies show that minority patients benefit from having a minority doctor and minority providers are more likely to deliver care in underserved communities. Yet, only about three percent of dentists, six percent of medical school graduates, and ten percent of registered nurses are African American; the statistics for other minority provider groups are similarly bleak.

Potential solutions:

- Access to providers of color, particularly in communities of color
- Provider education on caring for diverse populations, including implicit bias and cultural competency training
- Assessment of artificial intelligence bias in health care
- National Committee for Quality Assurance (NCQA) Multicultural Health Care distinction

At the conclusion of the first meeting, HBX staff emphasized that discussions are not limited by budgetary considerations or to options only relevant for payors participating in the Exchange. In preparation for subsequent Working Group meetings, Dr. Hughes asked members to identify the key issues they would like to explore through “deep dive” presentations from subject matter experts that would inform the development of recommendations.

**II. Overview of Health Equity Initiatives Sponsored by DC Health Link Carriers**

Dr. Hughes invited DC Health Link carrier representatives to share an overview of their activities to address health disparities and health equity in the District, and asked Working Group members to ask any questions they may have. Of note, CareFirst BlueCross BlueShield and

Kaiser Permanente offer coverage in both the individual and small group market, and Aetna, a CVS Health Company and UnitedHealthcare offer coverage in the small group market only.

**Kaiser Permanente.** Allison Mangiaracino, Regulatory Consultant for Health Plan Regulatory and Exchange Operations, and Stacey Shapiro, Director of Population Care Management in the mid-Atlantic region, presented on Kaiser Permanente’s (KP’s) equity initiatives. KP’s approach starts with executive leadership and an infrastructure commitment to support work in several key areas:

- **Data:** As an integrated delivery system, KP can collect data through direct methods. In the mid-Atlantic region, they have a high capture rate of race and ethnicity data, which is used to support their quality improvement efforts. In previous years, KP data helped to identify age as one of the greatest drivers of performance disparities; some of the performance gaps they tracked by age and/or race include glycemic control, blood pressure control, depression screening, and child immunizations before age two.
- **Disease-Specific Initiatives:** KP has reduced racial and ethnic disparities in a few key areas: flu immunization rates, glycemic control in patients with diabetes, and five-year colorectal cancer survival rates. Providers or staff conduct universal depression screening as part of every office visit, and they offer telephonic no-copay health coaching for tobacco cessation, weight management, physical activity, and stress management in English and Spanish. KP also offers clinical interventions in English and Spanish, such as primary care provider engagement for diabetes care. Prior to the pandemic, it utilized virtual visits, provided 24/7 lab and pharmacy availability, and sent colon cancer screening FIT kits directly to homes. In response to the COVID-19 pandemic, KP offers “drive through” phlebotomy, flu shots, and COVID-19 vaccines.
- **Equity-Specific Initiatives:** Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc. has earned the NCQA Distinction in Multicultural Health Care. Further, it is currently rolling out *Belong@KP*, a cultural transformation program that aims to cultivate anti-bias and anti-racism habits in the care setting. KP has adopted a documentation tool and reporting displays within electronic medical records to be more inclusive of LGBTQ+ populations. Through its “Thrive Local” program to address social determinants of health, case managers connect patients with social needs to social service providers in the community. KP is rolling out an initiative this year to help members sign up for SNAP benefits. It also established the Institute for Culturally Competent Care that develops and implements best practices in KP facilities.
- **Workforce:** KP is committed to hiring a diverse workforce and provides ongoing training opportunities to address bias. KP also has a qualified bilingual staff program to assist with interpretation. Further, KP engages health plan members through a variety of strategies in English and Spanish, including providing virtual educational programs, after-visit summaries, printed health education materials, and videos and Facebook Live sessions on a variety of topics.

Ms. Kofman asked Ms. Shapiro if KP has identified any barriers to increasing knowledge of health disparities and reducing biased behavior among its physicians. Ms. Shapiro stated physician engagement and enthusiasm is increasing with ongoing dialogue, and while bonuses are not tied to individual performance around these metrics, publicizing performance at the physician level may help drive action. She emphasized that patients can always change physicians if they believe they are not receiving the care they need.

Janice Davis (NAIFA Greater Washington) said her clients frequently ask how insurance companies decide what they cover, what they do not cover, and who makes those decisions. She asked, from a carrier's point of view, how Ms. Shapiro would answer that question. Ms. Shapiro said it has to do with what states require, what employers and employer groups choose, and organizational priorities. Michael Currie (UnitedHealth Group), who presented during the same meeting, added "it has everything to do with who is dictating the coverage."

Chair Lewis asked Ms. Shapiro to talk about the health outcomes that KP is seeing in communities of color. Ms. Shapiro said it is difficult to establish a cohort to track health outcomes over time; however, pre-pandemic, KP identified a decrease in some disparities among certain populations.

**UnitedHealthcare and UnitedHealth Group.** The Working Group heard presentations from Daniel Wilson, Director of Engagement & Advocacy for UnitedHealthcare Community & State and U. Michael Currie, Chief Health Equity Officer for UnitedHealth Group. UnitedHealth Group and UnitedHealthcare support efforts to identify, address, and monitor health disparities associated with age, gender, address, race and ethnicity, language, and disability. Their commitment to achieving health equity serves as the foundation for their efforts to offer culturally competent care management services to patients with diverse values, beliefs, and behaviors, including tailoring delivery to meet patients' social, cultural, and linguistic needs. Highlights of their work include the following:

- **Equity-Specific Initiatives:** In 2010, UnitedHealth Group founded the Health Equity Services Program, which works with health leaders to use data to identify gaps in access, care, and/or outcomes, and develop tailored materials and interventions based on members' cultural beliefs and behaviors. They provide clinical and non-clinical cultural competency training to staff, including web-based health equity education, and have launched a virtual LGBTQ+ support group. Multiple UnitedHealthcare community and state health plans have achieved the NCQA Multicultural Health Care Distinction.
- **Social Needs:** Mr. Currie emphasized that health is impacted more by social determinants of health than by clinical performance, and UnitedHealth Group works to identify where social needs exist within the member population, offer resources and support, and discuss health behaviors and compliance. UnitedHealth Group also has invested in affordable housing—the rehabilitation of Anacostia Gardens in southeast DC is among the projects

that will receive financing—and spearheads initiatives focused on food access and health literacy.

- Data: UnitedHealth Group conducts data analytics to integrate member age, gender, address, race and ethnicity, and language data with clinical data to identify any disparities in care.
- Disease-Specific Initiatives: Some examples of UnitedHealth Group’s health equity efforts include addressing disparities in maternal health outcomes and creating health disparities action plans using HEDIS measures.
- COVID-19: UnitedHealthcare has made investments in and partnered with community-based organizations and faith-based institutions in Wards 7 and 8 to expand access to health care, testing, and vaccination to residents east of the river. It has set up free COVID testing at a church in partnership with the Leadership Council on Healthy Communities, and is leveraging the STOP COVID framework for vaccine distribution. Further, it partnered with Mary’s Center in DC to connect individuals who tested positive for COVID-19 with a provider in their community, and uses data to identify racial disparities and comorbidities of patients with confirmed or suspected COVID-19 infection.

Ms. Kofman (HBX) asked Mr. Currie which activities targeting its network providers to advance health equity have been most successful. Mr. Currie responded that although UnitedHealth Group offers web-based training and resources, they have not been utilized at the desired rate. UnitedHealth Group plans to conduct listening sessions with provider groups related to providing culturally competent care and addressing health disparities in a meaningful way. He added they have not used contracts to incentivize health disparities or cultural competency work.

Dr. Hughes asked Mr. Currie to expand upon UnitedHealth Group’s health disparities action plans. Mr. Currie stated the health disparities action plan is a process for health plans to establish the health measure priorities--normally HEDIS measures--they want to address. Health plans may choose to address a specific measure of disparity because 1) it is a contractual obligation with the state; 2) it has been previously identified and there is a performance improvement plan associated with it; or 3) there is a community request to focus on it.

Chair Lewis asked Mr. Currie to identify health outcomes they are seeing in communities of color. Mr. Currie said having a standardized approach to data collection and measurement to identify what disparities exist, as well as establishing local partnerships, have been helpful in addressing health disparities. He gave the example of how engaging a local provider to conduct outreach to members increased adolescent well child visits.

**Aetna, a CVS Health Company.** Paul Speidell, Senior Director, State Government Affairs, and R.J. Briscione, Senior Director, Social Determinants of Health Strategy & Execution presented on Aetna’s work to address disparities. Aetna has an internal health equity team composed of



chief medical officers from different parts of the business that report on their health equity initiatives. In addition, Aetna has an external health equity advisory council composed of industry experts and is in the process of forming an internal health equity council. Mr. Briscione noted that while much of Aetna's health equity work is Medicaid- and Medicare-focused, it has started to influence their commercial work. Aetna's approach to eliminate racial and ethnic health disparities focuses on five key areas:

- **Data:** Aetna is seeking to enrich member data collection on race and ethnicity, as well as national origin, language preference, and language spoken at home, to enable targeted member and provider interventions. Aetna's self-reported data collection sources include eligibility files from employers, Medicare, navigators, and Aetna paper enrollment forms; it is increasing third party administrator capacity for data collection as well. Such data collection is associated with challenges—for example, the demographics for the household and other covered members default to the demographics of the primary member.
- **Disease-Specific Initiatives:** Aetna sponsors the campaign "Time for Care" to encourage preventive care. A second program called "Project Health" offers free health screening events at CVS stores to help detect the presence of or risk for chronic diseases that disproportionately impact people of color, including diabetes, hypertension, and heart disease. Aetna also provides informational resources on weight management, diabetes, and smoking cessation. A third example of a targeted initiative focuses on maternal and infant health, including preeclampsia prevention, contraception access, and telemedicine support in "obstetrical deserts."
- **Workforce:** Aetna has led workforce initiatives and financed several internally focused projects such as implicit bias and cultural competency training.
- **Equity-Specific Initiatives:** Aetna's "Close the Care Gap" initiative works to develop a framework and hierarchy of focus for improving health equity across Aetna's Black and Hispanic membership and create a culturally responsive Medicare clinical and community program design.
- **Social Needs:** Aetna is rolling out an initiative in 2022 for value-based care providers that will assist them in addressing social determinants. Aetna will initially pay providers to report Z codes (ICD-10-CM encounter reason codes used to document social determinants of health data) and then will pay for value-based improvements in social determinants. For example, if the provider recorded a food security need, Aetna would track and have the provider report on how they are closing the food security gap. Also, CVS Health is collaborating with Unite Us, a social care coordination platform, to help Medicaid and dual-eligible members in select locations more easily access social services within their community.

