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Massachusetts Medicaid Managed Care Organizations Address Racial and Ethnic Health Disparities and Take Action to Advance Health Equity

The COVID-19 pandemic has brought to the forefront the long-standing racial and ethnic disparities that exist in health care. Over the past year, we have witnessed the harm that inequities have caused to communities of color and vulnerable populations, not only in Massachusetts but also across the country. Data from across the U.S. has shown that racial and ethnic minority groups such as Latinx, Blacks, and indigenous communities have been infected, hospitalized, and died from COVID-19 at much higher rates than Whites have.

In Massachusetts, Hispanic and Black residents, respectively, are about 4.3 and 2.7 times more likely than Whites to be infected with COVID-19, and 1.7 and 2.3 times more likely to be hospitalized from the virus. As of June 30, 2020, Hispanic and Black residents, respectively, had 1.6 and 2.1 times higher age-adjusted COVID-19 mortality rates than white residents.[1]

Health disparities refer to differences in health and health care, such as a higher burden of illness, injury, disability, or mortality experienced by one group relative to another, driven by social and economic inequities.

Health inequities cause health disparities. They are the structural or institutional patterns that ultimately result in health disparities.

The disparate impact of COVID-19 has been attributed in part to disparities in preexisting conditions such as hypertension, diabetes, heart disease, and obesity that make individuals more vulnerable to poorer outcomes when they are infected. As noted in the National Health Survey, non-Hispanic Blacks are 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.[2] But studies are showing that structural differences that relate to social determinants of health have also played a key role in the disproportionate impacts of COVID-19 in communities of color and vulnerable populations. For example, many racial and ethnic minority families live in more densely populated areas and in multigenerational housing, which has made them more susceptible to COVID-19 infections. 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 multigenerational housing, compared to 16 percent of Whites.[3]

Massachusetts Medicaid Health Plans' Commitment to Health Equity

The plans that participate in the state's Medicaid program enroll MassHealth members in accountable care partnership plan organizations (ACOs) and managed care organizations (MCOs). These organizations serve an important role in addressing the health inequities that impact many of their members. Out of the MassHealth enrollees who report race/ethnicity, 40 percent identify as other than White, and 16.8 percent speak a language other than English.[4] MCOs have demonstrated a long-standing commitment to serving these diverse populations; managing the physical, social, and emotional needs of their members; and addressing racial and ethnic health disparities. Below are some examples of successful actions taken by MCOs with their ACO partners to advance health equity.

Actions Massachusetts Medicaid MCOs Are Taking to Address Racial and Ethnic Disparities and to Advance Health Equity

DATA COLLECTION AND ANALYSIS

MCOs recognize the importance of collecting and analyzing data on the race, ethnicity, and language (REL) of their members and of assessing racial and ethnic differences in utilization or health outcomes. This is the first step in identifying disparities and effectively targeting interventions that are culturally and linguistically appropriate and help families connect with social services. MCOs receive initial REL data from MassHealth's enrollment files. As this information is not always complete, some of the MCOs supplement it with additional information they collect directly from members through initial member outreach, welcome calls, member survey responses, health assessments, and care management interactions they have with members.

Some MCOs stratify quality data by race and ethnicity to help identify health disparities in care and potential areas of improvement. For example:

- **AllWays Health Partners** selects large population-based metrics for cancer and diabetes screenings and stratifies results by race, ethnicity, age, and gender to identify disparities and to develop potential improvement activities. Improvement projects include sending gap-in-care reminders through text messaging campaigns in Spanish to Latinx members identified with these chronic conditions and reminding them of diabetes eye exams and cancer screenings. The text messages include hyperlinks to direct members to websites with educational materials to help them control their conditions. Also, health coaches review responses received from members through these campaigns and refer them to appropriate care management services. They are in the process of implementing a pilot remote monitoring program for Latino and Black members with hypertension and diabetes to help them manage these conditions at home.
- **BMC HealthNet Plan** reviews data related to care management outcomes and analyzes subpopulations through a health equity lens focused on race and ethnicity to ensure there is equitable impact on the patients served through care management.
- **Fallon Health** convened a Health Equity Committee that is focused on addressing disparities among its members by identifying and prioritizing current barriers. One of the areas of focus will be utilizing available REL data to support their goal of making the delivery of high-quality health care more equitable for all their members.
- **Tufts Health Plan** tries to collect members' REL data when they first sign up with the plan. Their Member Services representatives collect REL data during their welcome calls with members. To better understand and serve them, they ask about their preferred language and ethnic background. In addition, they collect social determinants of health and sexual orientation and gender identity data. This data is used to identify health disparities and to support efforts to address bias in data analytics, regulatory requirements, and quality programs. Using available data, Tufts Health Plan expands services and benefits based on cultural and linguistic needs.

