Social Justice and Health Disparities Working Group
DRAFT 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%—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.

Potential Recommendations:

Carriers:

- **Provide incentives for both primary care and specialist physicians to practice in underserved areas in DC**
- **Support diversity in the medical professions**
  - Provide scholarships for STEM students and medical school students of color in health professional schools in the District.
  - Review their provider networks to determine the race, ethnicity and primary language of their providers to establish a baseline, and develop 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 3 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.

Potential 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 *(pending NCQA's final proposal)***

    - 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 and DISB baseline metrics for data collection, as well as annual goals and progress in meeting such goals.

    - Provide aggregate data by race, ethnicity and primary language to DCHBX and DISB for select diseases and health conditions, in consultation with DCHBX and DISB.

DCHBX:

- **Modify insurance design for DC Health Link standard plans to eliminate cost sharing, including deductibles, co-insurance and co-payment, for diseases and health conditions that disproportionately affect patients of color in the District**

    - For plan year 2023, eliminate cost sharing for services, care and prescriptions for specific conditions. This should apply for medical care, prescription drugs, supplies and related services for [heart disease, cerebrovascular disease, diabetes, mental health, and HIV, as well as cancer of the breast, prostate, colorectal and lung/bronchus.]

    - New insurance design should apply to standard plans in the individual marketplace.

    - DCHBX must also develop new standard plan 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 *(pending NCQA's final proposal)***

    - 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, 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.

Potential 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 in provider contracts cultural competency training tailored to both primary care physicians and medical specialists.
- **Obtain the National Committee for Quality Assurance's (NCQA's) Multicultural Health Care distinction** ***(Pending additional information from NCQA)***
    - 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**
    - Conduct and report to DCHBX and DISB carriers' assessment of their clinical management algorithms for bias and plans for correction, as needed, including timeline and milestones.
    - Prohibit use of race in estimating glomerular filtration rate (GFR) by hospitals, laboratories and other providers in network.