About the Association for Community Affiliated Plans

The Association for Community Affiliated Plans (ACAP) is a national trade association which represents not-for-profit Safety Net Health Plans. Collectively, ACAP plans serve more than twenty million enrollees. For more information, visit www.communityplans.net.

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The Role of Medicaid Health Plans in Addressing Racial and Ethnic Health Disparities

Executive Summary

Over the past several years, the evidence base supporting the idea that the U.S. health care system features systemic disparities in insurance coverage, health care access, and health outcomes has grown substantially. Awareness of underlying racial and ethnic health inequities in the United States has grown accordingly. The COVID-19 pandemic has brought these persistent health inequities—and the devastation they have wrought on communities of color—into sharp relief. Data from across the United States show that racial and ethnic minority groups, including Latinx, Blacks, and Pacific Islanders, have experienced significantly higher infection, hospitalization, and mortality rates from COVID-19 than Whites. Past efforts to reduce disparities have taught us that public health agencies and health care providers alone cannot fix this problem. Reducing racial and ethnic disparities require cross-sector partnerships and shared commitment to this important goal from a wide variety of stakeholders.

This report analyzes the factors contributing to the disproportionate impact of COVID-19 on communities of color and focuses on the role of Medicaid health plans in addressing racial and ethnic health disparities. It describes the federal and state policies governing the activities of Medicaid plans in this arena and challenges that plans face in developing actionable programming. It highlights work in five focal areas: data collection and analysis, language and cultural competency, member engagement, provider engagement, and community partnerships to address social determinants of health, where Association for Community Affiliated Plans (ACAP) member plans have acted. Lastly, it provides a case study of one plan that has taken innovative actions to address racial and ethnic health disparities which have shown meaningful impacts.

Introduction

The Centers for Disease Control and Prevention (CDC) defines health disparities as "preventable differences in burden of disease, injury, violence, or opportunities to achieve optimal health that are experienced by socially disadvantaged populations." Stark racial and ethnic health disparities exist in the United States across a wide spectrum of health measures starting from the beginning of life (e.g., preterm birth, maternal mortality) and persisting through adulthood (e.g., diabetes, hypertension). These disparities are entrenched in the fundamental fabric of the health care system from access to providers to insurance coverage. In a CDC report of pregnancy-related deaths between 2007 and 2016, Black and American Indian / Native Alaskan women were found to be two to three times more likely to die from pregnancy-related causes than White women. A study published in JAMA on HIV-infected persons found that Hispanics/Latinx and Blacks were less likely to be aware of their infection, less likely to be retained in care, and less likely to receive antiretroviral treatment than their White counterparts. Using data from 2013 to 2016, the 2020 National Diabetes Statistics Report estimated that Asian Americans had significantly higher rates of diabetes than non-Hispanic White Americans but were almost 50 percent more likely to remain undiagnosed. The CDC has attributed this disparity to the failure of the standard risk assessment tool, body mass index (BMI), to catch Asian Americans for increased risk of Type 2 diabetes.

Statistics like these are soberingly common in the United States across a range of diseases, health outcomes, and health care access. In 2010, Hispanics, Blacks, Asians, American Indians, Native Alaskans, and Pacific Islanders were all significantly more likely to be uninsured than non-Hispanic Whites. Despite improvements in coverage for all racial and ethnic groups due to the Affordable Care Act, sizable coverage disparities remain between most groups of color and Whites.
The COVID-19 pandemic has exacerbated and highlighted the longstanding racial and ethnic disparities in the United States. Data from across the country consistently demonstrate that COVID-19 has disproportionately ravaged racial and ethnic minority communities. The March CDC Morbidity and Mortality Weekly Report tracked COVID-19 hospitalizations in 14 states and found that Blacks made up 33 percent of hospitalized COVID-19 patients, while only representing 18 percent of the surrounding community. In Michigan, Blacks represent only 14 percent of the state’s population but account for 31 percent of overall cases and 40 percent of COVID-19 related deaths by May. At the time of writing, the Navajo Nation has higher COVID-19 infection rates per capita than any state in the U.S. These disparities can be even more striking at the county level. As Dr. Raynald Samoa, National Lead for the Pacific Islander COVID-19 Response Team, testified in Congress, Pacific Islanders in Los Angeles County, California have been dying from COVID-19 at 12 times the rate of Whites in the same district, according to data from Los Angeles County Department of Public Health.

