ACAP
Association for Community Affiliated Plans

ACAP Pathway to Improve Health Equity

JUNE 2022

About the Association for Community Affiliated Plans

The Association for Community Affiliated Plans (ACAP) is a national trade association which represents 74 not-for-profit Safety Net Health Plans. Collectively, ACAP plans serve more than twenty million enrollees. For more information, visit communityplans.net.

Acknowledgements

ACAP gratefully acknowledges the work of Alicia Turner of North Compass Solutions for her significant contributions to this report's structure and content.

Design & Layout by Winking Fish

Contents

I. Introduction

The Importance of Focusing on Equity

Health care is not an equitable experience in the United States today. Despite efforts to reduce health disparities, differences remain in health outcomes when comparing across race, ethnicity, socioeconomic status, gender identity, sexual orientation, disability, and other factors. The U.S. Centers for Disease Control and Prevention (CDC) define health equity as a state where every person is able to "attain his or her full health potential" and no one is "disadvantaged from achieving this potential because of social position or other socially determined circumstances."[1] There must also be a "process of reducing health disparities and their determinants."[2]

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).[3] In a CDC report of pregnancy-related deaths between 2007 and 2016, Black, American Indian, and Native Alaskan women were found to be two to three times more likely to die from pregnancy-related causes than White women.[4] 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.[5,6]

LGBT status is associated with increased risk for and earlier onset of multiple comorbidities, such as asthma, allergies, osteoarthritis, and gastrointestinal disease.[7,8,9] Studies have found that LGBTQI+ individuals are 2.5 times more likely to experience depression, anxiety, or substance use disorder than non-LGBTQI individuals. These communities also report higher rates of alcohol and tobacco use.[10, 11, 12, 13] These disparities are entrenched in fundamental inequities of the health care system from access to providers to insurance coverage.[14]

People who live with disabilities also experience significant disparities with respect to health access and outcomes. Data from the CDC show that people who live with disabilities are less likely to receive routine preventive care; are more likely to smoke; and experience adverse health outcomes such as elevated blood pressure, obesity, and depression at a higher rate.

There is no silver bullet to fix health disparities, no one weird trick. Achieving equity requires the investigation of the diversity of experiences and outcomes of individuals and crafting solutions that incorporate an understanding of that diversity. The Association for Community Affiliated Plans (ACAP) understands that the pathway to achieving health equity for all individuals is a journey that will require tremendous effort, creativity, and flexibility as health plans learn more and refine their interventions over time in an effort to improve outcomes.

Safety Net Health Plans: A History of Working Toward Equity

ACAP is a national trade association representing 74 not-for-profit Safety Net Health Plans, which collectively provide health coverage to more than 20 million people. As Safety Net Health Plans, ACAP plans serve their members through Medicaid, Medicare, the Children's Health Insurance Plan (CHIP), health insurance Marketplaces, and other publicly-sponsored health programs. Collectively, ACAP plans cover nearly one-third of all individuals in Medicaid managed care. ACAP and its member Safety Net Health Plans have undertaken numerous initiatives over the years to identify and address health disparities in access and health outcomes among the members that they serve.

ACAP stands firmly against all forms of discrimination in health care. Its member plans have forged efforts to end discrimination and close gaps in coverage and care for LGBTQI+ individuals, for people of color, for people whose primary language is not English, and for people who live with disabilities.

For example, they have engaged in advocacy, implemented programming, and adopted enterprise-level policies to address barriers to health care, increase training for providers, and ultimately, decrease disparities in care for LGBTQI+ individuals.[15]

Other plan initiatives address culturally and linguistically appropriate services: CenCal Health of Santa Barbara, Calif., developed a bicultural, bilingual Member Services Department to assist members and partnered with local community organizations to advance health messaging. Texas Children's Health Plan of Houston mandated intensive cultural competency training for all care coordinators to ensure that all individuals receive culturally-respectful assistance.[16]

ACAP recognizes that working to reduce health disparities and to make progress toward health equity is embedded in its member Safety Net Health Plans' commitment to serve their members appropriately and effectively.

Amida Care

An ACAP member, Amida Care, is a private, not-for-profit community health plan that specializes in comprehensive health coverage and coordinated care to New York City Medicaid members with chronic conditions, including HIV/AIDS and behavioral health disorders. Amida Care has developed a specialized model of care to provide individualized attention and support to people living with HIV/AIDS and other complex health conditions. The plan helps its members living with HIV achieve and maintain viral suppression. Viral load suppression among Amida Care members has increased from 64 percent in 2016 to more than 80 percent in 2019. Of Amida Care's transgender members living with HIV, 93 percent are virally suppressed. The plan has also observed decreased numbers of emergency room visits, decreased average length of stay in hospitals, and generally lower utilization of intensive care resources, which has produced significant cost savings to New York State.[17]

Commitment to high-quality coverage and care, using data to drive programmatic decision-making, and delivering member-focused care regardless of race, ethnicity, age, gender identity, sexual orientation, location, socioeconomic status, and other characteristics are principles by which ACAP plans operate not because they have become important at this moment, but because they have long been important to the success of health plans in their efforts to improve health outcomes for their members. And yet, ACAP and its member plans recognize that there is much more work to be done.

