

## Spotlight on MCO Health Equity Efforts: Health Services for Children with Special Needs, Inc.

The NORC Medicaid Managed Care Organization (MCO) Learning Hub shares timely and relevant resources to support Medicaid MCOs and other stakeholders in improving the health of their enrollees and increasing advancements in health equity and health care transformation. We encourage you to share your experiences and feedback on future Medicaid MCO Learning Hub work so we can better serve your needs. To start the conversation or join our distribution list, please email us at [MCOLearningHub@norc.org](mailto:MCOLearningHub@norc.org).

The Medicaid MCO Learning Hub “Spotlight Series” highlights key initiatives addressing health equity that are driven by, or in partnership with, MCOs to inform the Robert Wood Johnson Foundation (RWJF) and its grantees. In addition, the series provides MCOs, community-based organizations, states, and other key stakeholders with examples of successful models of organizations working together to advance health equity.

This “Spotlight” focuses on a managed care organization’s efforts to more intentionally integrate health equity into their organization and health systems. Forthcoming Spotlight Series briefs will center on other existing initiatives and partnerships around health equity.

The World Health Organization (WHO) defines health equity as “*the absence of unfair and avoidable or remediable differences in health among population groups defined socially, economically, demographically or geographically.*”<sup>1</sup> Achieving health equity is closely related to eliminating health disparities that often affect excluded or marginalized groups, including people of color and people with low incomes, among other groups. Due to the COVID-19 pandemic, the health care crisis paired with the country’s reckoning with racial injustices during 2020 has spotlighted existing and growing health disparities and health inequities, leading to growing calls and action to address health inequities and social determinants of health (SDOH).

NORC’s Medicaid MCO Learning Hub spoke with Health Services for Children with Special Needs, Inc. (HSCSN) to discuss their efforts to mitigate systemic challenges faced

by people with disability(ies) and moving towards health equity in Washington D.C.

**HSCSN** is the contracted health care plan provider for the District of Columbia’s (DC.) Child and Adolescent Supplemental Security Income Program (CASSIP) for children and young adults. HSCSN serves children and young adults up to age 25 who live in Washington, DC and receive Supplemental Security Income (SSI) or enrolled in Medicaid through the Katie Beckett eligibility group.

### Background

Q: Please describe your health plan and the services you provide?

HSCSN has been the sole source contractor for the District of Columbia’s CASSIP for nearly three decades. One of

<sup>1</sup> World Health Organization, [https://www.who.int/health-topics/social-determinants-of-health#tab=tab\\_3](https://www.who.int/health-topics/social-determinants-of-health#tab=tab_3)

four MCOs providing services to individuals requiring health care coverage, HSCSN's mission is to coordinate innovative, high-quality, community-based care for individuals with complex needs and their families. HSCSN has served over 17,300 beneficiaries and impacted over 100,000 lives since its inception in 1996. Today, HSCSN serves over 5,000 CASSIP eligible beneficiaries. Criteria for obtaining coverage begins with meeting the Social Security Administration (SSA) Disability Determination; other qualifying factors include financial and clinical identifiers associated with increased risk for a chronic, physical, and/or developmental condition(s). Enrollment into the plan is voluntary, and the enrollee and/or guardian can cancel coverage at any time. Families can exercise their choice to select CASSIP services upon initial outreach and continue coverage until the child ages out of the program or selects to disenroll. Each enrollee's care manager works with the enrollee, their families, and their providers to develop comprehensive [health] care plans, identify necessary services & supports, and coordinate access to health and relevant community-based programs. Our approach to care embodies the person-centered model.

HSCSN provides a full array of benefits and services tailored to meet enrollee needs. Covered services include medical care, dental services, behavioral health services, drug and alcohol abuse services, non-emergency medical transportation, preventive services through the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) program.