The disparate impact of COVID-19 has been attributed in part to disparities in pre-existing conditions such as obesity, hypertension, diabetes, and heart disease that make individuals more vulnerable to poorer outcomes when infected by COVID-19. Non-Hispanic Blacks are approximately 30 percent more likely to be obese, 40 percent more likely to have hypertension, and 60 percent more likely to have diabetes than non-Hispanic Whites, according to most recent statistics from the National Health Survey. Similarly, Native Hawaiian and Pacific Islanders are approximately 80 percent more likely to be obese, 40 percent more likely to have hypertension, and 250 percent more likely to have diabetes compared with non-Hispanic Whites.

While disparities in underlying chronic diseases represent and result from significant inequities that require national attention in and of themselves, recent data also suggest that differences in preexisting conditions alone cannot fully explain the racial disparities seen in COVID-19 cases and related deaths. According to the Data Center, a nonprofit group monitoring COVID-19 in Louisiana, Blacks make up 49 percent of COVID-19-related fatalities but only 32 percent of Louisiana’s population. Most notably, Blacks make up only 25 percent of Louisiana’s population over the age of 65, the age group with highest rates of preexisting conditions and at highest risk of COVID-19-related death. In contrast, Whites make up 58 percent of the population overall, yet account for just 49 percent of COVID-19-related deaths. The magnitude of the racial disparity is even more apparent when considering 86 percent of COVID-19-related deaths in Louisiana have been in individuals over the age of 60, a subpopulation that is predominantly White.

Multiple analyses show that structural differences related to social determinants of health likely play a significant role in the disproportionate impacts of COVID-19. CDC recommends that businesses implement flexible worksites like telework when possible, but less than 20 percent of Black workers and only 16 percent of Hispanic workers can work from home, according to 2017 and 2018 data from the U.S. Bureau of Labor Statistics. Black and Hispanic workers are also significantly more likely to work in essential industries and customer-facing service jobs. Undocumented workers may be especially vulnerable as they are excluded from receiving federal stimulus checks and are highly likely to lack health insurance. The Kaiser Family Foundation reports that around half of undocumented workers are uninsured. Many racial and ethnic minority families may also be more susceptible to COVID-19 due to living in more densely populated areas and living in multigenerational housing. In 2018, the Pew Research Center reported that nearly 29 percent of Asians (including Pacific Islanders), 27 percent of Hispanics, and 26 percent of Blacks lived in multi-generational housing compared to 16 percent of Whites. A multigenerational household, defined as a household that includes two or more adult generations or grandparents and grandchildren younger than 25, imposes special risks on families with essential workers and limited space, as it makes self-isolation nearly impossible.
The Role of Medicaid in Addressing Racial and Ethnic Disparities

In recent years, federal efforts have sought to reduce and eliminate health disparities. The Affordable Care Act (ACA) set forth several measures at the federal level to help identify disparities among Medicaid and CHIP enrollees. Section 4302(b)(1) of the ACA set standards for Medicaid and CHIP data collection on five demographic characteristics: race, ethnicity, sex, primary language, and disability status. While many states previously collected such data, Section 4302(a) of the ACA—which included a mandate for the Department of Health and Human Services (HHS) to develop data collection standards on these five demographic characteristics—would require the first collection of uniform demographics data comparable across states. Unfortunately, because Congress never appropriated funding, this provision never took effect.

Federal regulations currently do not require states to report on health disparities due to perceived burden, but do “encourage states to use quality-measurement activities to identify and evaluate health disparities, to the extent practicable” according to an HHS report to Congress. ACA specifically requires Medicaid managed care organizations (MCOs) to provide encounter data to states in a manner determined by HHS, with the potential goal to track health disparities. While some states have begun to build incentives for improvement into quality improvement programs, MCOs are seldom required by state regulations to address this area specifically. Managed care plans have formal responsibilities to evaluate and report data on health care quality, typically using HEDIS, CAHPS, or similar measures; however, they are often given latitude in developing quality improvement activities. Outside of federal and state regulatory measures, modest incentives exist for individual plans to collect data on and address racial and ethnic health disparities, such as receiving accreditations or distinctions (e.g., Multicultural Health Care distinction from the National Committee for Quality Assurance). Currently, there are minimal federal and state policies to enforce or sponsor such activities on a plan level.