Vice-chair Dr. James asked for what percentage of consumers does Aetna have Z codes, and Mr. Briscione replied "single digit percentages" thus far. Dr. James also asked what Aetna measures

when it determines return on investment, and Mr. Briscione answered while Aetna does look at cost for social determinants initiatives, it reviews other variables as well.

Ms. Kofman (HBX) asked what lessons Aetna has learned from its work in the Medicaid and Medicare space that could be implemented on the commercial side of its business, particularly for the small group market. Mr. Briscione responded that Aetna has done some targeted work with employers on building an index that is more closely aligned with specific attributed members and their associated costs, as well as providing employers a dashboard of social determinants issues. In addition, Mr. Briscione stated that Aetna has provider requirements for cultural competency training on the commercial side.

**CareFirst Blue Cross Blue Shield.** Colette Chichester, Vice President of Government Affairs, and Dr. Destiny-Simone Ramjohn, Vice President, Community Health & Social Impact, presented to the Working Group.

With respect to health equity, CareFirst joined other Blue Cross Blue Shield companies and the Blue Cross Blue Shield Association (BCBSA) in announcing the launch of a new National Health Equity Strategy in May 2021. The Strategy intends to “change the trajectory of health disparities and reimagine a more equitable healthcare system.” The strategy includes: 1) collecting data to measure disparities; 2) scaling effective programs; 3) working with providers to improve outcomes and address unconscious bias; 4) leaning into partnerships at the community level; and 5) influencing policy decisions at the state and federal levels. This multi-year Strategy will focus on four conditions that disproportionately affect communities of color, including maternal health, behavioral health, diabetes, and cardiovascular conditions. CareFirst will first focus on maternal health, followed by behavioral health. (BCBSA’s goal is to reduce racial disparities in maternal health by 50 percent in five years.)

In addition, CareFirst is working to demonstrate the Institute for Healthcare Improvement’s five core competencies, which are needed to ensure that equity efforts are sustainable and impactful. These competencies include 1) make health equity a strategic priority; 2) build the data infrastructure to support health equity; 3) address the multiple social determinants of health; 4) eliminate racism and other forms of oppression; and 5) partner with shareholders to promote health equity. Equity is embedded in how CareFirst thinks about its five-year vision to drive transformation of the healthcare experience with and for members and communities.

Prior to the launch of this new initiative, CareFirst had sponsored several initiatives to address disparities in care:

- **Disease-Specific Initiatives:** CareFirst covers insulin and diabetic supplies without cost-sharing, and recently announced a financial commitment to support diabetes initiatives across its jurisdictions. In 2021, CareFirst will invest \$10.5 million to address the root causes of diabetes, especially the economic, environmental, and social conditions that

shape unequal health outcomes. In addition, as part of its commitment to hands-on care management, CareFirst has partnered with CityBlock and anticipates its services will grow to include primary care and behavioral health care, among other services.

- Social Needs: CareFirst's Community Health and Social Impact Team identified six areas of focus that include 1) economic inclusion, 2) educational opportunity, 3) behavioral health, 4) chronic conditions, 5) access to affordable and quality health care, and 6) social responsibility and impact. From 2015-2019, CareFirst invested \$10.9 million to address social determinants of health in the District. CareFirst's 2020 investments supported the health, social, and economic needs of District residents intensified during the COVID-19 pandemic, in addition to supporting access to quality, affordable health care services.
- COVID-19: As part of their multi-faceted "Better Together" campaign, CareFirst provided relief funding to Federally Qualified Health Centers in the District of Columbia to support with staffing of vaccine administration, personal protective equipment, refrigeration units for vaccine storage, and other unanticipated vaccine demands.

Dr. Hughes asked Dr. Ramjohn to discuss the work CareFirst is supporting with providers to tackle unconscious bias. Dr. Ramjohn said that this year all patient-centered medical home providers are expected to complete cultural competency training within the first half of the performance year and implement an approach to serve diverse populations in the second half of the year. They are not currently mandating cultural competency training for other providers. Ms. Kofman reiterated that CareFirst changed its benefit structure to cover insulin and diabetes supplies at no cost to the patient, and asked what CareFirst is doing to study the impact of that change and if plans to expand that program to cover other services diabetics may need. Dr. Ramjohn said that although CareFirst has not had much time for observation, through member outreach it has heard that eliminating those economic barriers is positively impacting its enrollees. Ms. Chichester added that there is a robust evaluation component, but CareFirst is not at the point yet where it can report outcomes data.

Dr. Hughes asked for more information about CareFirst's plan to address maternal health and disparities in mental and behavioral health. Dr. Ramjohn highlighted that since 2007, CareFirst has invested more than \$20 million to support over 50 organizations in the District of Columbia, Maryland, and Northern Virginia to advance maternal and child health and reduce infant mortality rates. As examples of CareFirst's investments, she described 1) their partnership with Mamatoto Village to improve birth outcomes for African American and Latina women in Wards 5, 7, and 8 in the District of Columbia; and 2) a Baltimore City Health Department initiative called B'More for Healthy Babies that has demonstrated a 35 percent reduction in infant mortality over the past decade. Regarding behavioral health, CareFirst is considering a range of initiatives, including investing in racial trauma informed care, embedding behavioral providers into its primary care network, expanding telehealth opportunities, and exploring culturally competent care with organizations.

### **III. Deep Dive Discussions on Priority Topics Identified by HBX and Working Group**

Following the initial Working Group discussions, HBX and Working Group members identified the need for deep dive discussions on several key issues raised during the initial meeting: 1) bias in diagnosis and treatment; 2) promoting equity through insurance design; 3) racial and ethnic data collection; 4) additional carrier and employer strategies to advance equity, including clinical initiatives and contracting mechanisms; 5) pediatric disparities in the District; 6) provider supply and access; and 7) NCQA's equity proposal.

#### **1. Bias in Diagnosis and Treatment**

Dr. Hughes presented information on bias in health care to assist in the development of recommendations within *Focus Area 3: Ensure equitable treatment for patients of color in health care settings and in the delivery of health care services in the District*. Her presentation covered 1) the influence of implicit bias on clinical care; and 2) artificial intelligence and algorithmic bias.

Implicit bias and misperceptions can influence provider communication, diagnostic ability, and clinical decision-making, all of which ultimately impact quality of care and health outcomes. Dr. Hughes reviewed findings from several studies on physician bias. Such studies examined the prevalence of false beliefs held by medical students and residents about biological differences between Blacks and Whites, and the influence of false beliefs on clinical decision-making. She described implicit bias training programs designed not only to expose people to their implicit biases but also provide tools to adjust automatic patterns of thinking, with the goal of eliminating discriminatory behaviors.

Dr. Hughes also reviewed studies on bias in healthcare artificial intelligence. Artificial intelligence utilizes data and algorithms to perform certain tasks, such as clinical decision support. Data sets and algorithms, however, may be unintentionally biased and exacerbate inequities among certain groups or demographics. For example, [a 2019 study](#) in *Science* by Obermeyer et al. found racial bias in one widely used algorithm that uses health costs as a proxy for health needs. Unequal access to care often leads to lower health care utilization and therefore lower health care costs for Black patients. These lower costs lead to this algorithm erroneously concluding that Black patients are healthier than they are and require less intensive care.

Similarly, some diagnostic algorithms adjust outputs based on a patient's race or ethnicity in ways that may direct attention and resources away from Black patients and perpetuate race-based health inequities. [A 2020 article](#) in *The New England Journal of Medicine* by Vyas et al. examined the use of race correction in clinical algorithms in the fields of cardiology, cardiac surgery, nephrology, obstetrics, urology, oncology, endocrinology, and pulmonology. The authors' assessment identified a need to further analyze race-adjusted algorithms to determine if the use of race or ethnicity is appropriate; some institutions have already removed race

adjustment from eGFR and the VBAC calculator. There needs to be more accountability around the development and deployment of healthcare algorithms.

Subsequent Working Group discussion clarified the critical importance of racial and ethnic data, and also that gender bias, along with racial and ethnic bias, is an important contributor to disparities in care and outcomes.

Information from this deep dive and related discussions assisted in the development of recommendations in *Focus Area 3: Ensure equitable treatment for patients of color in health care settings and in the delivery of health care services in the District*. These include:

- Require network providers to complete cultural competency training, which should reflect widely available, recommended resources and tools to mitigate implicit bias
- Obtain the National Committee for Quality Assurance's (NCQA's) Multicultural Health Care distinction
- Review clinical algorithms and diagnostic tools for biases and inaccuracies and update appropriately.

## **2. Insurance Design**

Dr. Mark Fendrick, Professor and Director of the Value-Based Insurance Design Center at the University of Michigan presented on value-based insurance design, "V-BID X: Expanding Coverage of Essential Clinical Care Without Increasing Premiums or Deductibles," which provided information that assisted in the development of recommendations within *Focus Area 2: Eliminate health outcome disparities for communities of color in the District*. His presentation covered 1) expanding pre-deductible coverage/reducing cost sharing on high value clinical services; 2) identifying, measuring, and reducing low value care to pay for more generous coverage of high value care; and 3) implementing clinically driven payment models and plan designs to increase use of high value services and deter the use of low value ones. Dr. Fendrick's key takeaways included 1) cost neutral V-BID designs are feasible and coverage can be enhanced for targeted high-value services without raising premiums and deductibles; and 2) many possible combinations of services or cost sharing changes could fit different needs and goals, depending on the carrier and market.