Embedded in our approach is the hub-and-spoke model, ranging from individualized care management and case coordination to managing utilization, while growing a diverse provider network that is explicitly focused on meeting the demands for individuals with disability or otherwise medically complex needs. To address barriers, HSCSN considers the totality of the health care experience when identifying gaps in services, pinpointing the root causes of access limiting factors so that we may be proactive in managing population health.

Combating health disparities frequently has more to do with the ability to access necessary services in one's neighborhood than individual health literacy. To promote widespread use of preventive and timely care, HSCSN care coordination efforts remove barriers to health and wellbeing by connecting families to community-based supports (i.e. therapies, enrichment, educational organizations, government agencies, etc.) that provide resources and tools they need to overcome the social determinants of poor health, in their neighborhood whenever possible.

HSCSN has also adjusted our referral and authorization requirements to ease access to health care services. Enrollees do not need authorization for any primary care visits and certain specialties, including dental and mental /behavioral health services, are accessible without prior authorization.

The COVID-19 pandemic has brought social and racial injustice and inequity to the forefront of public health. It has highlighted that health equity is still not a reality as COVID-19 has unequally affected many racial and ethnic minority groups, putting them more at risk of getting sick and dying from COVID-19. We also learned that technologies for video visits, online appointment scheduling, and remote therapies are not equally accessible to the most vulnerable communities in our region. HSCSN's engagement with community leaders, disability advocacy groups, and other grassroots programs have created new opportunities for providing innovative and practical services to our Enrollees while closing gaps revealed and widened by the pandemic.

## OTHER HSCSN HIGHLIGHTS & PROGRAMMING

**Transitionally aged groups**, those in the 21 to 26 year age range, are particularly vulnerable to experiencing gaps in necessary preventive care and screenings. As they begin to identify and access adult health services, the transition from pediatric wraparound to adult care can be overwhelming for enrollees and their families. Although HSCSN Care Management Team's planning for transition begins at age 16, enrollees need significant support in order to successfully navigate their care without comprehensive care management as an adult. HSCSN also recognizes that many of our enrollees disconnect themselves from being identified or labeled as having a disability during their adolescent years because of the social pressures that come along with being "different" in any way – so we implemented targeted care coordination efforts specific to this age group. We host young adult support groups, collaborating with workforce programs, and partnering with community-based organizations (CBOs) with services dedicated to and designed for teens and young adults.

For example, we have a grant with the [National Alliance to Advance Adolescent Health](#) (NAAH) to pilot a program that addresses transitional services for young adults with disability(ies) or medically complex needs. This program focuses on delivering targeted health education in settings that allow for more frequent and meaningful engagement than traditional outreach efforts. We are also studying this work, NAAH is reviewing survey, focus group, and utilization data to determine if wraparound services contribute to sustainable health outcomes. Due to

physician office closures/changes related to the COVID-19 pandemic, this program was adjusted to include virtual engagement.

Throughout its history, HSCSN has strived to **address socio-economic factors** affecting our enrollees' access to care. In addition to programming on topics of job readiness, individualize education program (IEP), and community food resources, we provide transportation services, an essential factor for access to health care. We offer transportation through our Care Navigation (C.N.) Department, coordinating access with various mobile units, and HSCSN's vehicle fleet service.

HSCSN also has several internal programs that focus on priority groups by age, health condition, and geographic location, focusing on sustaining positive health outcomes. Managing maternal and prenatal care is at the forefront of our early intervention curriculums. Assisting enrollees with access to doula programs, identifying governmental assistance benefits, and facilitating health education wellness programs have encouraged our enrollees to be highly engaged after their child's birth, increasing continuity of care for moms and babies.

## Defining Health Equity

**Q: How does your organization define health equity?**

The [Annie E. Casey Foundation website](#) has a good definition of health equity as "the state, quality or ideal of being just, impartial and fair." We look at equity as fairness and impartiality.