AmeriHealth Caritas DC

AmeriHealth Caritas DC, an ACAP member, serves approximately 124,000 people in the District of Columbia through the DC Healthy Families Medicaid and the DC Healthcare Alliance programs. The plan 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. These residents include undocumented individuals, a group largely made up of racial and ethnic minority immigrants who are especially vulnerable to the impacts of the COVID-19 pandemic. By providing comprehensive health coverage through the DC Healthcare Alliance, AmeriHealth Caritas DC provides vital help to a disproportionately at-risk subpopulation with limited resources. AmeriHealth Caritas DC has been involved in several innovative programs to address racial and ethnic disparities. The plan's "Wellness Circles," which are programs designed to increase participant health literacy and improve disease control, have achieved measurable improvements in health.

61% of participants with diabetes or hypertension reduced their HbA1c levels.

55% of participants lowered their blood pressure.

55% of participants reduced BMI levels.

51% 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.[18]

ACAP's Philosophy to Approaching Health Equity

Recognizing that the advancement of health equity and the reduction of health disparities requires both tactical and systemic efforts to make change, ACAP has developed a three-pronged philosophy that it will employ to advance its future work in the health equity arena.

- **Build consideration of health equity into all future work.** By intentionally considering how each of its projects have an opportunity to affect health equity, ACAP believes that its efforts will expand and be more impactful.
- **Identify focused, targeted, achievable actions to initiate positive impact as soon as possible.** In parallel, ACAP will also support efforts that will have long-term impact on the reduction of health disparities and advancement of health equity.
- **Collaborate with other organizations and stakeholders across the health care community.** By selecting partners who share interest, strategic focus, and expertise in the areas of health equity, ACAP will maximize opportunities for learning promising practices from others' efforts and strategically exploring health equity innovations. One example is ACAP's participation in The Enrollment Coalition, along with other consumer advocates, patient advocates, health plans, health care providers, employers, technology and data organizations, and researchers who work together to support policy aimed at increasing access to health coverage for uninsured citizens.

Strategy

With its three-pronged philosophy undergirding its work, ACAP's strategy is to execute efforts that will have short-term, targeted impact while setting the stage for greater impact in the future. Recognizing that health disparities exist because of inequities that are systemic and embedded in the health system that it is seeking to improve, ACAP knows that health equity is not a short-term goal that can be resolved immediately. While this work is built for the long term, there are short-term ways to move the needle in the right direction.

ACAP will focus its efforts on three strategic themes:

- Listening and Learning;
- Measurement and Improvement Analysis; and
- Policies to Improve Health Equity.

As ACAP moves forward, insights will be learned, data will illuminate lessons, and strategic efforts will need to evolve. This is only the beginning of the long road to health equity.

II. Listening and Learning

Health Equity Learning Collaborative

The COVID-19 pandemic has illuminated the impact of inequities in the United States on health outcomes: it exacerbated the poorer health outcomes for people who live with disabilities and chronic illness that is further influenced by the physical and psychological effects of a legacy of discrimination and racism. National protests spurred by acts of police brutality against the Black community have created a political and moral imperative to address racial health disparities and injustices. Given not-for-profit Safety Net Health Plans' role in delivering care to individuals with low incomes, including many with intersecting identities (e.g., Black, limited English proficiency, LGBTQI+, living with disabilities or chronic conditions), the plans are uniquely situated to reduce health disparities and advance equity for their members and communities.

ACAP and its partner in this effort, the Center for Health Care Strategies (CHCS), have launched a new learning collaborative that will focus on how Safety Net Health Plans can advance health equity, specifically to decrease health disparities, across their Medicaid populations.

The twenty-four-month learning series will develop shared understanding of how improve health equity within the following identified topics:

- Strategy and goals;
- Data collection and analysis;
- Member, provider, and community engagement; and
- Internal staff change management.

A primary objective of the collaborative is to support each plan in developing or bolstering an overarching health equity strategic plan to address plan-related health equity priorities, assets, and needs.

Each health plan will be provided with individualized support and action-oriented, practical technical assistance tools to drive progress on the implementation of activities and tactics to advance health equity for their members. At the conclusion of the collaborative, plans will have conceptualized and operationalized a health equity strategic plan that will advance health equity for members based on local assets, context, and needs.

Plans in the Health Equity Learning Collaborative

AmeriHealth Caritas

Banner University Health Plans

CareOregon

CenCal Health

Commonwealth Care Alliance

Community First Health Plans, Inc.

Community Health Network of Connecticut, Inc.