In 2016, the Centers for Medicare & Medicaid Services issued the Medicaid and CHIP Managed Care Final Rule, which increased attention to racial and ethnic health disparities for states contracting with MCOs for Medicaid and CHIP. Specifically, the final rule requires states contracting with managed care organizations to create and implement written plans that “identify, evaluate, and reduce, to the extent practicable, health disparities based on age, race, ethnicity, sex, primary language, and disability status” as part of efforts to assess and improve the quality of health care and services furnished by these managed care entities; however, states were given significant leeway in developing their own policies and programming.
The Role of Health Plans in Addressing Racial and Ethnic Health Disparities

Approximately 50 percent of nonelderly Medicaid enrollees are members of a racial or ethnic minority, which suggests that racial and ethnic health disparities—particularly as exposed during the COVID-19 pandemic—may have profound impacts on plans’ Medicaid members, warranting plan attention and action. ACAP is a national association of 78 not-for-profit Safety Net Health Plans providing coverage in Medicaid, Medicare, and the Marketplaces to over 20 million individuals. ACAP firmly believes in the importance of reducing racial and ethnic health disparities and is committed to improving health equity in the spirit of its mission to strengthen Safety Net Health Plans in their work to improve the health of low-income individuals and people with significant health needs.

A deficit in disparities data, a lack of organizational framework for addressing racial and ethnicity disparities, potential financial burden, and insufficient personnel for new projects may act as barriers to action.

Many ACAP-member plans have expressed intentions to address racial and ethnic health disparities; however, the lack of significant prior work and established “best practices” in this area has resulted in varied approaches for implementing actionable and effective programming. The ACAP-member plans interviewed for this fact sheet indicated that a deficit in disparities data, a lack of organizational framework for addressing racial and ethnicity disparities, potential financial burden, and insufficient personnel for new projects may act as barriers to action in this arena. Recognizing these logistical and financial challenges, ACAP aims to provide support by helping to develop a framework to address racial and ethnic disparities and sharing examples of successful actions from our plans.

In this fact sheet, ACAP describes five areas in which our member plans have taken steps to address racial and ethnic health disparities. We then take a deeper dive into the innovative work of one plan that has taken extensive action and has made significant progress. We profile the efforts of the following five health plans, which are diverse in terms of geography, ownership, corporate status, size, and composition of covered populations:

- Amida Care, a New York Medicaid special needs health plan that provides comprehensive health coverage and coordinated care to 8,000 people living with HIV/AIDS or other chronic conditions, experiencing homelessness, and/or of transgender experience in New York City.
- CenCal Health, the oldest Medicaid managed care plan of its type in the nation, which serves approximately 180,000 Medicaid-eligible residents in Santa Barbara and San Luis Obispo Counties, California.
- Health Services for Children with Special Needs, Inc. (HSCSN), a Medicaid health plan located in Washington, D.C. and owned by the HSC Health Care System, which serves and empowers families with complex health care needs.
- Texas Children’s Health Plan (TCHP), which was founded by Texas Children’s Hospital as the first health maintenance organization in the United States created solely for children. TCHP now serves approximately 460,000 demographically diverse members across 54 counties in Texas and offers coverage through CHIP, STAR Medicaid, and STAR Kids programs. STAR is a Texas Medicaid managed care program primarily for children, and pregnant women. STAR Kids is a Texas Medicaid managed care program that provides unique medical benefits to individuals under the age of 21 with disabilities.

The examples and case study included in this fact sheet are based on interviews with and documentation from each of these plans.
Data Collection and Analysis

Interviewed plans unanimously agreed on the importance of collecting and analyzing data on race and ethnicity of their beneficiaries, including assessing racial and ethnic differences in utilization or health outcomes to identify disparities and understand how to most effectively target interventions. Plans regularly receive race and ethnicity data from state Medicaid enrollment files, but many note that state reported values are often incomplete and cannot independently provide an accurate picture of enrollees’ race and ethnicity. Plans have expressed concerns about the future stability of enrollment data as some states contemplate cutting Medicaid budgets.

To capture a comprehensive data set on race and ethnicity, Amida Care has supplemented state enrollment data with additional information collected from member surveys, member outreach, or medical management interactions. Amida Care actively tracks the race, ethnicity, birth sex, and gender identification of plan members through enrollment demographics received from the State and enrollee responses to plan surveys. Amida Care’s current member demographic is 55 percent African American and 32 percent Latinx. Amida Care has started stratifying quality data by race and ethnicity to better identify inequities in care and to highlight potential areas of need. Amida Care identified 300 members who tested positive for COVID-19; among them, 66 percent are people of color. Moreover, COVID-19 affected members are likely to be disproportionately and gravely impacted by HIV – 76 percent of Amida Care’s COVID-19 positive members are also HIV positive, requiring greater case management support. Collecting and analyzing member demographic data have permitted Amida Care to escalate support to members during the COVID-19 crisis as they identify and connect affected members with the dedicated support teams who can address specific health needs.