LANGUAGE AND CULTURAL COMPETENCY

MCOs understand that they represent a very diverse membership, and they have taken extensive action to provide linguistically and culturally appropriate services to their members. To address barriers to care, they collect data on preferred language and cultural considerations that may impact their members' health care decisions. All the MCOs' member services departments are staffed with bilingual and multicultural representatives and have access to translation services that provide members with real-time translation support and websites in multiple languages.

Member communications materials are prepared in a culturally and linguistically appropriate manner and are available in Spanish and on demand for many other languages. Below are examples of additional actions some health plans take to provide language and cultural competency:

- **Health New England** engages their ACO partners in the review of communications materials to ensure the content aligns with the needs of the communities they serve. They have hired interpreters and racially diverse health center staff to work at the health centers that are part of their *BeHealthy Partnership ACO* to provide a cultural understanding of the diverse populations they serve.

- **Tufts Health Plan** invested in *ConsejoSano*, a leading digital short message service (SMS) solution to engage culturally diverse populations in navigating their health care coverage and benefits. The services have been implemented across public programs to increase member engagement by using multicultural SMS text technology. By meeting members where they are in their cultural preferences, Tufts Health Plan is able to build trust with members by using ConsejoSano's white-label approach to identify additional health equity needs that can be addressed through care coordination teams.

MEMBER ENGAGEMENT

MCOs place a strong focus on understanding the populations they serve and engaging with them to promote activities that improve their health outcomes and result in healthier communities. They take concrete actions to understand their diverse members and engage them in their health outcomes. Member engagement activities include patient family advisory councils, outreach by integrated care teams, and patient education programs focused on addressing health disparities.

Patient and Family Advisory Council meetings allow a diverse group of patients and family members to regularly meet to advise their providers about challenges they face, identify gaps in services, and recommend ways to close these gaps. The MCOs and their ACO partners host patient and family advisory council monthly meetings that provide a forum for members and their families to share ideas and make recommendations on ways to improve member experience and access to care. The meetings provide an opportunity to collect feedback from members on support and services important to the delivery of person-centered quality care and to make plans to communicate upcoming changes to their programs. For example, during the pandemic, **Health New England** used their culturally and linguistically diverse advisory council meetings to hear about members' concerns about COVID-19 vaccines and to offer educational information on vaccines.

Integrated Care Teams provide outreach to members and engage them in care management that provides targeted and intensive support to help them access mental health care, addiction treatment, and chronic disease management care, often involving daily communication with members. The MCOs hire care management staff with diverse backgrounds and experiences shared with their members. This supports member engagement and helps inform program initiatives that meet the specific needs of the populations they serve.

During the COVID-19 pandemic, the MCOs escalated efforts to ensure members had the resources they needed. Understanding that many of their members stopped seeing their health care providers out of fear of contracting the virus, **BMC HealthNet Plan** identified high-risk members and scheduled virtual, comprehensive health assessments. The initiative identified barriers to care and allowed their staff to make referrals for care management, conduct medication reconciliations, and apprise the respective health care providers of the efforts and outcomes.

Patient Education Programs increase knowledge of access to care and treatment decisions, and MCOs have targeted education at members in communities of color. They maintain close relationships with the communities they serve. **BMC HealthNet Plan** community outreach staff attend community cultural events throughout Massachusetts to work with locally based community organizations and provider groups to educate members on health issues. Some of the cultural events include the Haitian Housing Fair, the Quincy Asian Resources Community Banquet, the Dudley Street Neighborhood Initiative Multicultural Festival, Whittier Community Health Center Haitian Heritage and Hispanic Heritage events, and Codman Square block parties.

During the pandemic, the MCOs focused on educating their members on COVID-19 prevention, testing, and vaccination efforts. In addition to reaching out to members through newsletters and social media, **Health New England** promoted town halls and webinars that were multicultural and multilingual, and **BMC HealthNet Plan** staff created a Q&A document specifically focused on addressing COVID-19 vaccine hesitancy among people of color.