Community Health Plan of Washington

Driscoll Health Plan

Fallon Health

Kern Health Systems

Partners Health Management

Partnership HealthPlan of California

South Country Health Alliance

VNSNY CHOICE Health Plans

Sylvia B. Kelly Medical Scholarship for Health Equity

To achieve true health equity within the health system, it is critical to ensure diversity in the educating, training, and hiring of the individuals who serve the community. It is important for them to resemble and understand the culture of the people they serve. To support workforce diversity, in collaboration with the National Medical Fellowship program, ACAP inaugurated the Sylvia B. Kelly Medical Scholarship for Health Equity. This $25,000 scholarship identifies a fourth-year medical student from an underrepresented background who has demonstrated an interest in addressing the Black maternal mortality gap and will help to significantly reduce their debt burden as they embark on their medical career.

The scholarship recipient will also have the opportunity for relationship-building and mentorship with the Chief Medical Officer of an ACAP-member plan to further their understanding of the health care system and the role that Safety Net Health Plans play in the support of patient care.

Sylvia B. Kelly

The scholarship is named for Sylvia B. Kelly, President and CEO of Community Health Network of Connecticut, Inc., a Federally Qualified Health Center-sponsored Safety Net Health Plan and founding ACAP member. Since joining the plan in February 2000, Kelly has grown the organization from serving 25,000 to nearly 1.1 million members. Under her leadership, the organization has improved health outcomes and increased access to care while reducing costs through person-centered care management, use of innovative technology, and data driven analysis.

Ms. Kelly's commitment to improving the lives of underserved low-income individuals, particularly persons of color, is a mission that ACAP hopes to instill in the scholarship recipients as they complete their studies and begin their careers in health care service.

Addressing Inequity Through the ACAP Center for SDOH Innovation

Social determinants of health, or SDOH, are defined by the U.S. Department of Health and Human Services as the conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks.

ACAP-member Safety Net Health Plans have been deeply engaged with addressing social determinants of health long before the term entered the health policy lexicon.

ACAP Center for SDOH Innovation
Addressing Social Inequities to Improve Health

To address SDOH in a more rational, systematic way and to leverage ACAP's advantages as a hub for information sharing among its member Safety Net Heath Plans, ACAP has developed its Center for SDOH Innovation to demonstrate and disseminate the leadership and promising practices of ACAP-member Safety Net Health Plans with respect to SDOH.

Addressing social determinants of health can be a powerful lever with respect to health care inequities. Deployed with careful thought and planning, they can powerfully address inequities. But at the same time, poorly-designed SDOH programs can backfire and exacerbate the problems that they are intended to address. For example, a strategy to address housing insecurity for various racial or ethnic populations may not lead to equitable outcomes if the underlying historical structure of discrimination in housing availability is not taken into account (e.g., redlining, unsafe or no housing stock in certain neighborhoods). The Center is dedicated to deploying SDOH programs in a way that will address inequities in the health care system.

III. Measurement, Analysis, and Improvement

For any initiative or program to have long-term success and impact, it must be steeped in quality measurement and analysis. Data allow plans and others to determine where health disparities exist; analysis of the data can suggest how plans can shape interventions to address those disparities in a way that delivers the greatest impact; and measurement is necessary to evaluate the outcomes of those health equity interventions. Efforts to address health disparities in the absence of data are shots in the dark likely to fall short of the improvements to which they aspire.

In *Improving Data on Race and Ethnicity: A Roadmap to Measure and Advance Health Equity*, the National Committee for Quality Assurance (NCQA) and Grantmakers in Health outline the challenges that currently exist in the nation regarding the collection of data to help advance health equity initiatives.

The "lack of complete, standardized, self-identified race and ethnicity data across federal and state health care and public health programs" is a sobering reality for the mission of health equity. Progress is necessary in the area of measurement and data in order for progress to be made toward health equity.[19]

Enhancing Medicaid Demographic Data Collection

Given that data are the lifeblood of actionable efforts to improve health equity, ACAP supports the recommendations of NORC, The Commonwealth Fund, and NCQA regarding the need to "standardize race and ethnicity data collection efforts in federal programs."[20]

ACAP recommends that CMS issue a report analyzing required efforts by State Medicaid Agencies to identify, evaluate, and reduce health disparities. Additionally, ACAP recommends that the Administration work with Congress either to appropriate funding for Section 4302 of the Affordable Care Act or have the appropriation requirement removed from the statute to enable the Department of Health and Human Services to fully implement the requirements in Section 4302, which sets standards for data collection and analysis on demographic characteristics in Federally-funded programs.

The scarcity of data is a major barrier to implementing targeted health equity efforts. By implementing these two initial steps to collect and share existing data regarding health disparities experienced by Medicaid program recipients and to standardize demographic data collection, short-term progress can be made in the effort toward improving health equity.