**"The service we provide is for individuals who require assistance with navigating and accessing quality health care services- that's what we do as a health plan. We are more than an average health plan. We are a CASSIP program and that in itself makes us unique. Being able to coordinate care for the most vulnerable populations whose voices are not sometimes heard or who have difficulty managing the multiple providers who care for their loved ones is the work that we provide- "It's who we are as a health plan.**

The concept of health disparities has been evolving over the last 20 years. For HSCSN, health disparity is about access beyond race and ethnicity, it encompasses a range

of socio-economic and SDOH factors that affect our population, and we work with community partners to help reduce those barriers to health and wellbeing.

Our plan serves an enrollee population with identities that are disproportionately exposed to environmental and social factors that lead to poor health - our enrollees are 90% Black/African American, 97% have household incomes under 300% FPL, and 15% speak a language other than English.

As a health plan, our most valuable tools to address the health disparities that exist in our region are our provider network (services), enabling services like transportation and care coordination (access to care), and community partnerships (referral pathways). We leverage these to ensure that fair and equitable services are afforded and available. We think of health care as being driven by the medical home, which drives the rest of the enrollee's care. Our Care Navigation team does the direct work of removing barriers to care on the individual level by coordinating medical appointments for every enrollee, tracking and closing gaps in preventive care, and reporting trends to plan leadership so that we partner with providers and community organizations that have the right resources for our enrollees.

**Q: Please explain HSCSN's efforts to advance health equity?**

### ENROLLEE ENGAGEMENT

Membership in the health plan is voluntary. HSCSN's engagement with potential enrollees begins with health education activities, school engagement, and community-based meetings, including media campaigns centered on promoting healthy behaviors. Once a potential enrollee is interested in the CASSIP services, the enrollee and/or family members initiate the required documentation process through governmental agencies for enrollment consideration. Apart from the clinical and financial documentation needed, they must meet the SSA Disability Determination. Once an enrollee referral is submitted for services, HSCSN completes a comprehensive assessment to determine the level of service required before assigning a care manager. Every enrollee will consent to coverage before any service and/or benefit is provided.

Once an enrollee is in our health plan, we can inform them about our wellness support services, from healthy living to medication management. Each enrollee has a care manager and team that works with them to provide comprehensive care coordination services, including our

unique home modification services tailored health education activities. Besides the educational outreach through our wellness program, we are engaged with several community-based partners who address our membership's health related social needs. Our community stakeholders are critical to helping the enrollee have the one-to-one care needed to reach their health goals. Our partners support the wraparound and HSCSN whole person and family-centered approach. Our programming and referral pathways drives enrollee engagement and increases their willingness to stay engaged in their health care and maintain health behaviors – key individual aspects of erasing poor health outcomes and moving toward erasing inequity.

**“When individuals choose to be in our plan they are looking for us to be their advocates and to help coordinate their care so that the family member and child gets more than simply selecting to go to the primary care physician or eye doctor. We sit in on meetings to develop individualized action plans, attend IEP meetings, and become an extension of the family. Our plan is family focused first.”**

Eighty percent of HSCSN's membership meet their yearly service visit goals, this means that they are seeing their doctor regularly and participating in age and condition appropriate screenings that contribute to long-term health. HSCSN is able to achieve this by building and maintaining and positive working relationship with our enrollees and their families. One of HSCSN's priorities is helping families achieve their overall health outcomes identified within their care plans. Our goal is to ensure all enrollees can access high-quality health care, understand the health resources available, and be able to utilize the services where they live in pursuit of optimal health.

## INDIVIDUALIZED APPROACH TO CARE

Our plan endeavors to engage the enrollee where they are. Although there is a rich landscape of government and community-based social supports to meet the needs of D.C. residents, it can be difficult to navigate alongside complex medical needs. Sometimes our enrollees lean on us to do things outside the scope of a standard health plan, which happens a lot with health plans that primarily serve children. As a small health plan, we have the challenge of providing a broad range of services to meet enrollee needs in a way that is comparable to our MCO counterparts with membership and budgets 20-fold larger than our own.