TCHP has supported the efforts of personnel to use health data to identify and address disparities in access and outcomes. TCHP’s team members serve as leaders on the Texas Maternal Mortality and Morbidity Review Committee, which helps to outline and develop solutions for the racial disparities in maternal mortality in Texas. The 2016 Biennial Report from this group analyzed maternal death data from 2011-2012 and reported that Texas maternal mortality for Black women was almost double that of White women, and that sixty percent of maternal deaths occurred more than 42 days after delivery; Texas limits postpartum Medicaid coverage to two months for the overwhelming majority of mothers. TCHP team members went on to serve as leaders for the “Improving Maternal Health in Harris County” project, which developed and advocated for solutions such as improving data collection, creating a campaign to increase public awareness of the need for postpartum support, and adapting Medicaid coverage policy. To reduce the racial disparity in maternal mortality, the local coalition urged lawmakers to extend the Medicaid coverage period offered to new mothers and ease the income verification process for children enrolled in the program so that mothers can receive the postpartum care they need.

Language and Cultural Competency

Many ACAP health plans have taken extensive action to ensure that they are providing linguistically and culturally appropriate services to their plan members, spurred in part by federal and state regulations in the past decade. For example, Section 1557 of the Affordable Care Act requires managed care plans to post taglines in at least the top 15 non-English languages spoken that inform people with limited English proficiency about the availability of translation services. Many states have additional requirements for translated member information. California, for example, requires managed care plans to provide written translations of member information to non-English preferred subpopulations that make up at least 5 percent of eligible enrollees or are highly concentrated geographically (1,000 in a single zip code or 1,500 in two contiguous zip codes).
Plans like CenCal Health and TCHP have gone above and beyond the requirements for providing linguistically and culturally appropriate services. A significant proportion of CenCal Health’s members identify as Hispanic and prefer Spanish as their primary language. Recognizing that having limited English proficiency in the United States can impede access to health care services, CenCal Health has taken steps to ensure culturally and linguistically appropriate assistance and care for their plan members, including developing a bi-cultural and bilingual Member Services Department to assist individuals with accessing health care services. Furthermore, CenCal Health has engaged with and sponsored community-based and nonprofit organizations to improve the health of the Latinx population through events such as health fairs at Latinx community events. During the COVID-19 pandemic, CenCal Health has provided extensive public health messaging to members in their preferred language(s) through popular platforms such as Facebook and a webpage dedicated to COVID-19 news.

TCHP has also engaged in significant efforts to promote culturally-sensitive care and reduce disparities. The plan organized a Cultural Competency Committee to implement National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care. In addition to requiring annual cultural competency training for all staff members, TCHP has mandated an intensive training on this topic for all care coordinators before allowing any interaction with plan members to ensure that all individuals receive culturally-respectful assistance. The organization has also increased efforts to hire employees from local communities to best meet the cultural and linguistic needs of their plan members.

Member Engagement

ACAP-member plans have emphasized the importance of understanding the populations they serve and engaging with members to promote activities that improve health outcomes and lead to healthier communities. Interviewed plans have worked to achieve these goals through programming and policies such as collecting member input on experiences and perceived insufficiencies, providing outreach to individual plan members, and developing targeted programming to address health disparities.

HSCSN hosts monthly community advisory meetings for insights on the challenges that their plan members face. The community advisory discussions help HSCSN, whose enrollees are 90 percent Black and 6 percent Latinx, identify and advocate for the needs of its plan members in the community. During the COVID-19 pandemic, HSCSN sent out a member survey to collect additional feedback on gaps in health care and other services that members were experiencing. Based in part on these results, HSCSN has initiated programming to address the special challenges faced by members during this time. Notably, HSCSN has worked in conjunction with social service agencies and with the broader HSC Health Care System to provide residential care for children whose guardians are ill with COVID-19 and temporarily unable to care for them. A wing of HSC’s subacute hospital has been converted to serve these children while their guardians recover, providing stable interim shelter for vulnerable children.

Amida Care is dedicated to a whole-person-centered care model that assesses the medical, psychosocial, and social determinants of health issues faced by each member. Integrated Care Teams provide outreach, obtain assessments from community case managers or review clinical profiles for each member every six months. These efforts have meaningfully improved the health of plan members; Amida Care helped increase the viral load suppression rate of members living with HIV from 60 percent in 2006 to 80 percent in 2020. Additionally, they have engaged 94 percent of members in regular outpatient care which led to significant reductions in hospital admissions, ER visits, and hospital length of stay.

