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**

Suggested report language:

Allison Mangiacino (Kaiser) asked for clarification on what was meant by "provide incentives." 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 Bartrum (CareFirst) noted one prior CareFirst initiative to assist incentivize providers was stymied by the need to obtain a Certificate of Need (CON). 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. Dr. Riley also mentioned the importance of carriers ensuring that their networks include providers that practice in underserved areas.

Purvee Kempf (HBX) reminded the Working Group that carriers have supported providers during the pandemic in a number of 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 to Federally Qualified Health Centers (FQHCs) 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.

- **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.

Suggested report language:

Patients of color are more likely to report being treated unfairly and with disrespect by providers because of their race. Studies show that minority patients benefit from having minority providers, who also 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.

Numerous initiatives, sponsored by various public and private entities, have sought to increase the diversity of the medical pipeline over the years. Such efforts often include scholarships, which, as mentioned by Drs. Cara James (GIH) and Pamela Riley (DCHF) ideally are accompanied by mentorship and experiential learning opportunities as part of a structured program. In addition, Yulondra Bartrum (CareFirst) noted that scholarships may have state or local residency requirements and service commitments of certain lengths of time, in order to maximize local investments. Chair Diane Lewis (HBX) emphasized that diverse medical professionals are needed throughout DC and not only in underserved areas. Allison Mangiaracino (Kaiser) noted that Kaiser's health equity scholarship program is funded with community benefit dollars, which may not be possible or desirable for other carriers. Dr. Pam Riley (DCHF) suggested that carriers contribute to existing programs in DC that have a supportive infrastructure and proven track record of success.

  - **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 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**

    - 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/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.**

    - Develop 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.

- 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.

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 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.