Dr. Fendrick noted that V-BID plans have shown they can increase utilization of high value drugs without increasing total expenditures, which is one of the reasons why the Medicare Senior Savings Model focused first on insulin. He also discussed the Medicare Advantage V-BID demo, which will encompass both medical and socioeconomic determinants. In terms of overall spending, with interventions related to chronic diseases like heart failure, diabetes, and chronic obstructive pulmonary disease, Dr. Fendrick asserted cost neutrality is achieved relatively quickly.

Ms. Kofman reminded the group that about half of the Exchange's twenty-five products on the individual side are standard plans with pre-deductible coverage. In addition, CareFirst recently modified its benefit structure to offer insulin and diabetes supplies at no cost to the patient, and the HBX Board approved the Standard Benefit Plan Designs to include this coverage in 2022.

Ms. Kofman asked Dr. Fendrick to speak further on how services are identified as low value, and Dr. Fendrick answered that they reference the U.S. Preventive Services Task Force's D Rated Services. Ms. Chichester asked if the selection of low and high value targets adequately addresses the needs of Black and Brown communities, and Dr. Fendrick replied that V-BID is just one small part of a broader initiative to ensure that people are educated to make their own decisions regarding what services they should and should not receive. Dr. Fendrick stated that underserved patients receive fewer low value services overall, but low value care issues are still problematic.

Members asked whether V-BID will reduce health disparities. Vice-chair James reiterated that while there is no one solution to address health disparities, V-BID is about reducing cost and improving access to care, including social needs, and she urged the group to think of V-BID as part of a package of interventions that will help reduce health disparities for communities of color.

Dr. Hughes asked the plans if they are already applying V-BID principles. Ms. Chichester described CareFirst's V-BID-type approach to care delivery in relation to its diabetes initiative, which was chosen because diabetes is a top issue across its jurisdictions. Data on the impact of this design change is not yet available, but CareFirst has heard from members that eliminating economic barriers has positively impacted its enrollees.

Daniel Wilson (UnitedHealthcare) said UnitedHealthcare is having these conversations related to COVID-19, as the pandemic has made it reconsider its delivery system to better meet the needs of enrollees.

Allison Mangiaracino (KP) stated that KP has not looked at applying V-BID principles beyond the benefit policies adopted by HBX for the Standard Benefit Plan Designs. She stated there is evidence V-BID could advance adherence but urged the group to consider the empirical basis for using V-BID to reduce disparities. She later commented that the group needed to further specify that the primary goal of eliminating cost-sharing for high-value services is to promote adherence to prevent secondary complications and decrease the severity of disease.

Information from this deep dive and related discussions assisted in the development of recommendations in *Focus Area 2: Eliminate health outcome disparities for communities of color in the District*. These include:

- Modify insurance design for DC Health Link standard plans to eliminate cost-sharing, including deductibles, co-insurance, and co-payments, for medical care, prescription drugs, supplies, and related services that prevent and manage diseases and health conditions that disproportionately affect patients of color in the District.

### 3. Racial and Ethnic Data Collection

Michelle Jester, Executive Director of Social Determinants of Health at America's Health Insurance Plans (AHIP) gave a presentation entitled, "Race and Ethnicity Data Collection: Strategies, Challenges, & Opportunities," which provided information that could assist in the development of *Focus Area 2: Eliminate health outcome disparities for communities of color in the District*. She reviewed indirect and direct data collection methods and identified direct data collection methods as "the Gold Standard." In her experience, collecting data at enrollment is the most effective data collection method, followed by collecting data from claims and entering into agreements with providers to share electronic health record data. If plans must use indirect methods, Ms. Jester believes geographic assignment is a better data collection method than Bayesian Improved Surname Geocoding, but there are limitations to both methods.

Ms. Jester explained that when collecting this data from enrollees, it is important to describe why the information is being collected, emphasize that providing the information is voluntary, describe how the data will be (and will not be) used, and explain how it will be protected. She also reviewed a NCQA proposal for stratifying HEDIS measures by race and ethnicity. Ms. Jester noted that plans use this data to identify disparities and communicate that information to providers. Plans may also use this data to help members identify providers they are more comfortable seeing for care, and guide plans in developing initiatives that meet the needs of the community.

Ms. Jester discussed the option of collecting more granular race and ethnicity data, and Dr. Hughes explained that because each primary race and ethnicity group encompasses many subgroups, disaggregating this data may expose significant differences in the incidence and prevalence of certain conditions among different subgroups.

Vice-chair James emphasized the importance of racial and ethnic data collection and provided two examples: 1) there is significant variation in infant mortality within Hispanic and Latino subgroups; and 2) there is variation in income, employment, health insurance rates, and health literacy within Asian subgroups. HHS, as required by the Affordable Care Act (ACA), disaggregates racial and ethnic subgroup data for Asian Americans, Native Hawaiians and Pacific Islanders, as well as for Hispanics, and this data collection approach is incorporated into applications for the federal health insurance marketplaces.

Dr. Hughes raised the issue of health data interoperability issues, and Ms. Jester described how the U.S. Core Data for Interoperability is a standardized set of health data classes and constituent

data elements for nationwide, interoperable health information exchange. It can help facilitate standardized data sharing between providers and plans.

Dr. Hughes then asked to hear directly from the plans on their racial and ethnic data collection efforts. Ms. Mangiaracino stated that KP collects race, ethnicity, and language data in the care setting, and its data collection rate in the mid-Atlantic across all lines of business is approximately 85 percent. KP does use indirect methods (the RAND methodology, which is a combination of geographic and surname analysis) for high level, national analyses where it has identified data gaps, but it does not use those methods at the regional level for quality improvement efforts. Because this information is in enrollees' electronic medical record, KP can stratify HEDIS measures by race and ethnicity and use these findings for clinical improvement activities.

Mr. Wilson stated that UnitedHealthcare does not collect race and ethnic data on the commercial side, but it has started an enterprise-wide initiative called "Supporting Underserved Communities" that includes a survey to better understand if it is meeting the needs of the community from a racial, ethnic, and language standpoint.

Vice-chair James then discussed her experience as Director of the CMS Office of Minority Health (OMH) working to increase collection of racial and ethnic health data. She specifically focused on increasing standardized data collection across programs, as well as the use of such data to examine quality, access, and other outcomes. Surveys and administrative data collection efforts use the ACA's data standards for race, ethnicity, sex, primary language, and disability. Dr. James also discussed data gaps and challenges related to collecting data through Medicaid because every state was collecting it differently; CMS was unable to provide a national picture of what is happening with the Medicaid program. Regarding Medicare, CMS OMH worked to analyze the HEDIS and CAHPS data used in the Star Ratings program. She also had begun to consider how they could better capture information on social determinants through standardized patient assessment tools used in post-acute care settings. Dr. James supported efforts to increase awareness of Z codes that are used to document social needs (e.g., housing instability, food insecurity, and lack of transportation access) and to incorporate health equity into quality improvement and value-based purchasing. Her office developed a health equity summary score in collaboration with RAND Corporation that can be applied to the Star Ratings program so that plans would be assessed on their performance across populations.

Dr. Hughes reiterated the importance of collecting racial and ethnic data to identify disparities and inform the allocation of healthcare resources and development of interventions. She noted that the Office of Management and Budget has developed standards for racial and ethnic data collection at the federal level, which are also used by many organizations in the private sector.



Information from this deep dive and related discussions assisted in the development of recommendations in *Focus Area 2: Eliminate health outcome disparities for communities of color in the District*. These include:

- Collect and use comprehensive, member-level racial, ethnic and primary language data to support and collaborate with network providers to reduce racial and ethnic inequities
- HBX should include race and ethnicity data (if provided by enrollee) in its 834 files to carriers for individual marketplace enrollees.
- Identify disparities in care by stratifying quality measures by race, ethnicity and primary language

#### **4. Additional Payor Strategies to Advance Equity: Blue Cross Blue Shield of Massachusetts and DC Medicaid**

##### Blue Cross Blue Shield Massachusetts (BCBSMA)

In addition to the carriers participating in DC Health Link, the Working Group learned about Blue Cross Blue Shield of Massachusetts (BCBSMA) efforts to address inequities in health care from Dr. Mark Friedberg, senior vice president for performance measurement and improvement.

BCBSMA's comprehensive plan is focused on addressing inequities in health care, maintaining an inclusive company culture, and standing for equity in their communities. On its website, BCBSMA has an Equity in Health Care page that includes a section where members may share their race, ethnicity, and language preferences. The page explains how the data will be used to address inequities, build solutions, and foster diversity. Internal actions include:

- Convening an advisory council of leading local and national experts
- Becoming the first health plan in the region to collect and use comprehensive, member level data to support and collaborate with the medical community to reduce racial and ethnic inequities
- Creating metrics and programs to address racial inequities in health care access and care
- Educating employees in cultural competence to support member engagement, service, and care
- Reviewing existing contracts with medical management vendors to assess their current or future roadmap for incorporating health inequities
- Evolving the company's current Diversity, Equity, and Inclusion governance structure to include health equity issues, and publishing—company-wide—an enhanced scorecard that measures progress against other best-in-class companies to ensure accountability and transparency.

Like many health plans, BCBSMA currently has limited "Gold Standard" self-reported race and ethnicity data from their members. It largely uses indirect methods for race, ethnicity, and

language data collection, specifically the RAND Bayesian Improved Surname Geocoding (BISG) method. By 2023, it hopes to put financial incentives in place for its provider networks that are explicitly tied to the equity of services they furnish to members, and so BCBSMA is currently engaged in several efforts to increase Gold Standard data, including:

- In December 2020, it began to invite all members to share information about their race, ethnicity, and preferred language (using OMB categories) when they log onto the Blue Cross member portal, MyBlue. The portal explains why they are collecting the data, and for what they will and will not be using the data. Approximately one million of their three million members are on MyBlue and about 315,000 of those using the app have received the pop up. Over 95,000 members have provided their race and ethnicity to date.
- Other strategies will include soliciting member race and ethnicity data via mail, email, telephone, and employment records.