## COMMUNITY NEEDS ASSESSMENTS

Our data analyst and accreditation specialists have compiled a list of needs that are closely aligned with [DC's Community Health Needs Assessment](#). On the list, they identified access to health services, nutrition weight status, reducing the new annual HIV infections, and reducing the portion of persons with poor control of diabetes. They have specific goals set out for the D.C. community, and we have activities that align with more than half of them. For example, we have eight disease categories that we focus on, some of which are:

- Asthma and attention-deficit/hyperactivity disorder (ADHD) because they are highly prevalent;
- HIV, because it is a high priority of D.C.;
- Sickle cell anemia disease, which has a low prevalence but is a high priority for D.C., and
- Oral health, in which we are making strides; D.C. has the highest rate of oral health compliance of any Medicaid program in the country, and HSCSN is part of that.

Addressing disparities is a high priority for us, but we consider all of our enrollees to be in need of these services. We are connected to the [DC. Health Matters Collaborative](#) and conduct community health needs assessment. This coalition of health care organizations came together to address the needs of our population, remove silos between health care and social services, and combine resources.

## SOCIAL DETERMINANTS OF HEALTH

Addressing SDOH is imperative to helping our enrollees achieve and maintain good health. Ninety percent of our enrollees live in an area considered a food desert. There is a lot of interest in putting as many resources as possible into that particular area to combat that disparity. Our engagement strategies are structured to meet enrollees where they are and identifying resources beyond health access. We take a unique approach to how and what our community outreach representatives work with enrollees. Other MCOs have outreach teams whose activities are less focused on engaging populations especially vulnerable to poor health outcomes due to social and environmental factors. When individuals are referred to us, we have a community outreach team that goes out to the community meets with the enrollee to complete a detailed needs assessment. We enter the relationship knowing that there are health care needs, and our community outreach representatives are especially skilled at teasing out the health related social needs like food, transportation and housing. This allows HSCSN to understand what needs

are most salient for our enrollees and their families so that we may partner with organizations that have the resources to address those needs. Our team also leverage findhelp.org (also known as Aunt Bertha) to make referrals.

As of May 2020, our referrals are tracked in Aunt Bertha; we have six months' worth of data. Housing and food insecurity were the most common reasons for referral, by far, followed by childcare. The findings are consistent with other data regarding SDOH needs in the region. About 25 percent of resources, such as CBOs, within Aunt Bertha, can accept an electronic referral and provide confirmation when enrollees use the service.

The DC Health Matters website, a one-stop resource for online access to community health services but to be linked to and counted in our data; referrals are coordinated through a HSCSN care manager or care navigator. This allows us to track the data, follow the data, determine the usefulness of resources, and then identify resource gaps.

## PARTNERSHIPS WITH CBOs

We leverage our community partnerships to build our team's capacity for addressing health related social needs, and increase our internal awareness of community resources, this allow us to take a truly interdisciplinary approach to serving our enrollees as whole people. The two way communication also helps our partners keep the disability community in mind as they design and promote their programs. We connect with a broad range of stakeholders including interfaith groups, social organizations, parent advocacy focused agencies, and schools. For example, we identified that many of the male caregivers for children enrolled in HSCSN did not have an outlet to discuss their own needs. We worked with Georgetown University, their students, and this population to develop a program to provide them with a setting to them to talk about their needs as parents and caregivers of a medically complex family member. Our model for the Male Caregiver Support Group has been recognized nationally.

Our partnerships have also underscored the importance of connecting with local schools. To this end, we have been providing wellness and parent support programs for over 10 years at, River Terrace, a school campus where we have provided programming for parents and young adults, health literacy, music, athletics, and more. These programs take place at the school site, which provides resources from both the community and health service perspective. Through our partnerships with River Terrace, we have created a blueprint for providing care coordination services within the school context.