Also, MCOs have implemented specific programs to engage members in health care related issues such as maternal mortality, diabetes, and mental health that have revealed disparities. Examples include:

- **AllWays Health Partners** developed interventions to raise awareness among Latino, Black, and African American members of the importance of taking medications and seeing a licensed mental health counselor. They communicate with members through text messages, available in Spanish, to encourage health and wellness in key clinical focus areas, such as asthma and diabetes. They hold community wide health fairs, where diabetes care managers provide diabetes education to members in the community to teach them how to manage their condition and to promote healthy eating habits.
- **Health New England** has instituted the "Women's Health Network," a community health worker model program for breast and cervical cancer screening and navigation, which targets low-income African American, Latina, and Muslim women, and they will be instituting a specific high-risk maternity program that will focus on addressing disparities in maternal morbidity.
- **Tufts Health Plan** created a doula program for expecting at-risk mothers to offer their members support leading up to, during, and after birth. The doulas help with vital nonmedical needs crucial to the health of infants, like family education, household organization, and general support. The impact of doula support improves birth outcomes and maternal health, while providing additional opportunities for member outreach and support on social needs and other health challenges.

PROVIDER ENGAGEMENT

MCOs believe that collaboration with providers is critical to helping them address racial and ethnic health disparities, and they share a commitment to work with their ACO provider partners to deliver high-quality health care for members in need.

- **AllWays Health Partners** works collaboratively with their ACO primary care providers, behavioral health community partners, and Lawrence General Hospital on a joint multi visit patient initiative to address patients with high emergency room and hospital utilization. The program aims to understand and address a patient's unique social determinants of health, which often drive utilization. There are systems in place to ensure that follow-up care is arranged, social needs such as food insecurity are addressed, and referrals to community-based organizations are followed up on. This is done through regularly scheduled multidisciplinary meetings, where care pathways are determined and documented for each patient and added to electronic medical records as appropriate. Additionally, care managers are assigned to ensure accountability for follow-up on members' needs.
- **BMC HealthNet Plan** holds interdisciplinary care team meetings with providers at many of their complex care management sites. Integrated behavioral health teams and primary care providers meet to discuss specific plans of care for patients in complex care management programs. They work together to address the patients' needs and to improve their engagement in care. The ACO strategy team regularly presents progress on ACO quality metrics and works with the clinic sites in strategies to address gaps in quality metrics. Complex care management staff support outreach for patients who have quality gaps in order to facilitate their engagement with providers.
- **Fallon Health** works with their ACO partner *(Berkshire Fallon Health Collaborative)* to address substance use disorder in the populations they serve. They leverage data to identify effective care models and develop care coordination strategies.
- **Health New England's** ACO *Be Healthy Partnership* is led by committees that have provider and health plan representation. They routinely meet with provider leaders to share data and formulate strategies for care. They have delegated care management to the health centers where their staff are integrated with providers. Also, they have offered *Healing Racism and Cultural Humility* training to leaders and clinical staff to create shared language and knowledge of racial health inequities.
- **Tufts Health Plan** engages with community health centers and has recently collaborated with the Bowdoin Street Health Center, the Martha Elliot Health Center, and the Cambridge Health Alliance to offer food vouchers for patients, support mobile markets and community events such as back-to-school and holiday donations, offer cooking demonstrations, and provide doula referrals to their members.

SOCIAL DETERMINANTS OF HEALTH – Building Strong Community Partnerships

MCOs recognize the intrinsic connection between social determinants and health and have established partnerships with community-based organizations (CBOs) to address social needs such as food access, employment, and housing, which have a profound impact on the health and well-being of their members.

Food Access Programs:

- **AllWays Health Partners** has partnered with Community Servings, an organization that delivers medically tailored, nutritious meals to chronically ill members with complex conditions. In 2020, during the height of the pandemic, they expanded this partnership to support members who fall into high-risk categories for COVID-19, including those who tested positive or were under quarantine, at no cost to members.
- **BMC HealthNet Plan** partnered with two Massachusetts-based CBOs and implemented a flex services program to provide food and nutrition support to ACO patients. This includes food delivery, financial assistance to supplement what members receive from the Supplemental Nutrition Assistance Program, education on diet and nutrition, and culturally appropriate food options.
- **Fallon Health** has facilitated partnerships with statewide and regional organizations focused on food security and works jointly with their ACO partners to develop programs that address food access issues among the populations they serve.
- **Health New England**, in partnership with Revitalize Community Development Corporation, will be launching a flexible services program called Food & Nutrition Rx Delivery, which aims to provide members who have diabetes and gestational diabetes with an intensive 10-week food delivery and nutrition support program.
- **Tufts Health Plan** partnered with Good Measures, a company that combines the expertise of a registered dietitian with a digital platform to help individuals make positive changes in eating and exercise behavior. It provides culturally tailored meal libraries and multilingual access. In addition, they offer food voucher programs at many local food pantries.