Data governance has been an issue, and BCBSMA adopted the Fast Healthcare Interoperability Resources (FHIR) standard as a consistent data structure to intake and store race and ethnicity data. As there is no industry standard for data provenance, it is in the process of creating its own. Without knowing the data source(s) for each member (e.g., self-reported, provider reported, account-reported, estimated, etc.) it is difficult to assess the accuracy and completeness of race and ethnicity data.

BCBSMA is increasingly using racial and ethnic data to perform equity audits within its membership, based predominantly on estimated race and ethnicity data. BCBSMA has completed an equity audit of HEDIS measure performance, and found the greatest inequities are in measures of depression care and statin use among members with diabetes. In addition, it is in the process of equity audits of—

- Patient experience, through surveys conducted between November 2020 and January 2021 of members about their experience with telehealth and in-person primary care during the pandemic. BCBSMA oversampled members of color to improve measurement reliability of inequities;
- Care management, through enhanced algorithms; and
- Provider payment, specifically focused on performance incentive payments and total medical expenses.

BCBSMA created a new D4E Opportunity Framework, “The Magnolia Model,” as an interactive tool that may be used to apply a health equity lens to every project.

Ms. Kofman asked Dr. Friedberg which request for proposals (RFPs) included new components relating to health equity. Dr. Friedberg replied that the RFPs for vendors include the components. When it renews contracts with its providers, BCBSMA is currently working to insert a shared equity initiative, although it has not yet added an equity related financial incentive into a

contract. Dr. Friedberg said that when BCBSMA begins to suggest financial accountability for equity measures, it will need to provide technical assistance to clinicians on how to improve equity of care.

Chair Lewis asked Dr. Friedberg if BCBSMA has reviewed clinical algorithms for bias, and Dr. Friedberg said it is broaching this issue with providers as part of their collaborative work on equity.

Purvee Kempf (HBX) asked Dr. Friedberg to clarify the number of members who have provided race and ethnicity info in MyBlue. Dr. Friedberg described the results and mentioned that to date, Black, Hispanic, and Asian members have been approximately 60 percent more likely to fill out the survey than White, non-Hispanic members.

Ms. Davis asked how BCBSMA acquired a representative member sample considering variations in MyBlue utilization. Dr. Friedberg says he does not think BCBSMA has achieved a representative sample, which is why it is important for BCBSMA not to rely just on the app to gather the data.

Vice-chair James asked if BCBSMA has considered that 1) younger members may be more likely to not only use the app but also provide race and ethnicity data; and 2) what advice he would give to other plans about engaging providers in this work. Dr. Friedberg said BCBSMA has not considered age but it should look at that. On collaborating with providers, he did not have any advice yet because programs are just now underway, but he did say the response from providers has been largely positive. Dr. James also asked 1) what percentage of member demographic data does BCBSMA think it needs to be able to use it for incentive programs; and 2) has it had any conversations with their peers on Gold Standard data collection on race and ethnicity? Dr. Friedberg said BCBSMA talks with other health plans and providers that participate in the Task Force on Performance Measurement convened by the Executive Office of Health and Human Services in Massachusetts. To date no other health plans have volunteered that they are doing this work, and the providers are “all over the map” in terms of gathering data. Concerning how much demographic data is enough, BCBSMA does not have an answer but it is working to determine if it is a question that it can solve. NCQA states demographic data is needed for 80 percent of plan enrollees, but BCBSMA wants to take a more empirical approach to the question.

Ms. Chichester asked Dr. Friedberg to describe BCBSMA’s journey to implementing this initiative. Dr. Friedberg said BCBSMA began laying the groundwork at least 10 years ago, and this summer it moved from inner facing work to outer facing work for their members.

Dr. Hughes asked if BCBSMA interacts with the Massachusetts’ marketplace regarding BCBSMA’s equity work. Dr. Friedberg said the marketplace is not on the taskforce. The

taskforce is composed of plans and provider organizations and is mainly focused on ACO type contracts.

### DC Medicaid's Health Equity Work and Future Plans

Dr. Pamela Riley, Medical Director, Department of Health Care Finance (DHCF) shared DC Medicaid's health equity strategies. Of note, DHCF plans to establish a staff position to lead diversity, equity, and inclusion efforts at an organizational level.

To date, DHCF's external-facing work has relied primarily on comparing DC Medicaid's population and performance with other populations and state Medicaid programs to identify areas of needed improvement. Over 80 percent of its Medicaid population is in managed care, which provides a significant opportunity to advance equity. Dr. Riley is currently in the process of planning value-based payment program specifications for inclusion in DHCF MCO contracts.

DC Medicaid also has a data warehouse that aggregates claims data, but it is missing race and ethnicity data for approximately 30 percent of its population. The biggest challenge to acquiring that data appears to be self-report at the time of application, and DHCF is looking at ways to improve its data collection efforts. Dr. Riley concluded by saying that it would be beneficial if HBX and DC Medicaid could align their equity work to maximize their impact.

Janice Davis (NAIFA Greater Washington) added that during the pandemic, she has noticed many enrollees have moved between HBX and DC Medicaid—in part due to changes in employment—and because enrollees do compare benefits, coordination makes sense.

Mila Kofman (HBX) asked Dr. Riley if DHCF has thought about doing something similar to their quality improvement report cards in the equity space. Dr. Riley replied not yet, but DHCF is aware that stratifying data by race and ethnicity will be an important part of developing a more comprehensive quality improvement strategy.

Vice-chair Cara James then asked if DHCF has engaged in efforts to capture and document data on social determinants of health. Dr. Riley said DHCF is working on developing a database that it plans to integrate with the health information exchange to access some of the data on social determinants.

Diane Lewis asked Dr. Riley if they are also considering the issue of algorithm bias. Dr. Riley said she does not know if any of the plans have investigated that.

Information from these deep dives and related discussions assisted in the development of recommendations in *Focus Area 2: Eliminate health outcome disparities for communities of color in the District* and *Focus Area 3: Ensure equitable treatment for patients of color in health care settings and in the delivery of health care services in the District*. These include:

- Require providers to complete cultural competency training;
- Collect and use member level racial, ethnic, and primary language data;
- Stratify quality measures by race, ethnicity, and primary language to identify disparities in care.
  - Conduct “Equity Audits” based on race, ethnicity, and primary language data with focus on HEDIS measure performance, patient experience, and provider payment.
  - Update existing contracts with medical management vendors to require assessment of vendor performance with caring for diverse populations

## 5. Pediatric Disparities in the District

Tonya Vidal Kinlow, Vice President of Community Engagement, Advocacy & Government Affairs at Children’s National Hospital reviewed data on disparities in poverty, infant mortality, and life expectancy in the District. Children’s National is preparing to conduct a new community health needs assessment using the Childhood Opportunity Index, which combines 29 neighborhood-level indicators into a single composite measure that focuses on three domains including education, health and environment, and social and economic impact. Children’s National recognizes that racism is a public health crisis and is the root of many of these disparities.

Top priorities for Children’s National in its effort to reduce child health disparities include asthma, infant mortality, and mental health.

- Asthma: Asthma is a chronic condition impacting more than 16,000 DC children, and DC’s Black children have approximately five times the rate of ED visits for asthma compared to White children. Strategies to reduce these ED visits include: 1) increasing resources to improve equity; 2) implementing institutional approaches; and 3) implementing community-based approaches. Resources to improve equity may include following-up with families and making sure they understand discharge instructions and have the resources they need to care for the child. Children’s National is partnering with an organization to identify and address asthma triggers in the home. It is also implementing institutional approaches to address childhood asthma, such as its Impact DC clinic, in partnership with schools, school nurse programs, and community-based organizations.
- Infant Mortality: Infant mortality rates (IMR) in Ward 8 are twice as high as the citywide rate, and seven times higher than in Ward 2. Strategies for reducing IMR include 1) increasing resources to improve equity; 2) collaborating with community-based organizations to provide home visits; and 3) providing education to high-risk women. Children’s National has a grant from the Clark Foundation and is exploring upstream approaches to address infant mortality, including pre-birth activity and postpartum activities.

- **Mental Health:** There is a growing demand for mental health care in DC that far exceeds capacity. Black and Latino/a teens are approximately three times more likely to report being depressed compared to White children. Strategies for increasing mental health access: 1) increasing resources to improve equity; 2) increasing integrated mental health services; 3) expanding mental health promotion; and 4) training in trauma informed care models.

Ms. Kinlow noted that Wards 7 and 8 have high rates of mental health needs but a shortage of mental health services to address these needs. A study done in 2020 found that 48 percent of DC youth with major depressive episodes did not receive needed mental health services. To address the issue of care access, Children’s National is working to co-locate psychologists and psychiatrists in primary care environments. Additionally, it is partnering with the Department of Behavioral Health on a program called DC Mental Health Access that allows them to train pediatricians to identify early signs of behavioral and mental health issues and link affected individuals and families to needed resources. Ms. Kinlow also emphasized that mental health parity has yet to be achieved, and network adequacy for behavioral health demands attention and action. The data show that when a child needs mental health care, it is much more likely that it will require an out-of-network visit.

Ms. Kinlow closed by discussing policy and systems actions that Children’s National believes will have the largest impact on population health. Strategies include: 1) engaging in CNHS CHIP; 2) building capacity in advocacy; 3) ensuring community engagement; and 4) advocating for policy/systems changes.