Mandating Maternal Health Quality Reporting in Medicaid and CHIP

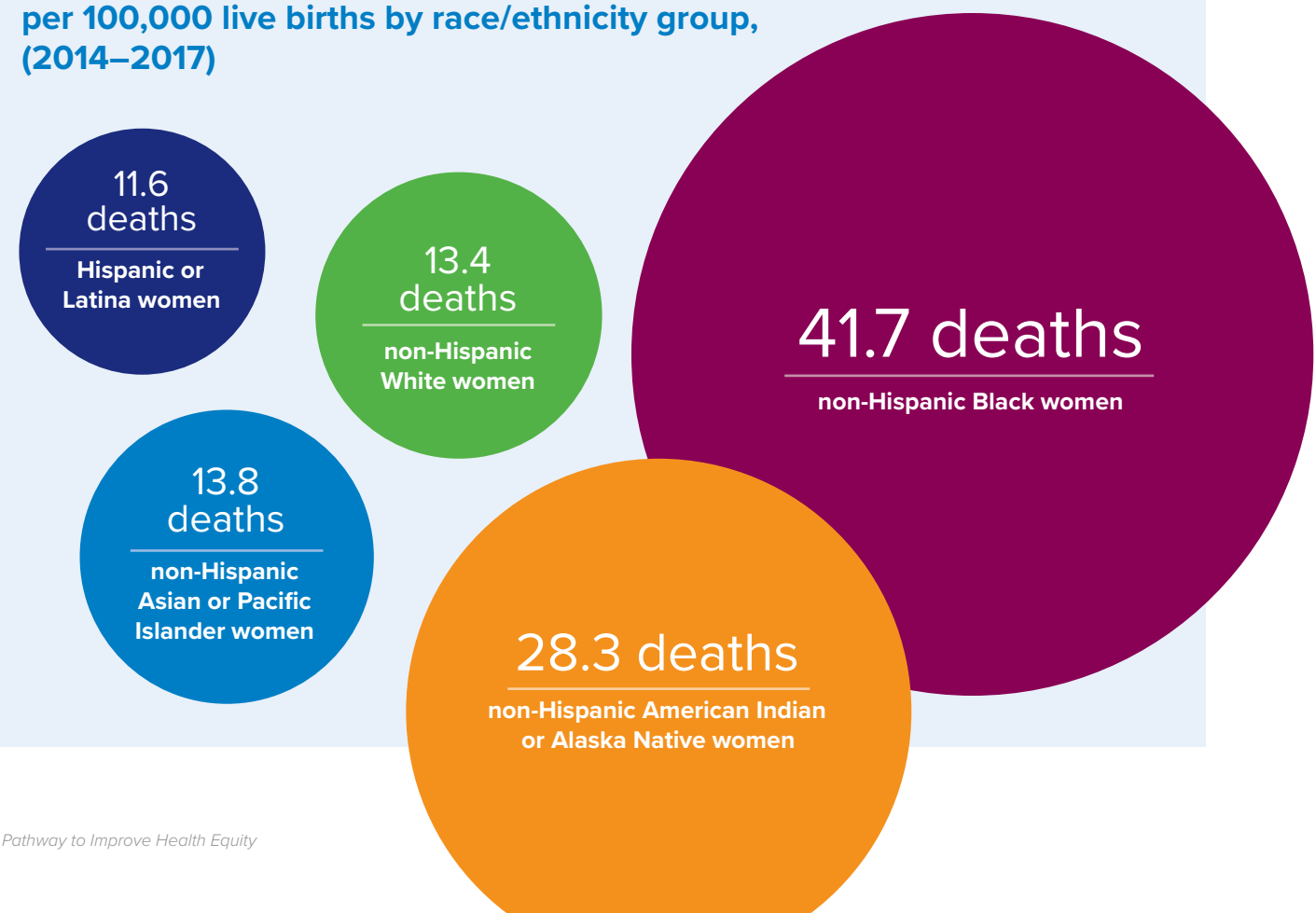
In 2018, Congress enacted the Bipartisan Budget Act, which requires states to report data to CMS on the core set of pediatric quality measures for Medicaid and CHIP starting in 2024. Later that year, Congress also passed the SUPPORT Act, which further required states to report on the behavioral health measures in the adult core measures set starting in 2024.

Reporting on these core measures is critical to providing an overview of the quality of coverage provided to Medicaid and CHIP enrollees across delivery systems. But the core measures are not currently disaggregated by demographic characteristics; the overview will lack some of the fine-grained detail that will help policymakers, plans and others assess disparities in health access and outcomes. And because Congress has not yet required states to report on the other, non-behavioral health adult core measures – including several focused on maternal health – we are unlikely to acquire a full picture of maternal health in the Medicaid and CHIP programs.

The failure to identify and address disparities in intermediate measures of care – for instance, whether new mothers receive proper checkups after delivery – can contribute to significant downstream disparities in outcomes. For example, according to the U.S. Center for Disease Control's Pregnancy Mortality Surveillance System, considerable racial and ethnic disparities in pregnancy-related mortality exist. From 2014 to 2017, the pregnancy-related mortality ratios were most significant for non-Hispanic Black women at 41.7 deaths per 100,000 live births and non-Hispanic American Indian or Alaska Native women at 28.3 deaths per 100,000 live births.[21] (see figure below)

Accordingly, ACAP urges Congress to also require states to report on all remaining adult core measures, which include several measures related to maternal health, and to take steps to stratify these data, where possible and where appropriate,[22] by race, ethnicity, sexual orientation, gender identity, language, and disability.