Housing Programs:

- **AllWays Health Partners** has partnered with HomeStart — an organization that helps with eviction prevention, assistance finding permanent housing, and stabilization — and with Women's Lunch Place, a day shelter community that provides nutritious food and individualized services for women who are experiencing homelessness or poverty.
- **BMC HealthNet Plan** has partnered with two housing authorities to prioritize access to housing for their most clinically vulnerable members and to advocate at the state and city levels for policies that address homelessness. Additionally, they provide housing navigation support to help members who have Section 8 vouchers access units, and they provide legal advocacy and navigation for those that are at risk for eviction.
- **Fallon Health** is working actively with its ACO partners and regional housing agencies in Pittsfield, Lowell, and Worcester to launch innovative programs using available flexible dollars that contribute to housing stability.
- **Health New England** has partnered with the Mental Health Association to offer their complex behavioral health members housing navigation and placement services to help find stable, permanent housing for these patients.
- **Tufts Health Plan** developed a pilot program to address housing needs for members, using a tiered approach designed to triage housing needs with the appropriate community or housing resource. This effort in collaboration with care management and care coordination teams is intended to prioritize housing needs for those at the highest risk and to help develop a formal referral process for all members.

Other Programs

- **Health New England** developed the *BeHealthy Medical-Legal Partnership* with Community Legal Aid, through which an attorney augments their health center care teams and provides legal assistance and representation in housing and domestic violence cases.
- **Tufts Health Plan** has a partnership with Union Capital Boston (UCB), an organization whose mission is to transform social capital into opportunity by rewarding community engagement, and with Bowdoin Street Health Center to encourage patients to join UCB's platform so they are able to engage in their communities to drive change and to learn about resources and programs available to them.

COVID-19 PROGRAMS

In the wake of the COVID-19 pandemic, the MCOs recognized their role in addressing the inequities and quickly implemented programs to address COVID-19-related disparities, with a focus on mitigation, testing, and vaccination efforts.

To mitigate the spread of the coronavirus, the MCOs conducted routine symptom screenings for members in care management programs. They worked with their ACO partners to locate at-risk patients, conducted culturally and linguistically sensitive needs assessments, and delivered on those needs by providing supplies to members and linkages to pharmacy delivery services.

The MCOs promoted the Center for Disease Control and Prevention's "Stop the Spread" campaign and participated in initiatives to increase access to COVID-19 testing for traditionally underserved populations, working with community partners to make testing highly accessible to their members.

To increase access to vaccinations, the MCOs have implemented campaigns that include targeted outreach for vaccine education in multiple languages and scheduling in the communities most impacted by COVID-19. They have partnered with their ACOs and have engaged their workforce and faith and community leaders from multiple cultural backgrounds to educate their members on the safety and efficacy of COVID-19 vaccines. Through phone calls, texts, social media platforms, and messages on Latino radio stations, they have communicated with members in English and Spanish to provide education, assistance with appointment scheduling, and coordination of transportation for members to and from vaccine appointments. Some of the MCOs also stood up mobile vaccination clinics in "hot spot" communities, where the vaccines were made available to vulnerable members, and they provided visits to homebound members.

MAHP'S ACTIONS TO PROMOTE HEALTH EQUITY AND INCLUSION

At the end of 2020, the Massachusetts Association of Health Plans (MAHP) announced two important initiatives to help combat social and racial disparities that persist in the delivery of health care services and within the health care workforce.

The first initiative authorizes MAHP to sponsor a broad-based research study to identify how access to telehealth services during the COVID-19 pandemic has differed based on race, ethnicity, and socioeconomic factors and how the health care sector can work together to eliminate identified barriers to equitable access. The second initiative supports employment opportunities for low-income communities and communities of color in health care through a workforce development compact. Both initiatives were based on recommendations from a MAHP subcommittee that was formed to examine how MAHP member health plans could address health care related disparities and broader social inequities.

TELEHEALTH RESEARCH STUDY

The 18-month telehealth study, led by researchers from the Department of Population Medicine at the Harvard Pilgrim Health Care Institute, aims to be the most timely and comprehensive evaluation of potential socioeconomic, racial, and ethnic disparities in telehealth usage in Massachusetts to date since the onset of the COVID-19 pandemic. The study will combine analyses of health care claims data from Medicaid, Commercial and Medicare members with qualitative interviews with members, providers, and health officials in communities with disproportionately low rates of telemedicine use. This study will build upon recent work led by the Massachusetts Attorney General's Office by looking expansively at access and use rates and identifying actionable implementation steps across the health care sector.