Information from this deep dive and related discussions assisted in the development of recommendations in *Focus Area 2: Eliminate health outcome disparities for communities of color in the District*, related to the addition of language specific to the pediatric population:

- Modify insurance design for DC Health Link standard plans to eliminate cost-sharing, including deductibles, co-insurance, and co-payment, for medical care, prescription drugs, supplies and related services that prevent and manage diseases and health conditions that disproportionately affect patients of color in the District.
  - HBX Standard Plan Working Group to review and develop for consideration a Value-Based Insurance Design to support adherence for patients with chronic conditions. The Social Justice and Health Disparities Working Group recommends the following prioritization of conditions to be assessed for AV and premium impact by the HBX Standard Plans Working Group: (1) for the adult population-- diabetes, cardiovascular disease, cerebrovascular disease, mental health, and HIV, as well as cancer of the breast, prostate, colorectal and lung/bronchus; and (2) for pediatric population-- mental and behavioral health services.

## 6. Health Equity and Access to Care in the District

Dr. Annetta Arno, Director of the Office of Health Equity, presented on Health Equity and Access to Care in the District. She began with an overview of DC Health's five strategic priorities:

- 1) promote a culture of health and wellness
- 2) address the social determinants of health
- 3) strengthen public-private partnerships
- 4) close the chasm between clinical medicine and public health
- 5) implement a data-driven outcome-oriented approach to program and policy development

Dr. Arno reviewed key insights from the Health Equity Report for the District of Columbia 2018, which includes data from 51 statistical neighborhoods. The data presented showed that health disparities and inequities in the District are evident by race, income, and geography, and differential health outcomes persist across the life course. She noted that approximately 96 percent of District residents have health insurance through private or public coverage. Dr. Arno also referenced DC Health's Health Systems Plan (2017) and Primary Care Needs Assessment (2018).

Key findings from the Primary Care Needs Assessment (2018) include: 1) there is sufficient primary care capacity to serve the District's residents; 2) physicians make up a high percentage of the District's primary care workforce; 3) the use of primary care is not defined by geography nor travel time for Medicaid patients; 4) there is low community-level preference for local health care resources; 5) there is low engagement with a medical home for primary care; 6) there is low utilization of primary care among all Medicaid enrollees; 7) there is higher than expected utilization among Medicaid enrollees who accessed care; 8) there is untapped Medicaid provider capacity; and 9) there are gaps in systems of care in some parts of the city.

Related recommendations include: 1) address patient perceptions of brand, quality, and convenience; 2) promote use of accessibility of medical homes, especially among women; 3) engage residents who are not accessing care; 4) promote development of systems of care that emphasize community-clinical linkages and care transitions, and ensure residents across the District can access these systems locally; 5) encourage maximizing and strategically leveraging existing provider resources to address identified and perceived gaps; 6) strengthen partnerships and systems to routinely collect, analyze, and disseminate data on access to care; 7) identify and explore emerging issues through targeted quantitative and qualitative data collection and analyses; and 8) ensure a workforce that supports team-based care delivery.

The Mayor's FY21 budget invests \$4.9 million to implement recommendations from the Mayor's Commission on Healthcare Systems and Transformation to reduce reliance on emergency care and improve health outcomes. Dr. Arno closed her presentation by stating that to

eliminate disparities in health outcomes, our collective actions must be intentional in 3 key areas: 1) access to quality health care; 2) social and structural determinants of health; and 3) structural and institutional racism.

Ms. Chichester asked if the agency has done analysis on preferred brands, and Dr. Arno said it does not have specific data related to brand preference. Chair Lewis asked Dr. Arno if the agency had an opportunity to conduct focus groups with residents of Wards 5, 7, and 8 related to their utilization of providers, and Dr. Arno said the agency has several opportunities moving forward to acquire this type of information.

Information from this deep dive and related discussions assisted in the development of recommendations in *Focus Area 1: Expand access to providers and health systems for communities of color in the District*. These include:

- Provide incentives for both primary care and specialist physicians to practice in underserved areas in DC
- Support access to diverse medical professionals

## **7. National Committee for Quality Assurance**

At the request of the Working Group, NCQA agreed to present information on 1) its Multicultural Health Care Distinction; and 2) its new equity proposal.

Amy Maciejowski, Program Manager of State Affairs, began the presentation noting that seventy-five organizations across the country have achieved NCQA's Multicultural Health Care (MHC) Distinction, and three states—Pennsylvania, Wisconsin, and South Carolina—have required their Medicaid plans to add the MHC Distinction to their existing accreditation requirements. Nevada Medicaid recently added language in its RFP encouraging plans to achieve the Distinction. Covered California has given the state's health plans until 2022 to meet the MHC Distinction requirements, and plans also will be required to have NCQA Health Plan Accreditation.

Dr. Rachel Harrington, Research Scientist with the Quality Measurement and Research Group, presented on how NCQA is advancing its equity strategy via measurement and research. NCQA is working to address the need for greater transparency on health care quality and performance for racial and ethnic groups and has proposed requiring stratification by race and ethnicity, beginning in HEDIS Measurement Year (MY) 2022. Measures that may be included for stratification in MY 2022 are: 1) controlling high blood pressure; 2) comprehensive diabetes care (HbA1c Control <8%); 3) colorectal cancer screening; 4) prenatal and postpartum care; and 5) child and adolescent well-care visits. The data for MY 2022 measures will not be publicly available. Moving forward, NCQA would like to focus on: 1) expanding race and ethnicity stratifications; 2) sexual orientation and gender identity; 3) social needs screening and referral



(food insecurity, housing, transportation, social isolation); and 4) supporting and incentivizing efforts to increase completeness of self-reported race and ethnicity data.

Natalie Mueller, Assistant Director in Project Management, reviewed NCQA MHC Distinction and Health Plan Accreditation (HPA) updates. Mueller noted that NCQA was informed by Pennsylvania officials that their decision to add the MHC Distinction requirement for their Medicaid plans was due in part to evidence that Pennsylvania plans with MHC Distinction performed better on HEDIS measures across races and ethnicities.

NCQA is in the process of updating MHC Distinction standards to address health equity. Changes may include new standards on organizational readiness and promoting diversity, equity, and inclusion; requiring collection of sexual orientation and gender identity data; and requiring reporting of the relevant HEDIS measurements that Dr. Harrington discussed. NCQA has also established an optional Social Determinants of Health Evaluation module that is customizable for different markets, as well as a component around algorithmic bias and expectations on how organizations evaluate the algorithms they are using. These updates will be released for public comment.

HPA 2022 final recommendations include 1) adding new factors to strengthen organizations' commitment to health equity and discovery of disparities within their populations; and 2) adding one new element to promote diversity, equity, and inclusion within the organization. Mueller noted that four organizations with MHC Distinction have commercial plans.

Vice-chair Dr. James asked if NCQA has considered how race and Hispanic ethnicity categories can be combined, and Dr. Harrington responded that NCQA currently does not allow dual stratification of race and ethnicity when reporting results to HEDIS, largely to improve reliability in scoring and maintain a larger sample size. She noted, however, that the field is evolving, and NCQA is open to looking at this data in a more granular way.

Dr. Hughes asked if organizations that have the MHC Distinction have reported any specific outcomes, and with what aspects of acquiring the MHC Distinction are organizations reporting the most difficulty. Ms. Mueller referenced the paper "[NCQA Distinction in Multicultural Health Care: Assessment of the Benefits and Recommendation to Require that Issuers Achieve this Distinction](#)" prepared by Health Management Associates for Covered California in 2020. Ms. Mueller said the most difficult aspect of MHC Distinction for organizations to achieve is data collection. She also confirmed that organizations are required to ask their providers for practitioner race, ethnicity, and language data. Dr. Hughes asked how NCQA will use the data it collects, and Dr. Harrington said its trajectory is 1) require reporting; 2) identify and close gaps within organizations; and 3) compare data to national, state, and regional benchmarks.

All HBX qualified health plan issuers have achieved NCQA [Health Plan Accreditation](#), and NCQA recently proposed the addition of race and ethnicity stratifications for select HEDIS

measures beginning in Measurement Year 2022. NCQA will allow a path for reporting using both direct and indirect data, regardless of completeness, with separate reporting fields by source.

Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc. also has achieved the NCQA [Multicultural Health Care Distinction](#), which evaluates how well an organization complies with standards for collecting race, ethnicity, and language data among other requirements.

Information from this deep dive and related discussions assisted in the development of recommendations in *Focus Area 2: Eliminate health outcome disparities for communities of color in the District* and *Focus Area 3: Ensure equitable treatment for patients of color in health care settings and in the delivery of health care services in the District*. These include:

- Collect and use comprehensive, member-level racial, ethnic and primary language data to support and collaborate with network providers to reduce racial and ethnic inequities
- Identify disparities in care by stratifying quality measures by race, ethnicity and primary language
- Obtain the National Committee for Quality Assurance's (NCQA's) Multicultural Health Care distinction

#### **IV. Review and Discussion of Preliminary Recommendations**

Informed by the Working Group meetings and deep dive presentations, GWU and HBX continued to revise and prioritize potential recommendations for consideration. Importantly, Chair Lewis emphasized that this work is “phase one” and that to have a meaningful impact on racism in health care, HBX will convene working groups in the future, including one that has large payors at the table to get a broader reach for policy interventions.

After Dr. Hughes and HBX developed the draft recommendations, the Working Group members provided both verbal and written feedback with suggested language. The Final Recommendations reflect Working Group members' concerns, issues, and suggestions.

This next section summarizes the Working Group members' feedback, which is followed by the final set of recommendations in the following section. The Final Recommendations were adopted by the Working Group unanimously by members present on June 24.

#### **Summary of issues, concerns, and feedback by Working Group members**

Two carrier representatives made overarching comments: 1) Paul Speidell (Aetna) suggested clarifying that the goal of these recommendations is to focus on issues that HBX has the power to change and that the recommendations are based on strategies that health plans are already or will be implementing; and 2) Colette Chichester (CareFirst) mentioned the importance of level setting expectations regarding the time that could be needed to implement some of these

recommendations and underscored the point that there may be a need to develop a multi-year strategy.