During the COVID-19 pandemic, Amida Care has escalated efforts to ensure members have the resources they need. In addition to maintaining crucial services, Amida Care developed COVID-19 Escalation and COVID-19 Support teams to assess COVID-19-related needs of plan members and directly connect affected members with Integrated Care Teams who can help members find the services and resources to address their specific needs. In response to the pandemic, Amida Care has also trained its call center staff to inquire about member well-being during
COVID-19 through questions about coping, depression, and social support. Since the beginning of the pandemic, Amida Care’s call center has received a total of over 9,000 calls from its 8,000 plan members. Amida Care also initiated COVID-19 related text messaging with information on topics such as Ways to Stay Safe, COVID-19 benefits, telehealth options, and food resources. Amida Care’s member engagement efforts in the pandemic have successfully helped members access the health care needed. Despite the public crisis, Amida Care has seen consistent prescription fills for their plan members, in contrast with the declines seen nationally.

The racial and ethnic health disparities observed in COVID-19 have spotlighted the need for specific Medicaid programming to address these inequities. CenCal Health has successfully leveraged claims data to identify disparities among care given by providers and worked with community-based provider partners to develop interventions to improve quality of care. For example, prior to the pandemic, CenCal Health identified a significant geographic disparity in HPV vaccination between two of the counties it serves. To address this health disparity, CenCal Health partnered with Santa Barbara Neighborhood Clinics to target members due for their vaccinations with an educational program and successfully increased HPV vaccination rates within several months.

CenCal Health has continued to promote preventative care during the COVID-19 pandemic. Due to fears about contracting COVID-19, patients have drastically delayed getting important preventative care such as vaccinations and well-child checkups. To address this problem, CenCal Health has reached out to members through newsletters, advertisements on radio and TV, and social media. In their commitment to providing equitable care for their Hispanic/Latinx members, CenCal Health provides all member communications in Spanish and through appropriate platforms such as Spanish-language stations like Telemundo. CenCal Health also created a webpage in Spanish dedicated to promoting vaccinations through culturally and linguistically targeted media content. One example is a creative and engaging “Fotonovela” that explains the importance of vaccinations in a telenovela narrative style. Another example is a video on HPV given in Spanish by Dr. Patricia Auchard, who is a bilingual and bicultural Medical Director at CenCal Health.

Provider Engagement

Given the importance of the physician-patient relationship to health care, plans have noted that collaboration with providers is critical for future efforts to address racial and ethnic health disparities. ACAP-member plans have demonstrated a shared commitment with providers to delivering high quality health care for members in need.

Amida Care has held close relationships with providers since its founding by six community-based New York City HIV/AIDS providers in 2003 as a Medicaid special needs health plan uniquely focused on people with HIV/AIDS and other complex health issues. Amida Care’s network providers are in NYC neighborhoods most affected by HIV/AIDS, including in many communities of color. As such, Amida Care and its provider partners have been vital in increasing access to HIV testing, treatment, and prevention in Black and Latinx communities disproportionately affected by HIV. In 2018, the National Black Leadership Commission on AIDS honored Amida Care with the “Choose Life Award” for its leadership in providing quality health care to communities of color impacted by HIV/AIDS and other health disparities. In addition to its full commitment to inclusion and elimination of discrimination in all forms, Amida Care works with provider organizations that prioritize hiring health providers who have high levels of cultural competency.

In response to the COVID-19 pandemic, Amida Care has taken prompt measures to work with providers to ensure members have access to care, medications, and supportive services. Amida Care has provided comprehensive guidance on and coverage for telehealth and telephonic services, allowing providers to deliver remote services with minimal hinderances. Additionally, Amida Care has adjusted requirements for programs such as “Live Your Life Undetectable,” an incentive program to improve viral load suppression among its members. Streamlining the program’s requirements in response to COVID-19 lowers administrative burden, freeing providers to focus on the health and safety of patients and staff.
During the COVID-19 pandemic, plans have increased support for certain types of providers to ensure access to care for members. For example, HSCSN has created a higher differential rate for home care providers visiting a home with COVID-19 positive patients or family members to ensure that patients affected by COVID-19 can still receive the home care services they need and that home care providers are compensated for their increased risk of exposure. HSCSN noted that essential home care workers such as home health aides and nursing assistants are disproportionately racial and ethnic minorities themselves, placing these individuals and their families at greater risk for exposure. HSCSN stressed that addressing disparities in COVID-19 also requires physically and financially protecting these at-risk essential workers.