Select maternal mortality rates, per 100,000 live births by race/ethnicity group, (2014–2017)



Improving Race/Ethnicity and Language Data

NCQA currently requires health plans that seek to earn or maintain accreditation to report on two HEDIS quality measures that evaluate the racial and ethnic and language diversity of a health plans' enrollees in health plans. The measures evaluate the completeness of health plan data regarding the race and ethnicity and language preferences of its members. ACAP is undergoing analysis of the completion of the data of its member health plans. The goal is to understand the current performance related to the completeness of the data measures across the health plans. NCQA is currently refining its reporting requirements to provide a clearer picture of the completeness of race, ethnicity, and language data.

While most health plans note that they receive most of their race and ethnicity data from their state agency, a recent analysis of those data in CMS Medicaid (T-MSIS) analytic files shows that two-thirds of states were missing more than 10 percent of race or ethnicity data, while less than one-third (15) received a "low concern" rating.[23]

Going forward, under the auspices of the ACAP Health Equity Learning Collaborative, ACAP will work to support its member Safety Net Health Plans to address challenges in data collection and reporting and improve member plan performance. We will evaluate the available data to establish a baseline performance level, and then set an appropriate goal for improvement. Plans with less-complete data will learn promising practices from plans that have demonstrated a higher level of success in capturing race, ethnicity, and language data. Understanding the unique challenges across its member Safety Net Health Plans will also help ACAP to further refine and expand on its recommendations for improvement.

ACAP is committed to continuing to measure and evaluate member plan performance with regard to race, ethnicity, and language data collection and reporting to accurately evaluate disparities in health equity, and to support improvement efforts.

IV. Policies to Improve Health Equity

ACAP is committed to supporting policies that address the inequities that exist in the health care system. By advocating for policies that address systemic inequities, ACAP can buttress efforts to implement strategies at the health plan and health system level to equitably address those issues. Inequitable access to health coverage and the presence of other systemic inequities such as employment, housing, education, and food security exacerbate the challenges that certain populations disproportionately face.

Insurance coverage is a door that opens to access to quality provider care and pharmacy needs that are important to the physical and financial health of many families in America. Individuals who come from low-income families disproportionately experience health disparities; in part this is due to their lack of access to insurance coverage which enables them to afford care.[24] Social factors also create inequities that can impact access to health care and also outcomes. According to NCQA, "Factors cited as considerably impacting health inequity include access to nutritious food, neighborhood safety, distance to public transportation and adequate housing."[25] Reducing the inequity of health coverage and mitigating the risks of social determinants of health are key steps toward achieving health equity in the nation.

Funding Social Determinants of Health (SDOH)

People who are eligible for both Medicare and Medicaid (dually-eligible individuals) are more likely than other Medicare beneficiaries to have low incomes and to have their health outcomes impacted by social determinants of health (SDOH) such as housing, food insecurity, or challenges with transportation and obtaining and seeking care.[26] Dually-eligible individuals often have multiple chronic medical and behavioral health conditions, as well as long-term care needs.[27] In addition, they must navigate multiple health care systems across Medicare and Medicaid, their care is frequently uncoordinated, and their health and social needs are often unmet.[28]

The more than 12 million Americans who are dually eligible for Medicare and Medicaid often have multiple chronic medical and behavioral health conditions, long-term care needs, and significant SDOH needs. Most of ACAP's Dual Eligible Special Needs Plans (D-SNPs) have reported that most of their full-benefit dually eligible members have high SDOH needs. ACAP plans have developed a variety of programs and community partnerships to address those needs.[29]

CMS allows Medicare Advantage plans to offer supplemental benefits that address SDOH needs, such as non-medical food programs, transportation, and general housing supports. ACAP recommends that a SDOH Adjustment for Integrated D-SNPs be the next step to CMS' foundational work.[30] ACAP estimates that a 5-percentage-point SDOH adjustment to the rebate would give integrated DSNPs an additional $10 per member per month dedicated to funding SDOH-related supplemental benefits.[31]

Integrated D-SNPs would be required to use this funding to offer food and nutrition programs, increased transportation, programs to combat social isolation, and social worker assistance for housing support. ACAP's D-SNP members are currently directly addressing some SDOH needs through supplemental benefits. However, the SDOH adjustment would enable the integrated plans to offer even more robust SDOH programs. Additionally, dedicated funding would allow the plans to make investments into infrastructure needed to support the services for the long term.[32]

Mandating Continuous Eligibility

Medicaid and CHIP enrollees are often unjustly disenrolled from the program owing to paperwork complexities, or minor, often temporary, fluctuations in income. ACAP is a staunch advocate for continuous eligibility for all people enrolled in Medicaid and CHIP. Although ACAP recognizes that coverage alone will not eradicate disparities in health outcomes, it considers continuous eligibility to be an important tool toward achieving this goal. Although some progress has been made in this arena, particularly with the enactment of legislation to ensure coverage during the COVID-19 pandemic, there is still more work to do to ensure people have access to the care that they need.