**Focus Area 1: Expand access to providers and health systems for communities of color in the District.**

- Janice Davis (NAIFA Greater Washington) mentioned that although 96 percent of District residents have health insurance through private or public coverage, lack of provider access is still a common complaint in some wards.
- Colette Chichester (CareFirst) commented that perhaps our attention should be focused on attracting quality health care providers to underserved areas, and referred to Dr. Arno's presentation that highlighted individuals in underserved areas often traveled to other Wards for care because of perceived quality problems. Dr. Pamela Riley (DHCF) asked if we should consider strategies like community health workers or navigators.
- Allison Mangiaracino (KP) asked if HBX could clarify what is specifically meant by the proposed recommendation for health plans to provide incentives for physicians to practice in underserved areas. Mila Kofman (HBX) responded that carriers have sponsored a variety of initiatives to encourage physicians to practice in certain areas and given the variety of carrier models in the District, did not want to be prescriptive.
- Yulondra Barlow (CareFirst) stated that in order to make incentives for physicians fully successful, we should eliminate barriers to securing a certificate of need (CON). She recommended working with DC Health to establish a CON waiver process to incentivize primary care and specialty physicians to practice in underserved areas in DC.
- Purvee Kempf (HBX) stated that HBX defers to DC Health on CON-related matters. Ms. Kempf said that because there are a variety of barriers to practicing in underserved areas, providing a CON may not be enough to ensure the desired outcome is fully successful. She reminded the Working Group that carriers have supported providers during the pandemic in several ways that did not require a CON, as reported in the East of the River report:
  - CareFirst offered a combination of advance lump-sum payments, increased fee schedules, and monthly cash advances for qualifying Patient-Centered Medical Home panels to support healthcare providers in Wards 7 and 8.
  - UnitedHealthcare provided short term investments in Federally Qualified Health Centers to assist them in building capacity and explored partnerships with Unity Health Care and Healthcare for the Homeless in Wards 7 and 8.
- Paul Speidell (Aetna, a CVS company) expressed appreciation for the non-directive wording of this recommendation that allows flexibility for carrier implementation.
- Dr. Pam Riley (DCHF) noted that in addition to incentives to encourage new providers to practice in underserved areas, existing providers in these areas may benefit from additional support.

- With respect to the recommendation to provide scholarships to STEM and medical students of color in the District, Allison Mangiaracino (KP) questioned if requiring carriers to provide scholarships and establish a scholarship program is within the scope of this Working Group and noted that it is possible not all carriers will have the capacity to develop and sustain a scholarship program. She also said she is not sure if providing scholarships is how all carriers would choose to allocate their community benefit dollars.
- Dr. Pamela Riley (DHCF) also noted that providing scholarships may not be the best use of carrier resources as there is other work that could be done to eliminate barriers to access and encourage appropriate utilization.
- In response, Mila Kofman (HBX) suggested that HBX could provide the infrastructure and coordinate a scholarship program on behalf of the carriers if necessary. In addition, given existing DC government scholarship programs aimed at increasing diversity in the District's healthcare workforce, Ms. Kofman asserted there are multiple ways carriers could accomplish this recommendation without establishing their own scholarship programs. Dr. Pamela Riley (DHCF) acknowledged Ms. Kofman's suggestion that this recommendation could be achieved by working within existing programs that already have the infrastructure to support students and have exhibited a level of effectiveness.
- Paul Speidell (Aetna) said that the current language is broad enough that it provides carriers with a level of flexibility that allows for creative solutions.
- Allison Mangiaracino (KP), Paul Speidell (Aetna), and Yulondra Barlow (CareFirst) asked about scholarship program retention strategies to ensure that students who have been awarded scholarships remain in the District and work in underserved areas. Colette Chichester (CareFirst) added that members need to consider how the impact of this recommendation will be measured and suggested the recommendation be linked to DC Health Professional Shortage Areas. Chair Diane Lewis clarified that the goal of this recommendation is to increase diversity in the healthcare workforce throughout all of DC and not just in underserved areas.
- Vice-Chair Dr. Cara James (GIH) noted that while scholarships are helpful, increasing diversity in the District's healthcare workforce will require additional support such as networking opportunities, mentorship, and internships, ideally as part of a structured program. In addition, Yulondra Barlow (CareFirst) noted that scholarships often have state or local residency requirements and service commitments of certain lengths of time to maximize local investments. Mila Kofman (HBX) said she does want to be realistic about what health plans are asked to do and is interested to know what support the health plans believe they could provide.
- Commissioner Karima Woods (DISB) requested examples of successful scholarship models. Daniel Wilson (UnitedHealthcare) cited Mercer School of Medicine's [Nathan Deal Scholarship](#) and Tonya Vidal Kinlow (Children's National Hospital) cited the [DC Health Professional Loan Repayment Program](#). Upon additional research, Allison

Mangiaracino (KP) later shared that KP has a [health equity scholarship program](#) already in place for all regions, which is conducted in partnership with UNCF.

- As another alternative, Patricia Quinn (DCPCA) suggested the carriers collaborate with the DC Hospital Association, which was awarded a [Healthcare Workforce Partnership Grant](#) in January 2021 from the DC Workforce Investment Council. This Partnership will focus on healthcare talent pipeline development.
- Regarding the issue of provider networks, several members noted the importance of improving the diversity of networks. Collecting race, ethnicity, and primary language data of providers will allow patient selection and help plans determine whether the healthcare workforce aligns with communities being served.

## **Focus Area 2: Eliminate health outcome disparities for communities of color in the District**

- A notable challenge identified by Working Group members is the lack of data by race, ethnicity, preferred language, and other demographics for enrollees in marketplace plans. Enrollees are not required to provide this data and only about one-third do so. Several participants emphasized the need for such data, which could inform interventions and allow evaluation. There was a suggestion for exploring options to improve data collection, possibly through incentives, surveys, or education on its importance. Members noted that an understanding of federal requirements would be an important first step.
- In follow up to Jester's presentation, Dr. Dora Hughes (GWU) underscored the importance of collecting racial, ethnic, and other demographic data, including for 1) identifying problems by assessing the incidence and prevalence of various health conditions, which supports the rationale for resource allocation and development of interventions; 2) targeting risk factors by helping providers characterize risk among various groups and identifying emerging problems; 3) expanding access to care; and 4) enhancing and evaluating quality of care, particularly given gaps between standards of care and the quality of care that patients of color receive, as well as patient experience and outcomes.
- Vice-chair Dr. Cara James (GIH) wondered to what extent plans are looking at the quality or provenance of data they have. (Their responses are summarized in the carrier presentation section above.)
- Allison Mangiaracino (KP) commented that the 834 enrollment file does not include race and ethnicity, but passing along data that is available through an enrollment file could be useful for carriers. In response, Mila Kofman (HBX) noted that on the individual side, this data is collected voluntarily, but HBX does not currently pass it along to carriers. The 834 could be modified, and HBX would be happy to provide carriers with that information. She also noted that carrier systems would need to be modified to absorb the

data. This is an issue HBX would need to discuss further with the HBX IT team and the carriers' IT/EDI teams.

- On the SHOP side (the small group side) this data is not currently collected, and HBX needs to do more research to determine if there are any restrictions in federal law on asking for such data on a voluntary basis. If there are no restrictions, HBX is willing to ask for the data, but that update will take time. Allison Mangiaracino (KP) replied that she is happy to take that information back to her team to see if it is possible for them to absorb the data, and Mila Kofman (HBX) requested that the carriers review the recommendation's current language to ensure it is feasible as written.
- Colette Chichester (CareFirst) asked that HBX work with the carriers to ensure feasibility and an adequate timeline for implementation.
- Dr. Fendrick focused primarily on the link between reduced cost-sharing and increased adherence to recommended treatment, which is critically important for individuals with chronic conditions. Following Dr. Fendrick's presentation, the Working Group members posed several follow up questions, which were researched and discussed at a subsequent meeting:
  - Members asked if there was evidence that V-BID improved actual health outcomes. Dr. Dora Hughes (GWU) presented one New England Journal of Medicine study that suggested full coverage for preventive medications for patients who had suffered a myocardial infarction improved cardiovascular outcomes for patients.
  - A second question was whether V-BID benefited higher income populations. Dr. Hughes described one study on Veterans Health Administration (VHA) coverage and cost-related medication nonadherence. Even for higher-income individuals (\$100,000 or more), full VHA coverage was associated with reduced nonadherence, defined as individuals who could not afford a prescription drug, skipped medication doses to save money, took less medicine to save money, delayed filling a prescription to save money, or any of the above.
  - These findings were stratified by race and ethnicity, and Blacks and Hispanics were more likely to benefit, which helped to answer the third question regarding whether V-BID could help to reduce disparities.
- Colette Chichester (CareFirst) reported that CareFirst has recently begun to cover treatment without cost-sharing for individuals with diabetes based on various factors, including the number of enrollees who could potentially benefit. There will be a robust evaluation to inform CareFirst's future work.
- Mila Kofman (HBX) reminded members that the standard plans already incorporate some V-BID principles.
- Another question pertained to the medical conditions most prevalent among communities of color in the District. Helen Mittmann (GWU) researched this question and found that the top conditions overall include heart disease, stroke, and diabetes, as well as cancer of

the breast, prostate, colon, and lung/bronchus. However, these conditions are relevant for the adult population and at the suggestion of Mila Kofman (HBX), Tonya Kudlow (Children's National) was invited to present on pediatric health disparities in DC. Following Ms. Kinlow's presentation, a proposal was made to require coverage without cost-sharing for mental and behavioral health services for children given the need and dearth of services and providers in the District.