### Community Partnerships – Social Determinants of Health

Health does not exist in a vacuum – social determinants such as food access, environment, vocation, and housing all have profound impacts on health risks and outcomes. The pandemic has resulted in widespread loss of employment and income, diminished food security, and increased housing instability, and these social impacts of the pandemic are firmly anticipated to exacerbate health outcomes. Recognizing the intrinsic relationship between social determinants and health, most Medicaid health plans have for years partnered with community organizations and local governments to close health gaps through improving social conditions.

HSCSN has long partnered with a variety of organizations to develop an extensive series of supportive programming to address the social needs of their enrollees and caregivers. Together with volunteers and the Department of Parks and Recreation, HSCSN has developed the Youth Athletic Program, which allows children of all abilities to engage in physical activity and learn discipline and teamwork through team sports. During COVID-19, HSCSN has switched to hosting virtual engagement sessions to showcase independent physical exercises and ways to stay healthy during the pandemic. Additionally, HSCSN lends financial support for children to attend summer camps, providing opportunities for children with low incomes to socialize, stay active, and learn during summer vacation. The impacts of such programming may be especially profound given findings from education policy research suggesting that differences in summer activities may be a key contributing factor to disparities in educational achievement.

During the COVID-19 pandemic, HSCSN has worked to make this programming available for their members in a safe manner. HSCSN is helping to enroll children in “Camp-At-Home” and limited in-person full day summer programs hosted by the DC Department of Parks and Recreation in accordance with DC Health Guidance. HSCSN also helps in the arena of economic stability by operating a Young Adult Support Group, hosted at the River Terrace Education Campus, a city-wide school that serves DC public school students with the greatest need. The Support Group aims to help DC youth become successful adults through discussions and workshops on topics such as college planning, employment skills such as resume writing and interviewing, and independent housing.

Beyond programming for enrollees, HSCSN has also developed supportive programming for caregivers. Through partnerships with Advocates for Justice and Education, Georgetown University Center for Child and Human Development, and Georgetown University School of Medicine, HSCSN has developed programs such as the Male Caregivers Advocacy Support Group which provides a weekly safe space for male caregivers to support each other and learn about
Caring for children with special needs. It is also notable that HSCSN has reduced barriers to attending their health and family support programs by offering free transportation for HSCSN enrollees, free childcare, and often free meals or snacks. In the COVID-19 setting, HSCSN is continuing to host these important events, but have adjusted operations to teleconference for public safety. Given HSCSN’s predominantly Black and Latinx enrollee demographics, the actions that HSCSN has taken to address social determinants of health may have a meaningful impact on improving racial and ethnic health disparities in the District.

Amida Care’s whole person model of care is developed on the understanding that social determinants such as housing instability, food insecurity, poverty, and racism are all closely linked to health outcomes. Moreover, Amida Care recognizes that communities of color face the greatest health disparities because institutional racism has created social, economic, and educational inequalities. As a plan serving those placed at elevated risk for HIV, including those in Black and Latinx communities, Amida Care has taken great lengths to close health gaps through addressing social determinants of health. Amida Care collaborates with several organizations such as Community Access, Project Renewal, ACMH- Beacon of Hope, Bronxworks, and Iris House to help members access housing. Amida Care’s HOME program aids with housing applications, transport to emergency housing, support for those at risk of losing housing, and other aspects of attaining housing. Since the program initiation in 2016, HOME has helped provide housing referrals for over 200 members and stably house over 50 members. Amida Care has also pioneered job training and employment programs to help members gain livable wage employment. In partnership with The Alliance for Positive Change and Housing Works, Amida Care has helped train over 90 members and provide job placements for 38 members at community-based organizations. Through the New York City Innovator Employment Project, Amida Care has helped 35 Medicaid beneficiaries living with HIV acquire employment in health navigation and outreach. In total, more than 600 members have obtained work experience through an Amida Care-sponsored program.

In the COVID-19 pandemic, Amida Care has provided virtual programming to help address social determinants of health. Amida Care’s Live Your Life wellness program has held virtual meditation, fitness, and healthy cooking events to help members develop healthier lifestyles. In addition, Amida Care has developed virtual wellness events such as weekly movie nights to help with isolation and coping during lockdown. Recognizing the importance of nutrition on health outcomes, Amida Care has partnered with God’s Love We Deliver to launch a pilot program offering medically tailored meals to members with HIV and other complex conditions. Under this program, individuals will be able to get meals tailored to their medical needs, prepared, and delivered to their homes. A Registered Dietician Nutritionist will assess the medical diagnoses, allergies, and medications for each member to design meals that will ensure the best health outcomes.