A September 2021 Medicaid and CHIP Access and Payment Commission (MACPAC) analysis shows that 7 percent of adults churn off their Medicaid and CHIP coverage in a year; studies have found that most who lost Medicaid were either still eligible or became eligible again within just a few months. Children are not immune; the MACPAC report found that 8 percent of children on Medicaid and CHIP churned each year. This eligibility churn leads to costly bureaucratic burden for state eligibility systems, lost reimbursement for our nation's safety net providers, and most importantly, missed care for people and financial hardship for their families.[33] A 2020 George Washington University study commissioned by ACAP found that nearly 600,000 children on Medicaid would have access to preventive care visits and nearly 175,000 children would get needed specialty care if Congress were to mandate

How Continuous Eligibility for Children Will Build on Improvements to Access and Coverage

	Gains so far in the 24 states that have adopted Medicaid continuous eligibility	Total gains if the other 26 states were to adopt Medicaid continuous eligibility
Kids who have at least one preventive care visit	294,000 KIDS	**585,000 KIDS**
Kids who get the specialty care they need	93,000 KIDS	**174,000 KIDS**
Kids who have no gaps in insurance coverage	261,000 KIDS	**520,000 KIDS**

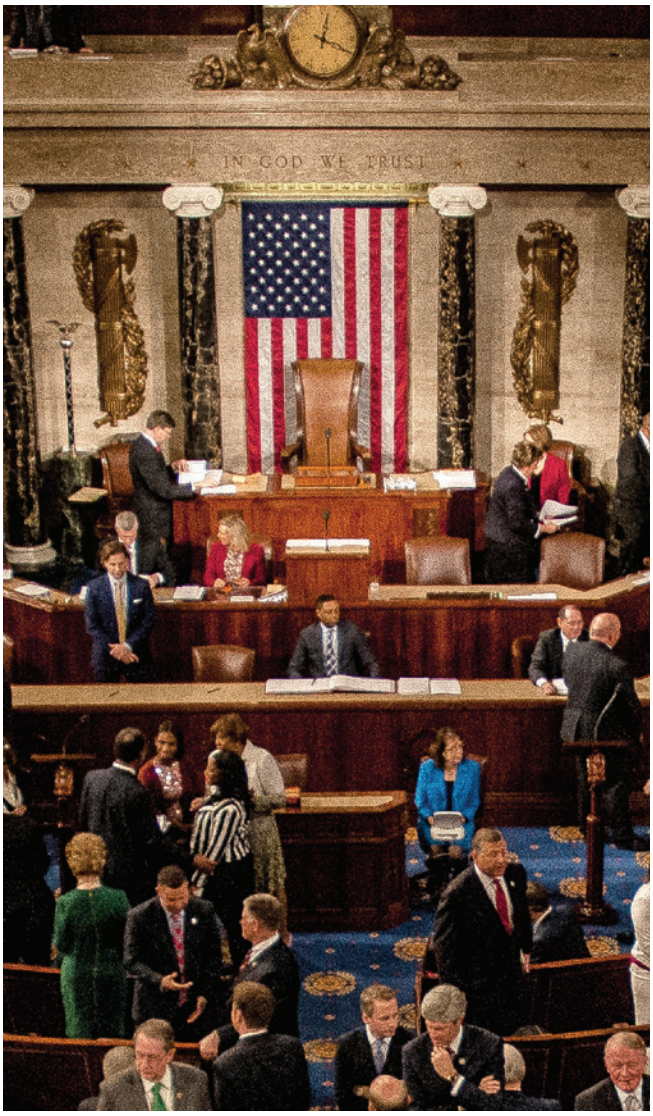
Source: Ku and Brantley, 2020, based on 2016-18 National Surveys of Children's Health

12-month continuous eligibility for children in Medicaid and CHIP.[34]

ACAP calls on Congress to enact permanent, national 12-month continuous eligibility for everyone covered by Medicaid and CHIP. States have an existing option to provide continuous eligibility for children, but only about half of states have implemented this policy in their own Medicaid and CHIP programs. The U.S. House of Representatives included 12-month continuous eligibility provisions for children as part of the *Build Back Better* Act it passed in 2021.

ACAP also strongly urges Congress to enact continuous eligibility during pregnancy and for 12 months postpartum; such provisions were also included in the *Build Back Better* Act. Medicaid pays for nearly half of all births in the United States. Unfortunately, Medicaid enrollees are 82 percent more likely to experience maternal mortality and morbidity than people who are privately insured.[35] The *Affordable Care Act's* expansion of the Medicaid program has been associated with significant improvements in maternal health outcomes, particularly for non-Hispanic Black women, and for all women during the period beginning 60 days after birth, when Medicaid eligibility currently ends for many postpartum individuals.

Still, far too many people fall into coverage and care gaps either during their pregnancies or in the months following birth, jeopardizing their health and exacerbating maternal racial and ethnic inequities. Providing stable health care coverage to everyone eligible for Medicaid and CHIP, including pregnant and postpartum individuals, has long been a top priority for Medicaid health plans. The House-passed *Build Back Better* Act included a permanent requirement for states to provide 12-month postpartum coverage in these programs; ACAP urges Congress to enact this requirement to protect the lives of new mothers.