- Margarita Dilone (HBX Standing Advisory Board) stated health insurance plans need to educate enrollees on what services are currently available and provide this information in multiple languages. Numerous carrier strategies were described, including customizing member materials (such as after-visit summaries, printed health education materials, and educational programs) to meet consumers' cultural and language needs, and providing care management services in multiple languages.
- Allison Mangiaracino (KP) raised another issue related to the actuarial value (AV) implications for V-BID. Waiving cost sharing for all or most services associated with care for specific conditions will have an AV impact, thus requiring enrollees in standard plans to pay more for other services. Cost-sharing relief for conditions that disproportionately affect patients of color in the District holds the potential to improve access and close health outcome disparities. However, substantial cost-sharing increases for other services could exacerbate barriers to care, especially for those with other diseases and conditions not targeted for V-BID. Ms. Mangiaracino noted that the carriers are bound by market rules on AV and asked if HBX could request an assessment from Oliver Wyman on the recommendation's potential impact on AV and premiums. Additionally, Ms. Mangiaracino suggested selecting services for which evidence demonstrates that removing cost barriers could improve adherence (e.g., medications for myocardial infarction). A V-BID initiative should be paired with a comprehensive quality improvement plan for narrowing disparities and incentivize care management to prevent the onset of chronic conditions and complications. The Medicare Advantage V-BID model is another approach that could inform the working group's recommendations.
- In follow up to this request, actuaries from the Oliver Wyman consulting firm have begun to consider implications for modifying insurance design to lower or eliminate cost-sharing for high-value services for the diseases disproportionately affecting Black and Brown communities in DC. Mila Kofman (HBX) also said they would review any constraints under the essential health benefits benchmark regarding eliminating coverage for certain low-value services. Further, Ms. Kofman emphasized that for this recommendation, the Working Group would charge the Standard Plans Working Group with modifying the standard plan design where appropriate. She noted that it is possible that the Standard Plans Working Group may find, given AV and premium impact, they can only change benefit design for diabetes. Ms. Kofman added that this recommendation will impact all four carriers as the standard plan design will be added to the SHOP side as

well. It will be important to further define what is meant by no-cost coverage for certain conditions and prioritize diseases and health conditions based on DC-specific data.

- Mila Kofman (HBX) stated that when benefit design is changed to include things at no-cost, health plan and provider education is necessary to ensure billing is done correctly. HBX anticipates the need for such an education effort, even if it is just in the first year for diabetes services. In addition, reporting requirements would help to ensure that the design changes are successful and determine if the model should be replicated in the future.
- Janice Davis (NAIFA Greater Washington) noted that she appreciated the recommendation related to modification of insurance design for DC Health Link standard plans to eliminate cost sharing and said it would be good to consider also the cost of medical devices.
- Purvee Kempf (HBX) noted the new insurance design would apply to standard plans in the individual marketplace as well as new standard plan designs for the small group marketplace.
- Mila Kofman (HBX) later noted that this recommendation should be narrowly focused on the underlying disease condition and would not include co-morbidities, and that cost-sharing may be waived for HSA compatible, high deductible health plans to the extent allowed by federal law.
- Allison Mangiaracino (KP) and Bill Wehrle (KP) requested edits to clarify that if the Standard Plans Working Group decides V-BID elements are not feasible because of other adjustments to cost-sharing, that this recommendation will not be implemented.
- One carrier asked why V-BID was being applied to both the individual and small group market at the same time and the rationale for application to the standard plans only. Mila Kofman (HBX) responded that there are 163 small group products and that applying the V-BID requirements to the standard plan in each metal tier represented a more targeted, “pilot” approach. To apply the requirements to the individual and small group market at the same time would enhance understanding of what elements of the V-BID approach are effective.
- Regarding the proposal for health plan “Equity Audits,” Colette Chichester (CareFirst) and Paul Speidell (Aetna) emphasized the importance of defining the purpose of reporting requirements and clarifying how the data will be used. Several members requested that HBX align its recommendation with NCQA’s final proposal for maximal efficiency.

### **Focus Area 3: Ensure equitable treatment for patients of color in health care settings and in the delivery of health care services in the District.**

- Members noted that several organizations for providers and staff support implicit bias training, including the Implicit Bias Association test and lectures.



- Patricia Quinn (DCPCA) mentioned the creation of Our Respectful Care Toolkit, co-designed with providers and Black women with recent experiences in our maternal health system, which includes a "Top 5 Do No Harm Checklist" for those impacted by inequity. Another suggested resource was NCQA's Multicultural Healthcare Distinction program, which is awarded to plans that have established an infrastructure for addressing equity and ensuring culturally and linguistically appropriate services.
- Daniel Wilson (UnitedHealthcare) emphasized the importance of ensuring physicians are familiarized with diseases that disproportionately impact patients of color, such as sickle cell disease. Mila Kofman (HBX) suggested the addition of an additional bullet focused on carriers working with provider networks to ensure diseases with a high prevalence in patients of color are included in physician training.
- Colette Chichester (CareFirst) reported that CareFirst added a requirement in its contractual arrangements with its Patient Centered Medical Home (PCMH) providers related to cultural competency training and other initiatives, and we may want to add a bullet point about how to best target the provider community to assist with some of this work. Several carrier representatives suggested that HBX work with other entities in the District to encourage and/or require cultural competency training among providers.
- Regarding the proposal to review clinical algorithms for bias, Allison Mangiaracino (KP) asked which algorithms carriers should assess, what specifically should be assessed within the algorithms, and if there are tools available to conduct these assessments. Dr. Dora Hughes (GWU) noted that given many health plans have started this process, the recommendation was kept intentionally broad. Chair Diane Lewis (HBX) shared the newly released [Algorithm Bias Playbook](#), which was developed by experts at the University of Chicago Booth School of Business.
- Allison Mangiaracino (KP) suggested adding language to clarify which race-adjusted tools carriers may need to review, citing the clinical medicine tools identified in the deep dive session on Bias in Diagnosis and Treatment. Dr. Dora Hughes (GWU) responded that there appears to be general consensus on removing the race correction from eGFR, which measures kidney function. Ms. Mangiaracino later reported that KP is currently monitoring the Task Force on Reassessing the Inclusion of Race in Diagnosing Kidney Diseases by the American Society of Nephrology and the National Kidney Foundation and will change their practice in alignment with [the official guidelines/recommendations](#) (expected this summer). She suggested adding language to the effect of "following publication of the National Kidney Foundation guidelines, prohibit use of race in estimating glomerular filtration rate (eGFR) by hospitals, laboratories, and other in-network providers."
- Paul Speidell (Aetna) suggested that carriers be required to conduct an internal assessment for algorithmic bias in the first year and report their findings in the second year. Mr. Speidell and Colette Chichester (CareFirst) both asked how HBX would use reports on algorithmic bias. Mila Kofman (HBX) responded HBX would use such reports

for informational purposes and the reports would be considered proprietary and confidential.

### **Consensus Recommendations**

On June 24, the Working Group's last meeting, the Working Group finalized the recommendations for HBX Board consideration. Dr. Hughes asked for the Working Group to vote. By a voice vote of members present, the Working Group unanimously adopted the recommendations. No member abstained and no member voted "no." Voting members present: Chair Diane Lewis, Vice-Chair Cara James, Colette Chichester, Janice Davis, Yolette Gray, Paul Speidell, Tamara Watkins, Bill Wehrle, Daniel Wilson, and Commissioner Karima Woods.

Chair Diane Lewis thanked the participants for their service. She said this effort has raised difficult and challenging issues, and the members' willingness to be open to new ideas and approaches has been important to the process. These recommendations provide guidance to the HBX Board on how to proceed in addressing health equity. She looks forward to working with the Working Group members on the implementation of these recommendations as we move forward.

## **Social Justice and Health Disparities Working Group**

### **Recommendations**

Although the problems are complex and require comprehensive approaches to stop racism in health care, DC Health Link health plans and DCHBX can be part of the solution.

#### **Focus Area 1: Expand access to providers and health systems for communities of color in the District**

The vast majority—over 96 percent—of District residents have health coverage, which ranks Washington, DC among the best in the country for coverage. However, there is a shortage of hospitals, urgent care facilities and other providers in areas of DC, leading to difficulties with obtaining medical care for many residents of color. Access to diverse providers is limited as well.

#### **Recommendations:**

Carriers:

- Provide incentives for both primary care and specialist physicians to practice in underserved areas in DC
- Support access to diverse medical professionals

- Provide scholarships for STEM students and medical school students of color in health professional schools in the District.
  - DCHBX will provide the infrastructure as necessary.
- Review provider networks to determine the race, ethnicity and primary language of their providers to establish a baseline, and develop 5-year goals to improve the diversity of the networks.

## **Focus Area 2: Eliminate health outcome disparities for communities of color in the District**

Blacks and Latinos are hospitalized at over three times the rate of their white counterparts. About 40 percent of non-Hispanic Blacks compared to 28 percent of non-Hispanic Whites have high blood pressure, and the rate of diagnosed diabetes is 77 percent higher among non-Hispanic Blacks than non-Hispanic Whites. African American men have the highest cancer death rate of any racial and ethnic group in the U.S.

### Recommendations:

#### Carriers:

- Collect and use comprehensive, member-level racial, ethnic and primary language data to support and collaborate with network providers to reduce racial and ethnic inequities
  - No later than Plan Year 2023, obtain race, ethnicity, and language data directly from members via mail, email, telephone and electronic portals, and other mechanisms. Share with DCHBX baseline metrics for data collection, annual goals and, beginning in Plan Year 2024, progress in meeting such goals.
  - Provide aggregate data by race, ethnicity, and primary language to DCHBX for select diseases and health conditions, in consultation with DCHBX.

#### DCHBX:

- HBX should include race and ethnicity data (if provided by enrollee) in its 834 files to carriers for individual marketplace enrollees. Carriers may have to modify their 834 consumption to absorb the data. HBX should also explore the feasibility of changing the application for small group employees to collect this information and provide to carriers via 834 files.

#### DCHBX:

- Modify insurance design for DC Health Link standard plans to eliminate cost-sharing, including deductibles, co-insurance, and co-payment, for medical care, prescription drugs, supplies and related services that prevent and manage diseases and health conditions that disproportionately affect patients of color in the District.