CenCal Health has partnered with community organizations to develop novel programming that aims to address social determinants of health. A compelling example is the Recuperative Care Program that CenCal has developed in partnership with multiple local organizations including Dignity Health, Tenet Healthcare, Community Action Partnership of San Luis Obispo, Good Samaritan Shelter, CottageHealth, and People Assisting the Homeless. The Recuperative Care Program seeks to provide safe recuperative care for homeless individuals in San Luis Obispo County and Santa Barbara County who are too frail to recover from their illness or injury on the streets but are not sick enough to require hospitalization. This program provides supervised shelter with access to necessities such as meals, clothing, and showers as well as case management and medical support. The Recuperative Care Program also coordinates with social and supportive services to help individuals get the resources they need to transition to safe, self-sufficient living. Results from the pilot program found that early hospital re-admission or death rates dropped by 50 percent and overall costs to the health care system decreased due to avoidance of preventable re-admissions or hospital stays.
Case Study: AmeriHealth Caritas

The AmeriHealth Caritas Family of Companies serves about 5 million people across 13 states and the District of Columbia. Each health plan within the AmeriHealth Caritas Family of Companies has taken specific and innovative actions to reduce health disparities; seven have earned the Multicultural Health Care (MHC) Distinction awarded by the National Committee for Quality Assurance (NCQA) for monitoring and improving culturally and linguistically appropriate services and reducing health care disparities. This case study highlights some of the programming and policies to address racial and ethnic disparities implemented by AmeriHealth Caritas District of Columbia (DC), a plan that has earned the NCQA MHC distinction.

AmeriHealth Caritas DC serves approximately 124,000 individuals in the District of Columbia, providing services through the DC Healthy Families Medicaid and the DC Healthcare Alliance programs. The DC Healthcare Alliance fills a unique need by providing medical coverage to low-income District residents who are not eligible for Medicare or Medicaid and who have no other form of health insurance. This group includes undocumented individuals, a group largely made up of racial and ethnic minority immigrants who are vulnerable to the impacts of the COVID-19 pandemic. Undocumented individuals are disproportionately employed in jobs that carry a high risk of infection, are prohibited from benefiting from COVID-19 relief enacted by Congress, and may be less likely to protest unsafe work conditions or seek out medical attention because of deportation concerns. By participating in the provision of comprehensive health coverage through the DC Healthcare Alliance, AmeriHealth Caritas DC provides vital help to a disproportionately at-risk subpopulation with limited resources.

Many Medicaid health plans face substantial challenges collecting accurate enrollee demographic data. AmeriHealth Caritas has implemented uniform approaches across its health plans to collect race, ethnicity, and language (REL) data to tailor enrollee engagement and care to the needs of its members. AmeriHealth Caritas DC does so by supplementing the enrollment data provided by the District with information gathered through member assessments and medical management interactions. AmeriHealth Caritas DC disaggregates performance measures such as Healthcare Effectiveness Data and Information Set (HEDIS) results as well as claims data by these demographic identifiers, reports this information to the District as part of quality improvement efforts, and shares it with key stakeholders, including the City Council and DCHealth. However, AmeriHealth Caritas DC notes that its primary motivation to collect REL data comes from its understanding that healthy behaviors and outcomes are indelibly impacted by the broader social determinants of health, including REL, and that effective policies and programming to improve health outcomes must take these factors into consideration.

AmeriHealth Caritas DC has been involved in several innovative programs to address racial and ethnic disparities. "Wellness Circles," for instance, comprise six- to eight-session programs designed to increase participant health literacy and improve disease control, particularly in racial and ethnic minority communities that have historically experienced poorer health outcomes. More than 600 AmeriHealth Caritas DC members with diabetes or hypertension have participated in Metabolic Wellness Circles and the majority have achieved measurable improvements in health. Sixty-one percent of participants reduced their HbA1c levels, 55 percent of participants lowered their blood pressure, 55 percent of participants reduced BMI levels, and 51 percent of participants reduced waistline measures. Even more impressive, longitudinal data indicate that the Wellness Circles have helped create long-term improvements in health for participants.