Far too many people fall into coverage and care gaps either during their pregnancies or in the months following birth, jeopardizing their health and exacerbating maternal racial and ethnic inequities.

V. Conclusion

ACAP respectfully offers this document not as the final word on health equity, but with the understanding that these are initial steps for a long journey toward improving our health care system and outcomes for individuals who have been disproportionately impacted. This journey will require sustained, concerted effort and demand considerable flexibility from stakeholders across the health care system.

ACAP's organizing philosophy around health equity will guide its future work.

- **Build consideration of health equity into all future work.** Simply stopping to momentarily consider health equity in a deliberate, intentional way is a basic and frequently overlooked first step.
- **Identify focused, targeted, achievable actions to initiate positive impact as soon as possible.** ACAP will seek out short-term specific goals to promote progress and build momentum toward closing gaps in access and care while at the same time supporting more ambitious, longer-term goals.
- **Collaborate with other organizations and stakeholders across the health care community.** ACAP and its member Safety Net Health Plans are a powerful force for addressing health equity. But ACAP and its member Safety Net Health Plans working in tandem with allied organizations is a more powerful force for maximizing health equity efforts and accelerating improvement.

Although ACAP recognizes that these modest proposals will not resolve the systemic inequities that have led to the health disparities that have been experienced in this country throughout history and into today, it believes that these are critical first steps to begin the process toward improvement and equity.

By implementing policies to ensure continuous coverage and funding to better address SDOH, inequities can begin to be addressed. By establishing standard and complete data related to demographics and other characteristics, health disparities can be measured, interventions can be developed to address them, and improvement can be measured over time.

By listening to and learning from one another, we can expand the knowledge across states, across health plans, and across the health care system. Learning what works—and just as crucially, what doesn't—will help us address health equity as swiftly and efficiently as possible.

However, health inequities are systemic and structural – and the systemic, structural solutions that they demand are unlikely to happen either swiftly or efficiently.

The pathway to health equity is long. These efforts are but the first few steps.

Endnotes

1 Melendez, M., Ubri, P., Leitz, S., and Nye, T. Framework for Advancing Health Equity in State Medicaid Programs. 2021. Retrieved from: https://www.norc.org/PDFs/Framework%20for%20Advancing%20Health%20Equity/Framework%20for%20Advancing%20Health%20Equity%20in%20State%20Medicaid%20Programs.pdf

2 *ibid.*

3 Association for Community Affiliated Plans. The Role of Medicaid Health Plans in Addressing Racial and Health Disparities. 2021. Retrieved from: https://www.communityplans.net/wp-content/uploads/2021/02/RacialEthnicDisparities_R3b.pdf

4 Centers for Disease Control and Prevention. MMWR. Racial/Ethnic Disparities in Pregnancy-Related Deaths — United States, 2007–2016. Published November 23, 2020. Retrieved from: https://www.cdc.gov/mmwr/volumes/68/wr/mm6835a3.htm

5 Association for Community Affiliated Plans. The Role of Medicaid Health Plans in Addressing Racial and Health Disparities.

6 Centers for Disease Control and Prevention. National diabetes statistics report, 2020. 2020. Retrieved from https://www.cdc.gov/diabetes/pdfs/data/statistics/national-diabetes-statisticsreport.pdf.

7 In general, ACAP chose to use the broadly inclusive acronym LGBTQI+ unless the cited study or activity was more specifically focused; in these cases, we did our best to mirror the language used in the original source.

8 Association for Community Affiliated Plans. Safety Net Health Plan Initiatives to Improve LGBTQI+ Health Equity. 2021. Retrieved from: https://www.communityplans.net/wp-content/uploads/2021/09/ACAP_LGBTQI_Case_Studies_2021.pdf

9 Lick, D., Durso, L.E., & Johnson, K.L. Minority Stress and Physical Health Among Sexual Minorities. *Pers on Psychological Sci, 8*(5), 521-548. 2013. Retrieved from: https://williamsinstitute.law.ucla.edu/research/health-and-hiv-aids/minority-stress-and-physical-health-among-sexual-minorities/

10 Association for Community Affiliated Plans. Safety Net Health Plan Initiatives to Improve LGBTQI+ Health Equity. 2021.

11 Lee, J.G.L., Griffin, G.K. & Melvin, C.L. Tobacco Use Among Sexual Minorities in the USA, 1987 to May 2007: A Systematic Review. *Tobacco Control, 18,* 275-282. 2009.

12 Hughes, T.L. Chapter 9: Alcohol Use and Alcohol-related Problems Among Lesbians and Gay Men. *Ann Rev of Nurs Res, 23,* 283-325. 2005.

13 Cochran, S.D., Sullivan, J.G., & Mays, V.M. (2003). Prevalence of Mental Disorders, Psychological Distress, and Mental Health Services Use Among Lesbian, Gay, and Bisexual Adults in the United States. *Journal of Consulting and Clinical Psychology, 71*(1), 53-61. Retrieved from: http://www.stat.ucla.edu/~cochran/PDF/PrevalenceDisordersLGBinUS.pdf.