- HBX Standard Plan Working Group to review and develop for consideration a Value-Based Insurance Design to support adherence for patients with chronic conditions. The Social Justice and Health Disparities Working Group recommends the following prioritization of conditions to be assessed for AV and premium impact by the HBX Standard Plans Working Group: (1) for the adult population-- diabetes, cardiovascular disease, cerebrovascular disease, mental health, and HIV, as well as cancer of the breast, prostate, colorectal and lung/bronchus; and (2) for pediatric population-- mental and behavioral health services.
- Waiver of cost-sharing is only for the underlying condition and does not include co-morbidities. For example, for an enrollee with diabetes, heart disease treatment would continue to have cost-sharing. Additionally, cost-sharing may be waived for HSA compatible, high deductible health plans only to the extent permitted by federal law. Insurance plan design changes are limited to AV standards approved under federal law.
- Health plans are encouraged to evaluate impact of design changes on enrolled population and provide periodic updates on trends to DCHBX. Furthermore, health plans are encouraged to expand their current health equity support and pilot programs to include patients for whom there will be no cost-sharing for treatment of certain specific conditions. Because product design changes will require provider education, DCHBX shall include in their budget funding for provider education in consultation with the health plans.
- New insurance design should apply to standard plans in the individual marketplace.
- DCHBX must also develop new standard plan design, which must include this new insurance design, for the small group marketplace to be offered for plan year 2023.

#### Carriers:

- Identify disparities in care by stratifying quality measures by race, ethnicity and primary language
  - Conduct “Equity Audits” based on race, ethnicity, and primary language data with focus on HEDIS measure performance, patient experience and provider payment. Such audits should align with NCQA requirements as feasible.
  - Update existing contracts with medical management vendors to require assessment of vendor performance with caring for diverse populations, and development of goals and timeline for improvement.

### **Focus Area 3: Ensure equitable treatment for patients of color in health care settings and in the delivery of health care services in the District**

Myriad studies have found that persons of color are less likely to receive equitable treatment across a range of health conditions, leading to significant disparities in health and health

outcomes. Implicit bias from providers and biased clinical algorithms contribute to inequitable treatment.

Implicit bias, along with false beliefs about biological differences, can lead to disparities in recommended treatment and poor provider communication during medical visits, which in turn contributes to experiences of perceived discrimination and poor quality of care. Blacks in particular are more likely to report being treated unfairly and with disrespect by providers because of their race.

### Recommendations:

#### Carriers:

- Require network providers to complete cultural competency training, which should reflect widely available, recommended resources and tools to mitigate implicit bias
  - Provide and require cultural competency training to support the delivery of culturally and linguistically competent services, in adherence to the Department of Health and Human Services Office of Minority Health's A Physician's Practical Guide to Culturally Competent Care and other resources listed by CDC's National Prevention Information Network.
  - Require cultural competency training annually for all providers in network. Incentives should be offered to encourage non-network providers to complete training as well.
  - Require cultural competency training in provider contracts, which should be tailored to both primary care physicians and medical specialists.
  - DCHBX will reach out to DC Health to learn how it has encouraged cultural competency training for providers, including whether provider licensure requirements could be leveraged for this purpose.
- Obtain the National Committee for Quality Assurance's (NCQA's) Multicultural Health Care distinction
  - Seek this distinction, awarded for organizations that meet or exceed standards in providing culturally and linguistically appropriate services.
- Review clinical algorithms and diagnostic tools for biases and inaccuracies and update appropriately
  - Each carrier will conduct and report to DCHBX on efforts to assess clinical management algorithms that may introduce bias into clinical decision making and/or influence access to care, quality of care, or health outcomes for racial and ethnic minorities. Within one year, carriers will report the outcomes of such assessments to DCHBX, as well as plans and timeline for correction, as necessary.
    - Such reports will be used for informational purposes regarding the types and prevalence of algorithms that are found to potentially bias care for diverse populations. These reports will be considered proprietary and confidential.
    - DCHBX may report aggregate outcomes from these reports.

- Within one year, prohibit use of race in estimating glomerular filtration rate (GFR) by hospitals, laboratories, and other providers in network, in alignment with guidelines promulgated by the National Kidney Foundation.

**Social Justice & Health Disparities Working Group Members and Affiliations**

<b>WORKING GROUP MEMBER</b>	<b>AFFILIATION</b>
Diane Lewis, Chair	HBX Executive Board
Cara James, Vice-Chair	Grantmakers in Health (GIH)
Colette Chichester	CareFirst Blue Cross Blue Shield
Janice Davis	Greater Washington Association of Insurance and Financial Advisors
Margarita Dilone	Broker, SHOP Customer, GWHCC Board, HBX Standing Advisory Board
Yolette Gray	DC Hospital Association
Tonya Vidal Kinlow	Children’s National Hospital
Mansi Kotwal	DC Medical Society
Allison Mangiaracino	Kaiser Permanente
Patricia Quinn	DCPCA
Paul Speidell	Aetna, a CVS Health Company
Tamara Watkins	HBX Executive Board
Daniel Wilson	UnitedHealthcare
Karima Woods	DISB and HBX Executive Board

<b>Staff Advisors &amp; Support</b>	<b>Affiliations</b>
Mila Kofman Debra Curtis Purvee Kempf MaryBeth Senkewicz	HBX
Philip Barlow Howard Liebers	DISB

Ciana Creighton Chikarlo Leak	DMHHS
Annetta Arno	DC Health
Pamela Riley	DHCF

<b>Professional Consultants</b>	<b>Affiliations</b>
Dora Hughes, Associate Research Professor Helen Mittmann, Research Associate	George Washington University, School of Public Health

### Appendix A: Meeting Materials

<b>Date</b>	<b>Meeting Materials</b>	<b>Meeting Overview</b>
2/3/2021	<a href="#">Agenda</a> <a href="#">Meeting Notes</a> <a href="#">Background Paper</a> <a href="#">Presentation Slides</a>	<ul style="list-style-type: none"> <li>• <b>Presentation:</b> District of Columbia Health Highlights – Dr. Dora Hughes, GWU</li> <li>• Discussion of potential areas of focus</li> </ul>
2/9/2021	<a href="#">Agenda</a> <a href="#">Meeting Notes</a> <a href="#">Presentation Slides</a> <a href="#">Suggested Priorities</a>	<ul style="list-style-type: none"> <li>• <b>Presentation:</b> Ensuring Equitable Treatment for Patients of Color – Dr. Dora Hughes, GWU</li> <li>• Discussion of potential areas of focus and additional priorities</li> </ul>
2/25/2021	<a href="#">Agenda</a> <a href="#">Meeting Notes</a> <a href="#">Presentation Slides</a>	<ul style="list-style-type: none"> <li>• <b>Presentation:</b> Value-Based Insurance Design – Mark Fendrick, VBID Center, University of Michigan</li> <li>• Discussion on potential action steps</li> </ul>
3/11/2021	<a href="#">Agenda</a> <a href="#">Meeting Notes</a> <a href="#">Presentation Slides</a>	<ul style="list-style-type: none"> <li>• <b>Presentation:</b> Collection and Use of Racial and Ethnic Data Collection – Cara James, Grantmakers in Health and Michelle Jester, America’s Health Insurance Plans</li> <li>• Open discussion</li> </ul>



3/25/2021	<a href="#">Agenda</a> <a href="#">Meeting Notes</a> <a href="#">Presentation Slides</a> <a href="#">Issue List</a>	<ul style="list-style-type: none"> <li>• <b>Presentations:</b> Health Plan Initiatives to Advance Equity – Stacey C. Shapiro, Kaiser Permanente; U. Michael Currie, UnitedHealth Group</li> <li>• Open discussion</li> </ul>
4/8/2021	<a href="#">Agenda</a> <a href="#">Meeting Notes</a> <a href="#">Presentation Slides</a>	<ul style="list-style-type: none"> <li>• <b>Presentation:</b> Blue Cross Blue Shield MA Initiative to Advance Equity – Mark Friedberg, Blue Cross Blue Shield MA</li> <li>• Review and discussion of “deep dive” issues</li> </ul>
4/22/2021	<a href="#">Agenda</a> <a href="#">Meeting Notes</a>	<ul style="list-style-type: none"> <li>• <b>Presentation:</b> Health Plan Initiatives to Advance Equity - R.J. Birscone, Aetna, a CVS Health Company</li> <li>• <b>Presentation:</b> Pediatric Health Disparities in the District – Tonya Vidal Kinlow, Children’s National Hospital</li> <li>• Review and discussion of preliminary recommendations</li> </ul>
5/6/2021	<a href="#">Agenda</a> <a href="#">Meeting Notes</a> <a href="#">CareFirst</a> <a href="#">Presentation Slides</a> <a href="#">DC Health</a> <a href="#">Presentation Slides</a>	<ul style="list-style-type: none"> <li>• <b>Presentation:</b> Health Equity and Access to Care in the District – C. Anneta Arno, DC Department of Health</li> <li>• <b>Presentation:</b> CareFirst and BCBSA’s National Health Equity Strategy – Destiny-Simone Ramjohn, CareFirst</li> <li>• Review and discussion of preliminary recommendations</li> </ul>
5/20/2021	<a href="#">Agenda</a> <a href="#">Meeting Notes</a> <a href="#">Presentation Slides</a>	<ul style="list-style-type: none"> <li>• <b>Presentation:</b> The National Committee on Quality Assurance – Amy Maciejowski, Rachel Harrington, and Natalie Mueller at NCQA</li> <li>• Discussion of draft recommendations and comments received</li> </ul>
6/03/2021	<a href="#">Agenda</a> <a href="#">Meeting Notes</a>	<ul style="list-style-type: none"> <li>• Discussion of draft recommendations and comments received</li> </ul>
06/17/2021	<a href="#">Agenda</a> <a href="#">Meeting Notes</a>	<ul style="list-style-type: none"> <li>• Discussion of draft recommendations and comments received</li> </ul>

06/24/2021	<a href="#">Agenda</a> Meeting Notes	<ul style="list-style-type: none"><li>• Discussion of draft recommendations and comments received</li></ul>
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\*Meeting recordings available [here](#).