AmeriHealth Caritas DC credits the successes of its health disparities programs in part to identifying and engaging appropriate community partners. To build trust among racial and ethnic minority communities for medical professionals and the health care system in general, AmeriHealth Caritas DC has enlisted credible community leaders, such as a local radio host and local ministers who open their churches as locations for Wellness Circles. The Wellness Circles are also made possible by partnerships with community organizations that share similar missions in addressing health disparities, such as Summit Health Institute for Research and Education, a group with a founding mission to eliminate health disparities and aid Black Americans and other Black, Indigenous, and people of color (BIPOC), as well as La Clinica de Pueblo, a community health center that helps teach Wellness Circles in Spanish. Additionally, AmeriHealth Caritas DC holds Wellness Circles in trusted community spaces, such as local churches or community centers so that plan members
can find a Wellness Circle in a location that is familiar and convenient.

AmeriHealth Caritas DC has taken actions to both monitor and address racial and ethnic disparities specific to COVID-19. First, it has leveraged the comprehensive COVID-19 data collected by the District to identify disparities in infection rates and outcomes as well as member-level population health data. For example, both Black and Latinx subpopulations have approximately double the percentages of COVID-19 infections compared with what one would expect based on the ethnic and racial composition of the D.C. populace.

AmeriHealth Caritas DC also prioritized care management activities to at-risk individuals for COVID-19 severity. These activities were developed with member input from the plan’s Member and Youth Wellness Advisory Councils. AmeriHealth Caritas DC has, for its highest-risk plan members or those who need to be in quarantine, made deliveries that have included meals, medications, and personal protective equipment kits. Focusing on its “whole-person” care model and recognizing the negative impacts of fear and anxiety about COVID-19 on well-being — particularly in communities of color ravaged by the pandemic — AmeriHealth Caritas DC has also increased mental and behavioral health support and outreach. Bilingual associates in the plan have reached out to members whose first language is not English to provide or arrange for these individuals to have the translation and interpretation services necessary during the pandemic.

As the racial and ethnic disparities in the COVID-19 pandemic become more evident, AmeriHealth Caritas stresses the importance of collecting and analyzing health disparities data and the need for the development of a suitable data collection framework. Moving forward, AmeriHealth Caritas plans to implement longitudinal support by continuing the programming initiated during this pandemic for its plan members, as AmeriHealth Caritas recognizes that the COVID-19 pandemic will likely have lingering impacts on the health and well-being of individuals even after the disease outbreak subsides.

Conclusion

COVID-19 has affected the lives of every individual in the United States, but the pandemic has disproportionately ravaged racial and ethnic minority communities. As Blacks, Latinx, and other minorities make up a large proportion of Medicaid enrollees, it is essential for us to recognize and support efforts to eliminate disparities and protect the health of these populations. The experiences of the ACAP Safety Net Health Plans highlighted in this fact sheet suggest that progress is underway in the five identified focal areas for addressing racial and ethnic health disparities, but also that more work needs to be done.

The pandemic has disproportionately ravaged racial and ethnic minority communities... it is essential for us to recognize and support efforts to eliminate disparities and protect the health of these populations.
In summary, Medicaid plans can undertake the following effective initiatives to address racial and ethnic health disparities and support communities disproportionately impacted by COVID-19:

Data Collection & Analysis

- Improve demographic data quality through supplementation of state enrollment data with information from plan-specific surveys or medical data.
- Disaggregate performance measures, claims data, and other data by demographic identifiers to identify possible disparities within the member population.
- Analyze disparities to determine potential contributing factors.
- Share data with providers to encourage provider-level action to improve disparities.

Language & Cultural Competency

- Identify and utilize preferred languages for communications with plan members.
- Promote cultural competency within the organization through trainings and directives.
- Recognize the multiculturalism within member populations and strive to provide a reflective member support service.

Member Engagement

- Provide targeted outreach, through field work, websites, and culturally-sensitive methods, to spread critical health information in underserved racial and ethnic minority communities.
- Listen to member feedback on special health challenges and needs during COVID-19.
- Develop programs to address identified disparities within member population.

Provider Engagement

- Increase awareness of existing health disparities as well as social and economic conditions that may increase risk of acquiring COVID-19.
- Promote more culturally and linguistically diverse provider networks.
- Utilize differential rates, when appropriate, to ensure care for COVID-19 affected patients.

Community Partnerships – Social Determinants of Health

- Build quality relationships with trusted local and community organizations.
- Collaborate with social service groups and community-based organizations to improve social, physical, and economic environments.

While the work to address racial and ethnic disparities may, for some Medicaid plans, still be in its infancy, it is important to recognize and remove barriers to this work, including federal and state priorities and lack of regulatory incentives, financial constraints, and operational concerns. Increasingly, Medicaid plans have expressed a commitment to changing the precedent and engaging in actions to make positive advancements in this high-need area.
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