## INTERNAL HEALTH EQUITY EFFORTS

One of the HSCSN four organizational goals is maintaining a company culture that supports diversity, equity, and inclusion of staff, partners, and communities we serve. As part of our commitment to our enrollees, community, and providers, we recently adopted a culturally and linguistically appropriate services (CLAS) policy. To do this, we completed an analysis of the culture groups, religions, and languages, of our enrollees and employees to inform our CLAS policies. We also know the importance of culturally appropriate care so we are working with providers to help them to get them trained and certified in CLAS.

Our care managers are highly trained, and in many cases licensed clinicians (RNs and Social Workers), who are skilled at responding to the needs of families from low socio-economic status backgrounds. We are also proud to share that 90 percent of our staff identify as Black/African American or Hispanic/Latino. Our provider network is also diverse, representing over 20 nationalities and provider services in more than 100 languages. To ensure that our enrollees have positive experience in the care setting, we also require network providers to complete cultural competency training, which also focuses on caring for people with disabilities.

## Challenges and Lessons Learned

### Q: What have been the challenges and lessons learned to date?

#### DATA CHALLENGES

Our most salient issue is around contact information - we have 15 to 20 percent of enrollees that are difficult to reach due to inaccurate or incomplete contact information. To overcome these challenges we are using every tentacle we have, from pharmacies to primary care physicians to the health information exchange, to get this data. For example, in 2020, we implemented text messaging as an additional method of communicating with our enrollees. Three years ago, we did not have email addresses or mobile phone numbers and were trying to differentiate between landline and mobile numbers. A big part of engagement is communicating with people in the method in which they want to communicate.

## ENROLLEES' SOCIO-ECONOMIC CHALLENGES

Housing insecurity and homelessness is a complex issue for our enrollees. While there are record highs of individuals at risk of losing their home due to the economic impacts of COVID 19 pandemic, there are many layers to the housing crunch in our region. We are working with our national and local partners now to get ahead of what may be a housing crisis after rent moratoriums are lifted.

The 'digital divide' is felt by our enrollees, those who do have access to the internet do so from a smart phone, and because of competing household priorities, many do not have reliable internet connection or a computer.

Educational support, whether through the development of IEPs or connecting to tutoring and enrichment programs, is critical to children who are managing chronic or complex medical conditions.

## Conclusion

Based on our conversation with HSCSN, there are various considerations for MCOs and other key stakeholders seeking to advance health equity efforts:

- Key elements to conducting health equity work include:
  - **Value members as individuals** by looking at the whole person in order to better serve their needs.
  - **Engage members where they are** by providing care managers that will go to the member to complete assessments and explain member services.
  - **Partner with community organizations** to understand the community the MCO is working for and to better provide services where the members are.
- **Develop regional partnerships across health plans, health care entities, and community health centers** to help breakdown siloes and improve access to SDOH data and services, align missions, and provide incentives in order to better identify, understand, and address community SDOH needs.
- When building a culture of health equity within their organization and across their health systems, MCOs should:
  - **Collect contact information that identifies the preferred communication mode for members** so that communication lines between the MCO and member can stay open via the mode preferred by the member.

- **Help break down access barriers to education and/or certification requirements for future providers** so that more people of diverse backgrounds can become a part of the health care workforce.

\*Interview has been edited for length and clarity.

### ABOUT NORC MEDICAID MCO LEARNING HUB

The key goal of the NORC Medicaid MCO Learning Hub is to serve as a source of information, expertise, and best practices to support managed care organizations in moving forward with system reform. NORC and its partner organizations identify, develop, and disseminate promising approaches and emerging opportunities for MCOs to improve the physical health, behavioral health, and social needs of their members.

Your ideas and opinions are important to us. We welcome your feedback on future Medicaid MCO Learning Hub work or programs you are working on to better serve your needs.

**We want to hear from you. Please contact us at [MCOLearningHub@norc.org](mailto:MCOLearningHub@norc.org) to start the conversation or join our distribution list.**

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