A preliminary report, scheduled to be released in September, will measure telehealth usage rates before and since the COVID-19 pandemic and will examine differences by insurance, socioeconomic status, race, and ethnicity. The preliminary report will also review activities that health plans have taken to enable access to telehealth services and will outline ways to improve the robustness of demographic data in the health plan setting. The final report, tentatively scheduled to be released in July 2022, will measure interval changes in telehealth usage rates and equity, identify communities with low rates of digital access and telehealth usage rates, and outline actionable steps to promote and sustain health equity.

WORKPLACE EQUITY AND INCLUSION

MAHP member plans, including our MCOs, are committed to increasing diverse representation among their leaders and workforce, educating them on health equity and racial justice, and taking steps to diversify and educate their leaders and their entire workforce. They have signed the MAHP Compact for Diversity and Inclusion in Health Care Workforce Development, committing to promoting a culture of diversity and inclusion across their organizations, supporting workforce diversity in health professions through creation of a pipeline to employment, and developing and increasing opportunities for diverse candidates through targeted entry-level health care jobs.

Below are some examples of workforce equity and inclusion efforts that have been implemented at each of the MCOs:

- **AllWays Health Partners** — Provide systemwide anti-racism training, *United Against Racism*, for leaders. Also participating in the Department of Transitional Assistance Health Care Training Internship program, where diverse candidates gain professional/employment skills in health care to help create a pipeline for employment opportunities.
- **BMC HealthNet Plan** — Provide cultural competence training for all staff. The plan also has a Diversity, Equity, and Inclusion Committee that focuses on increasing employee awareness and support for other cultures, languages, and abilities. In addition, complex care management staff host monthly training programs for staff on social determinants of health, such as criminal justice, housing, food security, mental health services, and addiction treatment.
- **Fallon Health** — Employees receive education and training in implicit biases and social and structural determinants of health, and they are encouraged to participate in forums on health equity.
- **Health New England** — Provide *Healing Racism and Cultural Humility* training to leaders and clinical staff to create shared language and knowledge of racial health inequities. They offer a series, *Leading with Dignity*, as well as *Think Again*, a training that supports individuals, organizations, and communities to enact social justice principles in their life and works to enhance skills to support trans people in the community.
- **Tufts Health Plan** — To increase representation of people of color (POC), they created a diverse slate policy, which requires the inclusion of POC in the hiring process for all positions of manager and above. They also offer cultural competence courses and anti-racism training to all their employees.

Conclusion

COVID-19 has affected everyone in the Commonwealth, but it has disproportionately impacted racial and ethnic minority communities, who make up a large number of Medicaid members in Massachusetts. Our MCOs are undertaking effective initiatives to address the existing health disparities, support the communities impacted, and protect the health of these populations. They are focusing on data collection and analysis to help identify the disparities, using preferred languages for communicating with members, and promoting cultural competency within their organizations through training. Through targeted outreach and culturally sensitive approaches, they are communicating with members and engaging providers in this effort. They continue to build quality relationships with trusted local and community-based organizations to improve social determinants of health. The MCOs are committed to engaging in actions to create a more equitable society and health care system for the members and the communities they serve throughout the Commonwealth.

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Footnotes

1. Massachusetts Office of the Attorney General, Building Toward Racial Justice and Equity in Health: A Call to Action (Boston, Massachusetts, Nov. 2020), https://www.mass.gov/doc/building-toward-racial-justice-and-equity-in-health-a-call-to-action/download

2. U.S. Department of Health and Human Services Office of Minority Health, Heart Disease and African Americans, www.minorityhealth.hhs.gov/omh/browse.aspx?lvl=4&lvlid=19/

3. Cohn, D'Vera, and Jeffrey S. Passel, Record 64 Million Americans Live in Multigenerational Households, Pew Research Center, July 27, 2020, www.pewresearch.org/fact-tank/2018/04/05/a-record-64-million-americans-live-in-multigenerational-households/

4. Blue Cross Blue Shield Foundation Massachusetts, Massachusetts Medicaid Policy Institute, Manatt Health, Health Care for All, Faces of MassHealth: Chart Pack https://www.bluecrossmafoundation.org/sites/g/files/csphws2101/files/2020-09/BCBSF_FacesofMassHealth_ChartPack_Final.pdf