14 Association for Community Affiliated Plans. The Role of Medicaid Health Plans in Addressing Racial and Health Disparities. 2021.

15 Association for Community Affiliated Plans. Safety Net Health Plan Initiatives to Improve LGBTQI+ Health Equity. 2021.

16 Association for Community Affiliated Plans. The Role of Medicaid Health Plans in Addressing Racial and Health Disparities. 2021.

17 Association for Community Affiliated Plans. Safety Net Health Plan Initiatives to Improve LGBTQI+ Health Equity. 2021.

18 Association for Community Affiliated Plans. The Role of Medicaid Health Plans in Addressing Racial and Health Disparities. 2021.

19 Grantmakers in Health and NCQA. (2021). Improving Data on Race and Ethnicity: A Roadmap to Measure and Advance Health Equity. Retrieved from: https://www.ncqa.org/wp-content/uploads/2022/01/GIH-Commonwealth-Fund-federal-data-report-part-2-1.pdf

20 Melendez, M., Ubri, P., Leitz, S., and Nye, T. Framework for Advancing Health Equity in State Medicaid Programs. 2021.

21 Coalition Letter to Congress. Make 12-Month Pregnant/Postpartum Continuous Medicaid Eligibility Permanent. May 20, 2021. Retrieved from: https://www.communityplans.net/wp-content/uploads/2021/05/Congressional-Letter-Final_Plans-and-Associations-Permanency-052021.pdf

22 Not all quality measures, especially those that pertain to comparatively rare conditions or disease states, will be stratifiable across all these criteria, as there may not be a sample size of patients sufficient to generate a statistically valid result.

23 State Health Access Data Assistance Center (SHADAC). Race/Ethnicity Data in CMS Medicaid (T-MSIS) Analytic Files Updated December 2021 – Features 2019 Data. Retrieved from: https://www.shadac.org/news/raceethnicity-data-cms-medicaid-t-msis-analytic-files-updated-december-2021-%E2%80%93-features-2019

24 Whitener, K. and Snider, M. Georgetown University Center for Children and Families/UnidosUS. Advancing Health Equity for Children and Adults with a Critical Tool: Medicaid and Children's Health Insurance Program Continuous Coverage. Retrieved from: https://www.unidosus.org/wp-content/uploads/2021/10/unidosus_georgetown_continuityofcoverage.pdf

25 NCQA. Health Equity and Social Determinants of Health in HEDIS: Data for Measurement. 2021.

26 Association for Community Affiliated Plans. The Role of Medicaid Health Plans in Addressing Racial and Health Disparities. 2021.

27 Centers for Medicare & Medicaid Services Medicare-Medicaid Coordination Office. FY2019 Report to Congress. February 2020. Retrieved from: https://www.cms.gov/files/document/mmco-report-congress.pdf

28 Association for Community Affiliated Plans. Addressing Social Determinants of Health Through an SDOH Adjustment for Integrated D-SNPs. 2021. Retrieved from: https://www.communityplans.net/wp-content/uploads/2021/10/ACAP-SDOH-Rebate-Policy-Brief_final.pdf

29 Association for Community Affiliated Plans. Addressing Social Determinants of Health Through Dual-Eligible Special Needs Plans Gap Analysis and Policy Development. 2020. Retrieved from: https://www.chcs.org/media/Arnold-Ventures-SDOH-Report-FINAL.pdf

30 As used here, the term "Integrated D-SNPs" includes both Highly Integrated Dual Eligible Special Needs Plans (HIDE-SNPs) and Fully Integrated Dual Eligible Special Needs Plans (FIDE-SNPs).

31 Association for Community Affiliated Plans. Addressing Social Determinants of Health Through an SDOH Adjustment for Integrated D-SNPs. 2021.

32 Association for Community Affiliated Plans. Addressing Social Determinants of Health Through an SDOH Adjustment for Integrated D-SNPs. 2021.

33 Liu, H., and Ku, L. The Rand Blog. Twelve-Month Continuous Eligibility for Medicaid Adults Can Stabilize Coverage with a Modest Cost Increase. Published December 8, 2021. Retrieved from: https://www.rand.org/blog/2021/12/twelve-month-continuous-eligibility-for-medicaid-adults.html

34 Leighton Ku and Erin Brantley, *Continuous Medicaid Eligibility for Children and Their Health,* Center for Health Policy and Research at the George Washington University. May 2020. Retrieved from: https://www.communityplans.net/wp-content/uploads/2020/06/GW-continuous-eligibility-paper.pdf

35 Heberlein, Martha. Medicaid and CHIP Payment and Access Commission. Maternal Morbidity among Women in Medicaid. January 24, 2020. Retrieved from: https://www.macpac.gov/wp-content/uploads/2020/01/Maternal-Morbidity-among-Women-in-Medicaid.pdf

NOTES

NOTES

ACAP

Association for Community
Affiliated Plans

1155 15th Street NW, Suite 600
Washington, D.C. 20005
202.204.7508

www.communityplans.net

@safetynetplans